



CASER INTEGRAL HEALTH
Health Insurance
Health care Policy

General Conditions

CAJA DE SEGUROS REUNIDOS

Compañía de Seguros y Reaseguros, S.A.

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In compliance with Article 3 of Spanish Act 50/80, dated 8 October, on Insurance Contracts, the clauses in the Policy's General Conditions that restrict the rights of the Insured are written in bold type.

This contract is governed by Act 50/1980, dated 8 October, on Insurance Contracts, by Spanish Legislative Decree 6/2004, dated 29 October, by means of which the revised text of the Law on Private Insurance is approved, and its Regulation.

The Authority that monitors the activity is the Spanish Ministry for the Economy and the Treasury, through the Directorate General for Insurance and Pension Funds.

Should the Spanish and English version of the hereby policy differ in any way, both parties agree that the Spanish version and interpretation will prevail.

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GENERAL CONDITIONS

PRELIMINARY ARTICLE

This Insurance Contract is governed by the provisions in Act 50/1980, dated 8 October, on Insurance Contracts (Spanish Official Gazette of 17 October 1980), by Royal Legislative Decree 6/2004, dated 29 October, by means of which the revised text of the Law on Private Insurance is approved, by its Regulation (Royal Decree No. 2486/98, dated 20 November) and by the covenants in this Contract's General, Specific and Special Conditions. Insurance companies are controlled and supervised by the Department for Insurance and Pension Funds of the Spanish Ministry of Finance.

The Policyholder, by signing this application, the Specific Conditions and the Insurance Certificate, expressly excepts the clauses in bold type that restrict the Insured's rights.

ARTICLE 1. DEFINITIONS

In this contract,

ACCIDENT means: Bodily injury suffered while the policy is in force, due to a sudden, violent, external cause that was not intended by the Insured.

INSURED means: The natural person or legal entity who, in the absence of the Policyholder, assumes the obligations set forth herein. Unless expressly stated otherwise in the Specific Conditions, the Policyholder and the Insured shall be the same person.

INSURER means: The legal entity that assumes the contractually convened risk at this CAJA DE SEGUROS REUNIDOS, Compañía de Seguros y Reaseguros, S.A. policy (hereinafter, the Insurer).

SPECIAL HOME CARE means: Care of the Insured by a general or family physician, and by a Nurse (A.T.S., in Spanish) or a nurse with a diploma in health education (DipHE), at the home stated in the policy, when the illness requires special care but not a hospital stay, and providing one of the Insurer's physicians has prescribed the home care.

NURSE /DIP HE means: A professional who is officially authorized to perform nursing activities.

SPECIFIC CONDITIONS means: An integral part of the policy, in which concrete and specific aspects of the insured risk are described.

HEALTH QUESTIONNAIRE means: A document with all of the data that needs to be known by Insurer in order to assess a risk, and that the Policyholder and/or Insured must complete fully and accurately before signing it.

DISEASE means: Any changes to the Insured's health, other than an accident, that has been diagnosed by a physician and that requires health care, the first symptoms of which appeared while the policy was in force.

CONGENITAL DISEASE, LESION, DEFECT OR DEFORMITY means: Birth defects due to hereditary factors or acquired during gestation until the moment of birth. A congenital disorder may appear and be recognised immediately after birth, or it may be discovered later on, at any point during the Insured's lifetime.

PREEXISTING DISEASE means: A disease suffered by the Insured prior to the date on which the policy was taken out.

FRANCHISE means: The sum that the Policyholder is to pay the Insurer for each health care service utilized by the Insured who are included in the Policyholder's policy. This sum will vary according to the health services and/or medical specialties and their cost, which are described in the Specific Conditions, and may be updated annually.

HOSPITAL means: Any centre which is authorised to treat diseases and bodily injuries medically and surgically, either in an out-patient service or in hospital. The centre shall have a permanent medical staff and admission shall only be for people who are ill or injured.

Hotels, residential homes, rest and convalescence homes, spas, institutions that house and/or treat drug-addicts and alcoholics, and similar institutions shall not be considered as hospitals.

HOSPITALIZATION means:

- General Hospitalization: The fact that a person has been admitted as a patient in a hospital and spends the night in a hospital or has a main meal there.
- Out Patient Unit: The fact that a person has been admitted as a patient in Day Patient Units, whether they are medical, surgical or psychiatric, to receive concrete treatment or because they have been under the effects of an anaesthetic, but have not spent the night in a hospital and have not taken a main meal there.

SURGERY means: Any operation involving an incision or any other type of internal approach, performed by a surgeon at an authorised institution, and that normally requires the utilization of an operating room.

LIST OF PHYSICIANS means: A published list of professionals and health institutions in each province that either belong to the Insurer or have an arrangement with them, with their address, telephone number and visiting hours. Apart from the physicians and health institutions in the province, each provincial listing includes all of the information services and help lines for the Insured throughout Spain.

PHYSICIAN means: A professional who is officially authorised to practice Medicine.

SPECIALIST DOCTOR OR SPECIALIST means: A physician who is entitled to practice Medicine in one of the officially recognised specialities.

CHILDBIRTH means: A normal pregnancy carried to term shall mean births that occur 37-42 weeks after the last menstruation. A premature birth shall mean births that occur between 28-36 weeks of the gestation period.



LAPSE IN COVERAGE means: A time period during which some of the coverages included in one of the policy's warranties are void. The said period is computed by months counted from the date on which the policy came into effect for each one of the Insured.

DISPUTABILITY PERIOD means: A time period counted from the date the policy became effective for each of the Insured, during which the Insurer may refuse to cover the benefits or impugn the contract by alleging that the Insured had a pre-existing illness that was not stated when completing the Health Questionnaire. After the disputability period, the Insurer shall base their claim on the Insured's wilful omission.

POLICY means: The document or documents that contain clauses and covenants that govern the Insurance Contract. They are an integral and inseparable part of the policy: Insurance Application form, Health Questionnaire, General Conditions, Specific Conditions for each separate risk, and the Special Conditions, if any, as well as any Supplements or Schedules that record any changes made while the contract was in force.

BENEFIT means: The Health care provided after an event has occurred.

PREMIUM means: The price of the insurance. In addition, a premium receipt includes any lawful surcharges, taxes and rates. Insurance premiums are annual, although they can be paid by instalments.

PROSTHESIS means: Any element that temporarily or permanently replaces the absence of an organ or a member, either in full or in part.

REHABILITATION means: Any acts directed by a physician who holds a degree as a specialist, who is assisted by physiotherapists and works in a proper rehabilitation centre, who restores the functions of a part of the locomotion system that has been affected by a disease or accident caused while the policy is in force.

EVENT means: An occurrence which causes the need to use the health services that are covered, either in full or in part, by the policy.

CASER SALUD CARD means: A document belonging to the Insurer that is issued and given to each Insured included in the policy for their personal and exclusive use, and that is required in order to receive the services covered by the policy.

POLICYHOLDER means: The natural person or legal entity that enters into this contract with the Insurer, and who assumes the obligations herein, except for the ones that are to be met by the Insured.

EMERGENCY means: A situation in which the Insured requires immediate medical care in order to prevent irreparable damage to his/her health.

ARTICLE 2. PURPOSE

Within the limits and provisions set forth in the policy, and by means of the payment of the premium and franchises due in each case, the Insurer undertakes to provide the



Insured, in Spain, with the necessary medical, surgical and hospital care for any illness or injury that is described in the policy's coverage.

In all cases the Insurer assumes emergency care set forth in the policy's terms and conditions, and pursuant to Article 103 of the Insurance Contracts Act.

Health care services shall not be replaced by indemnities in cash under this Health care insurance contract.

ARTICLE 3. COVERAGE

The specialities, health care provisions and other services covered herein are:

1. FAMILY MEDICINE

General Medicine/Family Doctor: Health care in a surgery or at home. In the latter case, providing the sick person is unable to go to the surgery for medical reasons.

Paediatrics – Childcare: For children under 16, including preventive care and childhood development.

Nurse/DipHE nurse care: At the surgery and at home. In the latter case, providing the sick person is unable to go to the surgery for medical reasons and with a prior prescription by one of the Insurer's physicians.

2. EMERGENCIES

Emergency Health care shall be provided in the permanent (24 hour) emergency centres given in the list of practitioners and health centres that have an arrangement with the Insurer. The care shall always be home care when the patient's conditions so requires, and shall be provided by one of the Insurer's general physicians and/or nurses.

3. SPECIALITIES

Health care as an out-patient or at a hospital (according to the criteria of one of the Insurer's physicians), in the specialities listed below:

3.1. Allergology. The cost for vaccinations shall be met by the Insured.

3.2. Anaesthesiology and Resuscitation. Treatments for pain are included, providing they have been prescribed by a physician who is on the list of practitioners, in relation to the pathology.

3.3. Pathological Anatomy

3.4. Angiology and Vascular Surgery.

3.5. Digestive System.

3.6. Cardiology. Includes cardiovascular risk prevention in people over 45.

3.7. Anorectal Surgery. Proctology.

3.8. Arthroscopic Surgery.

3.9. Laparoscopic Surgery.

3.10. Cardiovascular Surgery.

3.11. General Surgery and Digestive System Surgery. Includes laparoscopy.

3.12. Maxilla-Facial Surgery.

3.13. Paediatric Surgery.

3.14. Plastic Surgery and Repair Surgery. Includes breast reconstruction after a radical mastectomy undergone by the Insured while the policy is in force. Includes breast prosthesis.

3.15. Thoracic Surgery.

3.16. Medical-surgical dermatology and venereology. Treatments that are purely for beauty purposes are not included.

3.17. Endocrinology and Nutrition.

3.18. Geriatrics.

3.19. Haematology and Haemotherapy. Autologus (self) bone marrow transplants are included.

3.20. Immunology.

3.21. Infectious and Tropical Diseases.

3.22. Internal Medicine.

3.23. Nuclear Medicine.

3.24. Nephrology.

3.25. Neonatology.

3.26. Pneumonology.

3.27. Neurosurgery.

3.28. Clinical Neurophysiology.

3.29. Neurology.

3.30. Obstetrics and Gynaecology.

- a) Pregnancy and Birth Insurance/Control: Pregnancy monitoring by an obstetrician, and care during childbirth/caesarean deliveries.
- b) Family Planning: Control of anovulatory treatments, intrauterine device implantation and check-ups, including the cost of the I.U.D. Tubal ligation.
- c) Preventive medicine: An annual gynaecologist check-up for the early detection of breast and cervix neck neoplasias. Studies and diagnostics of infertility and sterility are also included, as well as laparoscopic gynaecological surgery.
- d) Control and treatment of menopause.
- e) Assisted reproduction: For treating sterility in couples. Coverage includes the study, diagnosis (with the usual complementary studies and processes) and treatment of infertility in couples, up to **3 attempts at artificial insemination and 1 attempt at in vitro fertilization**. ICSI (Intracytoplasmic Sperm Injection) is also included, if needed. **The age limit for applying the above techniques is set at 40 years of age. Treatment is not included if the sterility was caused voluntarily or if it the consequence of a natural physiological process. An essential requirement of this coverage is for both members of the couple to be insured. The waiting period is 24 months.**

The treatment shall be given in medical centres and hospitals, by physicians designated by the Insurer, who do not necessarily have to work in the same province where the Insured resides.

Assisted reproduction techniques shall be performed according to current legislation.

3.31. Dentistry/Stomatolgy. This coverage only includes tooth extraction, stomach cures due to the former, X-rays and tooth cleaning once a year, prescribed by one of the dentists/stomatologists on the Insurer's list of practitioners.

3.32. Ophthalmology. Includes laser photocoagulation and cornea transplants. The cost of the cornea to be transplanted shall be met by the Insured.

3.33. Medical Oncology. Implantable endovenous perfusion reservoirs used in chemotherapy are also included.

3.34. Oncological Radiotherapy.

3.35. Otorhinolaryngology.

3.36. Clinical Psychology. Includes individual and temporary psychological care, on an out-patient basis, prescribed by a psychiatrist who is on the Insurer's list of practitioners, when the reason for the care is to treat processes that may require psychological sessions, up to a maximum of 20 sessions per Insured and year.

This coverage includes **Child Psychology**: 20 sessions per year with a specialist who is on the Insurer's list of practitioners, for Insured's who are under 16.

The Insurer's prior authorization is needed in order to provide child psychology treatment.

Not included: psychoanalysis, hypnosis, out-patient narcolepsy, sofrology, psychological and psychometric tests, psychoanalytical psychotherapy, and psycho-social or neuropsychiatric rehabilitation.

3.37. Psychiatry.

3.38. Rehabilitation and Physiotherapy. Only if prescribed by one of the Insurer's specialised physicians and in one of the health centres or hospitals that are on the list of practitioners.

3.39. Rheumatology.

3.40. Traumatology and Orthopaedic Surgery. Ozone therapy for slipped disks is included.

3.41. Urology. Includes vasectomies, diagnostics of impotence (but not treatment for impotence), and the study and diagnosis of infertility and sterility.

4. DIAGNOSTIC METHODS

Diagnostic tests shall only be carried out when prescribed by one of the Insurer's physicians. Coverage includes the usual diagnostic methods acknowledged by medical practice at the time that the policy was taken out. **It does not include diagnostic methods related to studies and research (for scientific purposes).** The contrast methods and radio-pharmaceuticals used are also included in the coverage.

- Medical analyses: biochemistry, haematology, microbiology, parasitology, surgical pathological anatomy, cytopathology.
- Conventional radiology.

Other diagnostic methods:

- Radiodiagnostic: includes normal diagnostic methods, such as digital arteriography, angiography, bone densitometry, ultrasound, mammograms, and non-invasive radiology.
- Nuclear Medicine. Radioactive isotopes and Gammagraphy.
- Nuclear Magnetic Resonance (NMR)
- Computerized Axial Tomography (CAT/Scanner)

- Positron Emission Tomography (PET): included only in the cases and for the purposes defined and accepted by the competent official Spanish institutions.
- Tomography taken by means of an array of detectors (DMD): only for vascular system pathologies.
- Endoscopies: including the capsule endoscopy method.
- Heart diagnostic. Electrocardiogram, the physical strain test, Echocardiography, Holter, Doppler and Haemodynamics.
- Medical Neurophysiology: Electroencephalography and electromiography.
- Triple Screening, Amniocentesis and Fetal Karyotype Studies in difficult pregnancies.
- Polysomnography. Only for studying the obstructive sleep apnoea syndrome.
- Invasive or surgical radiology.
- Sentinel gland detection. Breast pathologies.

5. HOSPITALIZATION

Hospitalization shall be in the Insurer's own hospitals or hospitals with which they have an arrangement, following a physician's orders. Patients shall be in an individual room equipped with a bath and a bed for an accompanying person (unless this is obviously impossible), except in the cases which are expressly not included. The cost of the operating room, anaesthetic products and medicines used during surgery and during the hospital stay, dressings and the patient's maintenance for the duration of the stay shall be met by the Insurer.

5.1. Medical hospitalization (with no surgery): The duration of the hospital stay shall be decided by the Insurer's physician who is in charge of the case, until the physician deems that the patient is ready to go home. One-day hospital stays are included.

5.2. Paediatric hospitalization: Includes conventional hospitalization and incubator stays (in the latter case, a bed for the accompanying person is not included). Coverage also includes the hospitalization in a specialised (neonatology) hospital of premature babies and newborns with pathologies.

5.3. Hospitalization due to maternity: Assisted by an obstetrician and a midwife. Includes anaesthesia (including epidural anaesthesia), as well as a crèche and incubator for the newborn child.

5.4. Hospitalization for surgery: One-day hospital stays are included (major out-patient surgery).

5.5. Hospitalization in an Intensive Care Unit (I.C.U.): In hospitals designated by the Insurer, at the orders of one of the Insurer's physicians, and in the appropriate

facilities. The Head of the Intensive Care Unit shall decide how long the patient will remain in the unit. **Given the nature of an I.C.U., a bed for the accompanying person is not included.**

5.6. Psychiatric hospitalization: Only for patients who have been diagnosed by one of the Insurer's specialists, in order to treat an acute attack that is curable, either as an inmate or at a day hospital, **up to a limit of sixty days per calendar year. Given the nature of the treatment, a bed for the accompanying person is not included.**

5.7. Special Home Care: Health care and health services may be provided at the address given in the policy when the Insurer's physician considers that the Insured requires the kind of care that a hospital provides and that is covered by the policy, but does not require hospitalization.

Coverage does not include the expenditure generated by social services, hotel and restaurant services, laundry, eating, medicines, dressings and care that do not concern a general doctor, nurse, DipHE nurse, and the permanent presence of health professionals in the Insured's home.

6. PROTHESES

Coverage includes any type of fixed internal prostheses, whether temporary or permanent: heart valves, vascular by-passes, pacemakers, stents, hip prostheses, osteosynthesis material, and other kinds of fixed internal prostheses, intraocular lenses and post cancer-related mastectomy breast prostheses, providing the mastectomy was performed while the policy was in force.

Coverage does not include orthopaedic material, orthoses, external braces, osteo-integrated dental and cochlear implants, penis and scrotum prostheses, skin stretchers and/or hearing aids, and intraocular multifocal lenses.

7. SPECIAL TREATMENTS

In all cases, special treatments shall require a prior written prescription by a specialist doctor who is included on the Insurer's list of practitioners, at centres designated by the Insurer and which are related to the pathology concerned.

- Aerosoltherapy-ventilation therapy. **The cost for the medication, in all cases, shall be met by the Insured.**
- Oxygen therapy. In situations of hospitalization and in out-patient surgeries. Out-patient oxygen therapy for patients who require oxygen treatment for at least 16 hours a day is also included.
- Dialysis (Haemodialysis and Peritoneal dialysis). Only for treatment, during concrete days, of acute renal insufficiency. **Chronic conditions are expressly not included.**
- Speech Phoniatics. **Only as rehabilitation in major larynx surgery,** up to a maximum of 60 sessions.

- Laser therapy. Only included in ophthalmology treatments and rehabilitation of skeleton muscle.
- Chemotherapy and radiotherapy oncology. In hospitalization or a day hospital regime. The Insurer shall only assume the cost of cytostatic medicines that are sold on the Spanish market and are authorized by the Spanish Ministry of Health.
- Extracorporeal Renal Lithotripsy.
- Early detection and treatment of deafness in children. Includes consultation and examination, acoustic otoemissions and potential truncus cerebral hearing evocatio.

8. ADDITIONAL SERVICES

- Ambulances: The insurance only covers the distance from the Insured's home to the hospital and vice versa, and only for a hospital admittance or emergency care. Ambulances require an order from one of the Insurer's physicians, except in the event of an emergency.

In any case, transport shall be by road and shall only take place if the physician gives written orders and if physical impossibility prevents the Insured from using normal means of transport (public transport, a taxi or a private vehicle).

This service does not include trips to receive rehabilitation and physiotherapy, dialysis, and out-patient diagnostic tests.

- Podiatry: chiropody, only in consultancy.
- Childbirth Education. This includes all of the methods that are applied to prepare a pregnant woman for delivery physically and psychologically. It targets pregnant women after the sixth month of pregnancy.

ARTICLE 4. RISKS EXCLUDED

a) Bodily harm due to war, rebellions, revolutions and terrorism; caused by officially declared epidemics; that have a direct or indirect relationship with nuclear radiation or reaction, and radiation from cataclysms (earthquakes, floods and other seismic or weather conditions).

b) Pharmaceuticals and medicine in general that does not belong to the hospitalization regime (except for chemotherapy given in centres that have signed an arrangement with the Insurer), as well as vaccinations in general and products that are sold over the counter.

c) Health care for chronic alcoholism or drug addictions in general.

d) Health care for injuries caused by drunkenness, fights (unless in legitimate defence), self-inflicted injuries and suicide attempts.

e) Health care that is needed due to injuries caused by high-risk activities such as bull-fighting and running of bulls, dangerous sports such as deep sea diving, caving, boxing, martial arts, mountaineering, rugby, motor vehicle racing, quads, paragliding, air activities not authorized for the public transportation of passengers, navigation or white water sports, bungee jumping from a bridge, canyoning, and any other obviously hazardous activity; as well as health care for practicing any sport as a professional sportsperson.

f) Health care in any disease, injury, congenital defects or deformities, or pre-existing on the date on which the policy was taken out for each Insured, even if there had not been a concrete diagnostic, unless the said diseases, injuries, defects or deformities were stated in the health questionnaire by the Policyholder or the Insured and the coverage was expressly accepted by the Insurer in the Specific Conditions. This exclusion shall not apply to the Insured who were included in the policy from birth, pursuant to Article 10, section 1.e.

g) Alternative medicine. Treatments in shelters, residential homes for the elderly, spas and similar places.

h) Preventive check-ups and medical examinations in general, except for those that are expressly included in Article 3, section 3.

i) treatments for sterility and infertility (except for those that are expressly included in Article 3, section 3.30), voluntary interruption of pregnancy for any reason, as well as diagnostic treatments related to the said interruption and treatments for impotence (including surgery).

j) Diagnostics, treatments and surgery performed for purely aesthetic or cosmetic reasons. The Insured shall not be allowed to allege purely psychological reasons if no functional defect of the affected body part exists.

k) Anything related to psychology, psychoanalysis, hypnosis, individual or group psychotherapy, psychological tests, narcolepsy, rest cures and sleep cures, except for what is expressly included in Article 3, section 3.36.

l) Organ transplants, except for autologus (self) bone marrow transplants and cornea transplants (the Insurer shall not meet the cost of the cornea that is to be transplanted).

m) Health care for A.I.D.S. and diseases caused by the Human Immunodeficiency Virus (H.I.V.)

n) Hospital care and treatment for social or family reasons, and care that can be replaced by home or out-patient care.

o) In the dentistry and stomacology speciality, sealing, endodontic treatment, dental prosthesis placement, orthodontics, periodontics and implants are excluded, as well as other dentistry treatments that are not given in Article 3, section 3.31.

p) Surgical correction of myopia, hypermetropia and astigmatism, and presbyopia and any other refractive eye pathology.

q) Any surgical and/or therapeutic methods that use laser, unless they are expressly included in Article 3, section 7.

r) Travel expenses, except by ambulance under the terms and conditions given in Article 3, section 8.

s) Chronic dialysis treatments.

t) Physiotherapy and rehabilitation treatments after functions have been restored fully or as much as possible, or when they have been turned into an occupational maintenance therapy or when they have been ordered by the specialist who is in charge of the treatment and who is on the list of practitioners. Educational therapy is not included.

u) The insurance coverage expressly excludes any diagnostic and/or treatment method that uses genetic therapy, studies to determine the genetic map and any other genetic technique, with the sole exception of those that are expressly included in the coverage, such as amniocentesis and karyotypes, and the ones required for haematology.

v) Any diagnostic and/or therapeutic method that is not usual and is not accepted under the Spanish national health system.

ARTICLE 5. – SERVICE PROVISION METHOD

The Health care covered by the policy shall be rendered in any town in which the Insurer has a branch or a list of practitioners. In the event that a town does not have one of the services given in the contract, the said services shall be provided in another town where such services can be rendered, at the Insured's choice.

1. CARE GUIDANCE

The Insurer has a Care Guidance Office where the Insured will find insurance for gaining access to the services, information on the processes to be followed and where the procedures will be facilitated as much as possible.

2. FREE CHOICE OF PHYSICIAN

The Insured may go to the primary care physicians and specialists who are on the Insurer's updated list of practitioners freely and directly.

The Insurer recommends each Insured to have a family physician or paediatrician. Each Insured may choose their own family doctor or paediatrician and nurse from the list of practitioners provided by the Insurer, by simply notifying the Insurer of their choice or of a change in their choice. The Insurer shall not be obliged to provide home care when the choice is for a practitioner who does not practice in the region where the Insured resides.



3. HOME VISITS

Home visits by the family doctor or nurse require a prior telephone call to the practitioner 9-17 hours before the planned visit. Home visits shall only be provided at the address given in the policy. Any change of address shall be notified to the Insurer no less than 8 days before a service is required.

In emergency cases, the Insured shall go to the 24-hour emergency services provided by the Insurer, or call the telephone service given in the literature provided by the Insurer.

4. THE INSURED'S SHARE OF THE COSTS

The Insured shall pay for the health care given, to the amount of excess or according to the share that is set forth in the Specific Conditions.

To that effect, the Insurer shall send the Policyholder a comprehensive extract of the services used by the Insured who are included in the policy, with the corresponding deductibles.

Collection of the resulting sum total shall be made by direct debit through the bank given by the Policyholder for premium payments.

Deductibles may be updated by the Insurer according to Article 12 (ANNUAL UPDATING OF THE POLICY'S ECONOMIC TERMS AND CONDITIONS).

5. PROVISION AUTHORIZATION

In general, the Insurer's express prior authorization shall be needed for hospitalizations, surgery and certain special treatments and diagnostic tests, with a prior written prescription by the practitioners to the Insurer.

The Insured shall obtain the Insurer's prior confirmation before the service is provided. The Insurer shall grant the confirmation unless the service is not included in the policy coverage. Written confirmation is economically binding for the Insurer.

In the event of an emergency, an order by one of the Insurer's physicians shall be sufficient. However, the Insured shall obtain the Insurer's confirmation before seventy-two hours have elapsed since the Insured's admission in the hospital or since care began to be provided. The Insurer shall be economically bound until the moment they express their reservations in regards to the doctor's orders, in the event that they construe that the policy does not cover the health care or hospitalization.

6. EMERGENCIES

The emergency service shall be requested by telephone or by going to a 24-hour Emergency Centre provided by the Insured, whose address and telephone number appears on the list of practitioners.

7. TEMPORARY CHANGE OF ADDRESS

The Insurer undertakes to provide Health care when the Insured is temporarily away from home, at any place in Spain. To this end, the Insured shall use the services that are owned by the Insurer or that have an arrangement with them, and which appear in the literature given to the Insured.

8. CARE IN INSTITUTIONS THAT DO NOT HAVE AN ARRANGEMENT WITH THE INSURER

The Insurer shall not be held liable for the fees of practitioners who are not on their list of practitioners, nor for the cost of hospitalization and services that such practitioners may prescribe.

9. THE INSURED'S CREDENTIALS

When applying for health care, the Insured shall exhibit the individual Caser Salud card provided by the Insurer, and their latest premium payment receipt, which is to be current. The Insured shall sign a receipt for the service.

The physician or the medical centre that are providing the service may also request a Spanish national identification card from those who are obliged by law to have it, when they deem this to be necessary

ARTICLE 6. WAITING PERIODS

All of the coverages assumed by the Insurer by virtue of the policy shall be provided from the moment the contract comes into force. The exceptions to the above principle are listed below and shall require a prior lapse in the coverage period:

Waiting period of six months:

- **Family planning.**
- **Surgery and admissions into Hospitals for medical treatment or surgery. This waiting period shall not be required in the event of a vital emergency.**
- **Dentistry, and cardiovascular, lithotripsy, dialysis and ozone therapy treatments.**

Waiting period of eight months:

- **Childbirth assistance: This waiting period shall not apply to premature and dystocic deliveries.**

Waiting period of 24 months:

- **Assisted Reproduction.**

ARTICLE 7. GROUNDS, LOSS OF RIGHTS, TERMINATION AND INDISPUTABILITY OF THE CONTRACT

1. The statements made by the Policyholder and the Insured on the insurance Questionnaire-Application in regards to their health shall be the basis for accepting the risk herein and shall be an integral part of this contract.

2. The Insured shall lose the right to the warranted benefits if:

a) The Insured has incurred in misrepresentation or inaccuracies when completing the health questionnaire (Article 10. of the Act).

The Insurer may rescind the contract by a statement addressed to the Policyholder before one month has elapsed since the date on which the Insurer became aware of the misrepresentation or inaccuracy on the part of the Policyholder or the Insured. Providing the Insurers has not incurred in wilful deceit or serious fault, they shall have right to the premiums for the period that was current at the time that they made the statement that terminated the contract.

If the event occurs before the Insurer makes the statement mentioned in the previous paragraph, the Insurer's benefit shall be reduced proportionately to the difference between the convened premium and the premium that would have been applied if the true nature of the risk had been known. The Insurer shall be freed of their obligation to pay the benefit if the Policyholder or the Insured have incurred in wilful deceit or serious blame.

b) If the Policyholder or the Insured fail to notify the Insurer that the risk has increased and they have acted in bad faith (Article 12. of the Act).

c) In the event that the loss whose coverage as a risk is under warranty should occur before the premium has been paid, unless otherwise convened (Article 15.of the Act).

d) In the event that the loss was caused by the Insured's bad faith (Article 19. of the Act).

3. The Policyholder may rescind the contract if there are changes in the list of practitioners for the province where the Policyholder resides, providing such changes affect the primary care or 50 percent of the list of specialists, in which case the Insurer shall be notified of their decision to rescind the contract in a reliable manner. This rule shall not apply to temporary substitutions for justifiable reasons, surgeons who use special surgery techniques, dentists, analysts and electroradiologists.

4. In the event of a medical examination or full rights have been acknowledged, the policy shall be indisputable in regards to the health of the Insured. In such cases the Insurer shall not have a right to deny their services by alleging pre-existing diseases unless, as a result of the said examination, an exception is expressly mentioned in the policy's Specific Conditions.



If there has been no medical examination and full rights have not been acknowledged, the policy shall be indisputable after one year has elapsed since the policy was signed, unless the Policyholder has incurred in wilful deceit.

5. In the event that the Policyholder misrepresented the date of birth of one or more of the Insured when applying for the policy, the Insurer shall only be able to rescind the contract if their true age, on the date that the policy came into full force and effect, exceeds the limits set forth in the policy.

In the event that, as a result of an incorrect statement of a birth date, the premium paid was lower than what would have been paid, the Policyholder shall be obliged to pay the Insurer the difference between the premium actually paid and the premium that should have been paid for the Insured's true age.

If, to the contrary, the premium paid was higher than the premium that should have been paid, the Insurer shall be obliged to reimburse the Policyholder for the excess premiums paid, without interest.

ARTICLE 8. DURATION

The insurance is contracted for the period of time foreseen in the Particular Conditions and, unless agreed otherwise, the policy will be adjusted to the calendar year. Once expired, and in accordance with article 22 of the Insurance Contract Law, it will be tacitly extended for annual periods.

However, either one of the parties may oppose the extension by written notification to the other party, made before two months have elapsed since the date on which the current insurance period concluded. The Policyholder's notification shall be made to the Insurer.

The Insurer shall not be allowed to terminate the policy while the Insured is in treatment at a hospital, unless the Insured expressly waives a continuation of the treatment.

In regards to each Insured, the insurance shall expire in the following situations:

1. Death.
2. If the policy includes family members who live with the Policyholder, when their usual place of residence is no longer the Policyholder's home. The Insurer shall be notified of the fact. If the said family members take out a new insurance policy before one month has elapsed since the Insurer was notified, the Insurer shall maintain all of their acquired rights, providing they take out the same warranties.

Minors shall only be included in the insurance if the person or people who have their custody or guardianship are likewise insured, unless otherwise convened.

The contracted coverage shall not take effect until the first premium receipt has been paid.

ARTICLE 9. PREMIUM PAYMENTS

The Policyholder, pursuant to Article 14 of the Act, is obliged to pay the premium.

1. The first premium, or a first instalment of it, shall be payable pursuant to Article 15 of the Act, after the contract has been entered into. In the event that the premium has not been paid due to the Policyholder, the Insurer shall have the right to cancel the contract or claim payment through an enforcement procedure, on the grounds of the policy. In any event, if the policy has not been paid before a loss has occurred, the Insurer shall be free of their obligation, unless otherwise convened.

2. In the event of a failure to pay the second and subsequent premiums or instalments thereof, the coverage shall be suspended one month after the payment receipt expired. In the event that the Insurer fails to claim payment during the six month period following the said expiration date, it shall be construed that the contract has terminated. If the contract has not been terminated pursuant to the above conditions, the coverage shall take effect again at midnight of the day on which the Policyholder pays the premium. In any event, while the contract is suspended, the Insurer shall only have a right to claim payment of the premium for the current period.

3. The Insurers shall only be obliged by virtue of the receipts made out by their lawfully authorized representatives.

Payment of the premium sum by the Policyholder to the Broker shall not be construed as a payment to the Insurers unless, in exchange, the Broker has provided the Policyholder with a premium receipt issued by the Insurer.

4. The Specific Conditions shall specify the bank account designated by the Policyholder for premium payments. The rules given below shall apply:

a) The Policyholder shall give the Insurer a letter addressed to a Bank or Savings Bank, giving the order for direct debit.

b) The premium shall be construed as paid when it expires, unless the Policyholder's account does not have sufficient funds to meet the payment during a time period of thirty calendar days following the premium's due date. In the latter case, the Insurer shall notify the Policyholder that the receipt is available at the address given on the premium, and the Policyholder shall be obliged to pay the premium at the said address.

c) In the event that the Insurer allows the time period mentioned in the previous section to elapse without presenting the receipt for payment, or if, upon presentation of the receipt, the Policyholder's account does not have sufficient funds to pay it, the Insurer shall notify the Policyholder of the fact by letter or any other reliable method. The Policyholder shall be granted a new time period of thirty calendar days in which to notify the Insurer how he or she plans to pay the premium. This second time period shall be computed from the date on which the said letter or notification arrives at the last address given to the Insurer.



ARTICLE 10. FURTHER OBLIGATIONS, DUTIES AND AUTHORIZATIONS OF THE POLICYHOLDER AND THE INSURED

1. The Policyholder and, where appropriate, the Insured, shall have the obligations given below:

a) To state all of the circumstances known to the Policyholder that may have a bearing on the assessment of the risk, according to the questionnaire provided.

The Policyholder shall be exonerated from this obligation if the Insurer fails to provide the questionnaire or, having provided the questionnaire, it does not include certain circumstances that may have a bearing on risk assessment.

The Insurer may rescind the contract by addressing a statement to the Policyholder before one month has elapsed since the date on which the former became aware of the Policyholder's or the Insured's misrepresentation or reservation. The Insurer shall have a right to the premiums for the period that was current when the said statement was made, providing they do not incur in wilful deceit or serious blame.

In the event that a loss occurs before the Insurer makes the statement mentioned in the previous section, the Insurer's compensation shall diminish in proportion to the difference between the convened premium and the premium that would have been paid if the true dimension of the risk had been known. The Insurer shall be free of the liability to pay compensation of the Policyholder has incurred in wilful deceit or serious blame.

b) While the contract is in force and as soon as possible, the Policyholder shall notify the Insurer of any circumstance that, according to the health questionnaire provided by the Insurer previously, may increase the risk and that is such that if it had been known to the Insurer at the time they entered into the contract, they would not have entered into it or they would have made the conditions stricter.

c) To notify the Insurer of any change of address at the least possible delay.

d) To notify the Insurer, at the least possible delay, of any changes in an Insured's inclusion in the policy while the policy is in force. Inclusions of an Insured shall take effect on the first day of the month following the date on which the Policyholder notified the Insurer. A removal of an Insured from the policy shall take effect on 31 December of the said year, and the premium shall be adjusted accordingly.

e) If assistance to the biological mother in birth-giving is carried under her own Caser policy, the newborn children will have a right to be included on the policy of their mother from the moment of birth. To this end, the Policyholder shall notify the Insurer of the said circumstance before **thirty (30) calendar days** have elapsed since the date of the delivery, by completing an insurance application form. The effects of inclusions notified in due time shall be retroactive to the date of birth, and a waiting period shall not be longer than the waiting period remaining to the mother.

Failure to notify the inclusion of a newborn child before the allotted time period has elapsed shall require the completion of a Health Questionnaire and the

Insurer may deny inclusion. In the event that the new Insured is accepted, the waiting periods set forth in Article 6 of the Specific Conditions shall apply.

In any event, the Insurer shall cover the newborn's Medical Assistance during the first fifteen (15) calendar days of life. Coverage will end after the said time period, unless the child's inclusion has been applied for pursuant to the first paragraph in this section.

f) To diminish the consequences of a loss by using all available means for rapid recovery. Any breach of this obligation, with the obvious intention of causing damage or deceiving the Insurer, shall free the latter of any obligation to provide any service as a result of the loss.

g) To grant and facilitate the subrogation in the Insurer's favour that is set forth in Article 82 of the Act.

2. The Caser Salud card is the Insurer's property and is given to each Insured. The card is for personal use alone. In the event of loss, theft or wear and tear, the Policyholder and the Insured are obliged to notify the Insurer of the fact before seventy-two hours have elapsed.

In such cases, the Insurer shall issue a new card and send it to the Insured's address that appears on the policy. The lost, robbed or worn card shall be annulled.

Likewise, the Policyholder and the Insured shall be obliged to return the card of an Insured who is no longer included in the policy to the Insurer.

The Insurer shall not be held liable for the inappropriate or dishonest utilization of a Caser Salud card.

3. The Policyholder shall have the right, before one month has elapsed since the policy was delivered, to make a claim to the Insurer for the correction of any differences between the policy and the agreed insurance proposition or clauses, pursuant to the provisions of Article 8 of the Act.

ARTICLE 11. – FURTHER OBLIGATIONS OF THE INSURER

In addition to the contracted care, the Insurer shall delivery an insurance policy to the Policyholder and, where appropriate, a temporary coverage document or whichever document is necessary pursuant to the provisions of Article 5 of the Act, as well as a copy of the health questionnaire and any other document signed by the Policyholder.

Likewise, the Insurer shall provide the Policyholder with a Caser Salud card, which is for personal use alone, to each one of the Insured who are included in the policy.

At the time that the policy is taken out, the Insurer shall also provide a copy of the list of practitioners who are in the province where the Policyholder resides, and of the centre or centres that offer 24-hour medical and surgery emergency services, of the 24-hour out-patient services, of the hospitals and clinics, of the practitioners' addresses and surgery hours, and of the information, emergency and 24-hour out-patient services in the capitals of all of the other provinces.

The list of practitioners may be updated annually by the Insurer by including or removing practitioners, professionals, hospitals and other institutions from the list. It shall be the Policyholder and/or Insured's obligation to use the services of the care providers who are on the list when the application for care is made. They may ask the Insurer's office to provide an updated list of practitioners for that purpose.

ARTICLE 12. ANNUAL UPDATE OF THE POLICY'S ECONOMIC TERMS AND CONDITIONS

The Insurer may update the sum of the premiums and the sum for excesses and the Insured's share in the cost of services which are mentioned in section 4 of Article 5 of these General Conditions.

Premium and excess updates shall include the adjustments required to ensure that the premium rate is sufficient and are based on the technical and actuarial computations made, on the basis of the increase in health service costs, the increase of the frequency of the benefits covered by the policy, the incorporation of new technologies that appeared or were used after the policy was taken out, and that are added to the warranted coverage, and other facts of a similar nature.

The premiums to be paid by the Policyholder shall vary according to the age of each one of the Insured, their sex, and the geographical area where the benefit takes place, applied to the rates that the Insurer has in force on the date of each renewal.

Upon receiving the notification of the updated premiums and/or excesses for the coming year, the Policyholder may choose between extending the Insurance Contract, which will imply an acceptance of the new economic terms and conditions, and terminating the current year's subscription by sending a notice to that effect to the Insurer.

ARTICLE 13. NOTIFICATIONS

1. Notifications to the Insurer shall be sent to the address that appears on the policy.
2. Notifications and premium payments that are made at the Insurer's or the Agent's delegations, branches and offices shall have the same effect as though they had been made directly to the Insurer.

ARTICLE 14. PRESCRIPTION

The actions arising from the contract prescribe after **five years** have elapsed, counted from the day on which they may be used.

ARTICLE 15. – COMPETENT JURISDICTION

This contract is subject to jurisdiction of the Spanish courts. The competent Judge for hearing any actions arising from this insurance contract shall be the judge assigned to the Insured's area of residence in Spain.

This Insurance Contract includes Specific Conditions and Special Conditions, if they exist, which are an inseparable part of the above General Conditions, and Schedules that set forth any changes that have been agreed between the parties.

SCHEDULE 1 - COMPLEMENTARY WARRANTY TO THE HEALTH CARE INSURANCE

SECOND MEDICAL OPINION COVERAGE

1. Purpose

The purpose of this service is to warrant the provision of Second Medical Opinion services to the people who are named as Insured. Such services are described below.

The Second Medical Opinion service shall consist in an assessment of the diagnostic and the treatment given to the Insured during the process or development of his/her disease, with a report on the said assessment. The Second Medical Opinion shall be given by experts of national and international renown in the disease concerned.

2. Insured

The Insured shall mean the people who hold the policy and the Beneficiaries who are included in the policy at the time that an application is made for the service, and throughout the duration of the service.

3. Description of the service

The purpose of the service herein is to warrant the provision of the services described below to the Insured, providing the services have been applied for while the Health Care Insurance herein was in force, and pursuant to the definitions given below:

a) Second Medical Opinion of the pathologies described in this contract in the section **diseases that are the object of a Second Medical Opinion**. The service consists in:

- A Second Medical Opinion service with specialists of top national and international prestige.
- Without the need to travel and with an answer provided before ten working days have elapsed, counted from the date on which the Insured sent a completed Second Medical Opinion form and the appropriate documents.
- Patient support, if the patient considers it necessary, after the formalities for a Second Medical Opinion have been carried out.

b) Choice of experts and hospitals:

- Choice and references of national and international medical experts and hospitals.
- Advice on the medical care given at national and international hospitals.

c) In the cases in which the Insured considers that the provision of a medical service that is not included in the Insurer's list of practitioners and hospitals is necessary, a Cost Management service shall be provided. This service consists in:

- Management of appointments with Spanish physicians who are not on the Insurer's list and international physicians.
- Obtaining hospitalization cost estimates.
- Execution of the formalities for admission in Spanish and international hospitals.
- Coordination of the patient's transportation (reservations, ambulances by air and road, and translation services).

Under no circumstance shall the above services be provided without the Insurer's prior authorization

4. Diseases Object of a Second Medical Opinion

The Second Medical Opinion service shall be provided in the cases in which the Insured has a first diagnostic in the serious diseases given below:

- Cancer.
- Cardiovascular diseases.
- Neurological and Neurosurgical diseases, including cerebrovascular accidents.
- Chronic renal insufficiency.
- Idiopathic Parkinson's Disease (paralisis agitans).
- Multiple sclerosis.
- Childhood diabetes.
- Tropical diseases.

5. Further terms and conditions

The services included in this Health Care insurance policy shall only be provided if the Insured or the Insurer's physician who is caring for the Insured make a call to the telephone number provided to apply for a Second Medical Opinion.

After an application has been made by phone, the Insurer shall give the Insured a questionnaire that is to be completed and returned to the Insurer, together with a medical/clinical report on the case, and any laboratory tests, medical reports, X-rays, biopsies and other medical documents available to the Insured and that refer to the first



diagnostic given, as well as any additional reports and tests that the Insured may have requested, depending on the disease.

The Second Medical Opinion service includes the fees and costs for the medical consultations and second diagnostics indicated above, providing they were applied for in the above-mentioned manner. **Any other disbursement, costs and fees arising from medical consultations and treatments, tests and analyses, reports, radiographs and other types of examinations shall be met by the Insured, if methods that are not included in the Insurer's list of medical treatments and physicians are used, even if they are related to the disease or medical condition for which the Second Medical Opinion was requested.**

6. Service utilization

This service offers information from a medical expert that complements the information that the Insured receives from the physician in charge of his/her case. In no case is it intended to be a medical diagnostic or a decision on the therapy to follow on its own.

The reply obtained through the Insurer shall depend on the truthfulness and accuracy of the data provided.

The reply received by the Insured shall not be used in place of the physician in charge of his/her case, since any medical decision requires personal care that can only be obtained during person-to-person medical interviews.

7. Application for a Second Medical Opinion

Applications for the Second Medical Opinion services shall be made at the telephone number: 901 33 22 33. The Insured shall give the details that certify his/her right to the service.

SCHEDULE 2 - COMPLEMENTARY HEALTH CARE INSURANCE WARRANTY

COVERAGE FOR TRAVEL INSURANCE IN A FOREIGN COUNTRY

The Insurer warrants the Insurer and the other policy Beneficiaries coverage for this additional warranty while the policy is in force. Travel insurance is to be provided by the SMASA Sociedad Mundial de Asistencia, S.A. Company.

Terminology:

INSURED: The natural person, a resident in Spain, who is the policyholder and the policy's Beneficiaries. The rights of the Insured are not changed or limited if they travel separately.

RISKS TO PEOPLE: This warranty is valid in any country in the world except Spain.

TERM: To be able to benefit from the warranted services, the Insured must have a home in Spain that is his/her permanent home. Stays away from the permanent home shall not exceed 90 days per trip.

SERVICE PROVIDER: SMASA, Sociedad Mundial de Asistencia, S.A., whose registered address is at C/Albacete, 5 28027, in Madrid.

An essential requirement in order for the Insurer to assume their obligations is the immediate notification of the loss to SMASA, Sociedad Mundial de Asistencia, S.A., at the telephone number given herein.

Warranties covered

1. Repatriation of a deceased Insured and any accompanying persons

In the event of the demise of an Insured, the Insurer shall organise and meet the cost of transporting the body from the place where the death took place to the interment place in Spain, as well as the return to their homes of those who were with the Insured, providing they were Insured.

Post-mortem treatment (such as embalming and the coffin required for transport) shall also be covered, pursuant to legal requirements, **up to a limit of Euros 601.01.**

In any event, the cost of an ordinary coffin, interment and the ceremony shall not be met by the Insurer.

2. Medical repatriation of injured or diseased people from a foreign country

Depending on the urgency or seriousness of the case and the criteria of the physician in charge, the Insurer shall meet the cost for transporting the Insured to a hospital in Spain that is close to the Insured's place of residence or to his/her home if no hospitalization is

required. The coverage shall include medical surveillance, if needed. If the Insured cannot be hospitalized close to home, the Company shall meet the cost of the subsequent trip from the hospital to the Insured's home.

Modes of transportation:

- By a special medical airplane in European countries and Mediterranean countries.
- Regular airlines, trains and ships.
- Ambulance.

In the event of benign conditions or light injuries that do not require repatriation, the transport shall be made by ambulance or any other means, to a place where appropriate care can be given.

Under no circumstance shall the Insurer substitute emergency aid organizations, nor meet the cost of their emergency services.

In any event, the decision as to whether or not the Insured should travel shall belong to the physician designated by the Insurer, in agreement with the physician who is attending the Insured and, if appropriate, with the Insured's family.

Likewise, the Insurer shall meet the cost of transporting up to two of the people who were travelling with the Insured and who are in the same condition, to their place of origin or destination, providing the cost of the latter does not exceed the cost of returning home.

3. Payment and reimbursement of medical, surgical, pharmaceutical and hospitalization costs in a foreign country

With this coverage, the Insurer undertakes to meet the costs incurred by the Insured outside of Spain as the result of an unforeseeable accident or disease that occurred during a trip and while this coverage was in force, **up to a limit of Euros 15,000.00.**

In any event, **emergency dentistry costs are limited to Euros 120.20.**

The reimbursements herein shall complement any other benefits to which the Insured or the assignees have right, either under the Spanish Social Security System or any other insurance regime to which they may be subscribed.

Therefore, the Insured shall undertake to take the necessary steps to recover any disbursements from the said organizations and to repay the Insurer for any advance payments.

4. Travelling expenses for a family member who accompanies an Insured who is hospitalized in a foreign country

If an Insured who is ill or injured is not in condition to travel and the hospitalization in the place where he or she is to be found exceeds five days, the Insurer shall meet the cost of:

- A round trip train ticket (first class) or airplane ticket (tourist class) that will enable a member of the Insured's family or the person named by the Insured to go to his/her bedside at the hospital.
- The Insurer shall also pay for the accompanying person's stay and subsistence **up to Euros 66.11 per day. The sum total shall not exceed Euros 661.11.**

5. Extension of a hotel stay in a foreign country

If an Insured who is ill or injured cannot travel, in the opinion of the physician who is attending him and with the agreement of the physician assigned by the Insurer, the latter shall meet the cost for an extension of the hotel stay and subsistence, **up to the sum of Euros 66.11 per day, and up to a total of Euros 661.11.**

6. Sending medication to a foreign country

The Insurer shall manage the localization and dispatch of medication of vital importance that cannot be obtained in the country where the Insured is hospitalized.

The said dispatch shall be subject to the legislation of the country for which it is requested.

However, the Insurer's liability shall end if the Spanish Council of Chemists (Consejo de Farmacéuticos) report that the required product does not exist on the Spanish market.

7. Sending urgent messages arising from the warranties

The Insurer shall avail the Insured with a 24-hour telephone service from which they can send urgent messages in relation to incidents arising from the Travel insurance warranties.

8. Repatriation and transportation of family members under 15 years of age

If minors under 15, who were travelling with an Insured, are left without attendance due to the Insured having an accident, illness or removal to a hospital that is covered by the insurance, the Insurer shall organise their return to the designated home or place of residence, by sending a family member to accompany them, or by providing an accompanying flight attendant, if necessary. The Insurer shall decide which mode of transportation shall be provided and the date.

9. Interpretation services in the event of an accident or illness

If, as the result of an accident covered by the policy or a serious illness occurring in a foreign country, an interpreter is needed at the place of the occurrence, the Insurer undertakes to provide one for the Insured at the least possible delay.

The costs covered by the Insurer are limited to Euros 30.05 per day, up to a maximum per loss of Euros 180.30.

10. Advance payment of bail and proceedings costs

If, as the result of a lawsuit due to an automobile accident that occurred in the place of residence given in the policy, the Insured requires bail in order to obtain temporary freedom, or needs to make provision of a fund for lawyers' fees, he/she may apply to the Insurer for an advance payment of **up to Euros 6,010.12 for bail and Euros 601.01 for court proceedings**. This coverage shall require a formal commitment to repay the sums to the Insurer before sixty days have elapsed.

In order to ensure repayment, prior to making the advance payment, the Insurer reserves the right to require that the person designated by the Insured shall undertake to repay the advanced payment in a reliable manner, by an appropriate acknowledgement of the debt.

The Insured's legal defence shall not be included in this coverage.

11. Hospital formalities management service

The Insurer shall collaborate in the management of any formalities related to the admission of the Insured in a Hospital.

12. Hospitalization bonds

If the Insured needs to be hospitalized due to a serious accident or disease covered by the policy, the Insurer shall meet the cost of the any security that the hospital may require before the Insured's admission, **up to a maximum limit of Euros 601.01**.

13. Cash advance in the event of an accident, theft or serious illness in a foreign country

If the Insured is in urgent need of cash as the result of an accident covered by the policy, the theft of his/her belongings, or serious illness, the Insurer shall advance the sum required, **up to a limit of Euros 1,502.53 €**.

In order to secure the sum advanced, the Insurer reserves the right to require that the person in Spain whom the Insured designates shall undertake to repay the cash advance in a reliable manner, by an appropriate acknowledgement of the debt.

The said cash advance shall be subject to the legislation of the country from which it was requested.

The Insured shall undertake to return the sum advanced by the Insurer before 10 days have elapsed since the trip ended and, in any case, before two months have elapsed since the date on which the cash advance was provided.

14. Accompaniment of mortal remains

In the event that there is no one to accompany the mortal remains of a demised Insured during travel, the Insurer shall provide the person designated by the assignees with a return train ticket (first class) or airplane ticket (tourist class) to accompany the corpse.

15. Cost for the stay of the person who accompanies the mortal remains

In the event that the coverage mentioned in the previous section is required, and if the accompanying person must stay at the place where the demise took place due to formalities related to the transportation of the mortal remains, the Insurer shall meet the cost of the stay and subsistence **up to the sum of Euros 60.10 per day, for a maximum of three days.**

16. Unexpected return due to the death of a family member

In the event that an Insured who is on a trip must return unexpectedly due to the death of their spouse, ascendant or descendent to the first degree, brother or sister, the Insurer shall provide the Insured with a train ticket (first class) or an airplane ticket⁶ (tourist class) from the place where they were at the time to the place where the demised family member will be buried in Spain, and a return ticket to the place where they were before the event took place; or two tickets from the Insured's usual place of residence, providing the accompanying person is also an Insured.

17. Assistance in locating and shipping of baggage

In the event that baggage is lost or delayed, the Insurer shall collaborate in the baggage search, location, and shipment to the Insured's home.

18. Shipment and/or forwarding of objects forgotten and/or stolen during a trip

The Insurer shall organize and meet the cost of the shipment to the Insured's home of any objects that the Insured forgot in the place or places that were visited during the trip.

GENERAL EXCLUSIONS TO THE COVERAGE FOR TRAVEL INSURANCE IN A FOREIGN COUNTRY

Coverage under this policy does not include:

- **Relapses of pre-existing diseases that risked becoming suddenly worse and that were known to the Insured before setting out on the trip.**
- **Pathological states that were known to the Insured and with a medical record, that could become worse while travelling.**

- **Pregnancies. However, unpredictable complications prior to the sixth month of pregnancy shall be covered.**
- **In the event of acute dentistry problems that require emergency treatment, such as infection, pain and trauma, the cost shall be limited to a maximum sum of Euros 120.20.**
- **Rescue of people on mountains, at sea or in a desert.**
- **Practicing high risk sports such as mountaineering, climbing, motocross, gliding, delta wing and similar sports.**
- **Skiing accidents.**
- **Costs related to chronic diseases, prostheses of any kind and thermal treatments.**
- **Any kind of medical expense that is under Euros 9.02.**
- **Suicide, self-inflicted injuries and drug and alcohol intoxication.**
- **Under no circumstance shall the Insurer replace emergency aid organizations nor the cost of such services.**
- **Diseases such as Acquired Immunodeficiency Syndrome (AIDS) and other problems caused by alcoholism and drug addiction.**
- **Vaccinations and monitoring of previously known diseases.**
- **Thermal and therapeutic treatments with UVA rays.**
- **Physiotherapy and kinesiotherapy.**
- **Mental illnesses, as well as psychoanalysis and psychotherapy.**

FURTHER CONDITIONS FOR TRAVEL INSURANCE COVERAGE IN A FOREIGN

1. This supplement complements the Health Care Insurance policy and shall not be valid unless the two are together.
2. The Insurer shall not be held liable for any delays and breaches that are due to force majeure.
3. In regards to the travelling costs of those who are insured, the Insurer shall only meet the cost of the excess over and above normal travelling expenses (train tickets, air tickets, ocean voyages, boat tickets, fuel for the vehicle, etc.)

4. The Travel Insurance Warranty shall be provided through the SMASA, Sociedad Mundial de Asistencia, S.A. Company, whose function shall be strictly limited to providing the service.

5. An essential requirement in order for the Insurer to assume their obligation is to notify a loss immediately to SMASA, Sociedad Mundial de Asistencia, S.A., at the telephone given herein.

6. To use the specified services, just call the following number, reversing the charges:

Assistance in a foreign country:

34 91 325 55 55

Or

34 91 595 50 49

CUSTOMER CARE DEPARTMENT

1. Caser has a Customer Care Department available to their customers at Avenida de Burgos, 109, 28050 Madrid (Spain). Fax: (+34) 91 595 54 96, e-mail: atencionclientes@caser.es.

2. The Department shall attend and resolve issues pursuant to current Spanish legislation, within a maximum period of two months after a complaint or claim has been made directly, via authorized representation by a natural person or legal entity, by insurance users and by the beneficiaries of employment pension plans and Caser pension funds, providing that the complaints or claims refer to lawfully acknowledged concerns and rights related to Caser's insurance and pension plan operations, whether they are the result of the contracts as such, the regulations on transparency and customer protection, or good use and practices, particularly the principle of equality.

Complaints and claims shall be delivered in writing at one of Caser's offices, by mail or computer, electronic or telematic means, providing they allow the messages to be read, printed and saved, and meet all legal requirements set forth in the Rules.

3. If a customer is still not satisfied after a decision has been obtained and after placing a claim via the Customer Care Department, or if two months have elapsed since the date on which the claim was made and the Department has not yet reached a decision on the issued, the claimant may present the claim before the Comisionado para la Defensa del Asegurado y del Partícipe en Planes de Pensiones (Committee for Policyholders, Insured, and Pension Plan contributors), at Paseo de la Castellana, 44, 28046 Madrid (Spain), fax (+34) 91 339 71 13, whose decisions, however, are not binding. Likewise, they can submit the claim to the competent courts.

4. Forms for making comments and complaints are available to Caser customers, users and damaged third parties at Caser's offices and on Caser's Web page at www.caser.es. Caser's Rules for Customer Defence are also available. The Rules govern Customer Care Department activities and functions, as well as the manner in which complaints and claims are to be made.

5. Decisions shall take into account the rights and obligations set forth in the General Conditions, Specific Conditions and Special Conditions of the contracts; the regulations that govern insurance activities, and the regulations on transparency and the protection of financial service customers (Insurance Contract Act, the revised text of the Law on Private Insurance, the Law on Financial System Reform, the Law on Collective Investment Institutions, Royal Decree 303/2004, dated 20 February, and ECO Order 734/2004, dated 11 March, the Law and Regulation for the Defence of Consumers and Users, and the Law on General Terms and Conditions for Contracting).