HEALTH 60+

Health Care Contract

General Terms and Conditions

CAJA DE SEGUROS REUNIDOS

Compañía de Seguros y Reaseguros, S.A.-CASER-

Registered Office: Avenida de Burgos, 109 - 28050 Madrid

caser.es

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Member state: Spain
In accordance with the provisions of Article 3 of Law 50/1980 of 8 October, on Insurance Contracts, the clauses limiting the rights of the Insured contained in the General Conditions of the policy are highlighted in bold print.

This contract is subject to Law 50/1980 of 8 October, on Insurance Contracts, Law 20/2015 of 14 July on the Regulation, Supervision and Solvency of insurance and reinsurance companies and its implementing regulations.

The Authority responsible for controlling the activity is the Directorate-General for Insurance and Pension Funds.

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GENERAL TERMS AND CONDITIONS

INTRODUCTORY ARTICLE

This Insurance Contract is governed by the provisions of Law 50/1980, of 8 October, on Insurance Contracts (Official Journal of 17 October 1980), by Law 20/2015, of 14 July, on the Regulation, Supervision and Solvency of insurance and reinsurance entities, and its Development Regulations (Royal Decree no. 1060/2015 of 20 November) and by what is agreed in the General, Particular and Special Conditions, if applicable, of this contract. The authority responsible for the control of Insurance Activity is the Directorate-General of Insurance and Pension Funds.

By signing the application form, the Particular or Special Conditions or, where applicable, the Insurance Certificate, the Contracting Party specifically accepts the limitation clauses of the rights of the Insured which are highlighted in bold print.

ARTICLE 1 - DEFINITIONS THAT WE WILL USE IN YOUR CONTRACT

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

INSURED/BENEFICIARY: is the person who receives the corresponding benefit in the cases provided for in the contract. Usually they have a common bond of personal, family or financial interest with the Contracting Party or Policyholder.

ACCIDENT: bodily injury suffered during the term of the contract arising from a violent, sudden, external cause beyond the control of the Insured and occurring at an identifiable time and place.

COST-EFFECTIVENESS ANALYSIS: an economic comparison of different health techniques to select the most appropriate in terms of health results, according to the available resources.

INSURER: the legal entity that assumes the contractually agreed risk, in this policy, CAJA DE SEGUROS REUNIDOS, Compañía de Seguros y Reaseguros, S.A. -CASER-, hereinafter referred to as the Insurer.

OUT-OF-HOSPITAL MEDICAL ASSISTANCE: this is the outpatient diagnostic and/or therapeutic medical assistance provided in a medical centre, at the patient's home and/or at a hospital or clinic without an overnight stay and which results in a stay of less than 24 hours.

ONLINE MEDICAL ASSISTANCE/TELEMEDICINE: medical care provided remotely through technology.

SPECIAL HOME CARE: assistance to the Insured by a general practitioner or family doctor and a nurse at the home indicated in the contract, when the patient’s illness so requires, and always after a prescription from a specialist doctor included on the Insurer's list of professionals.

CASER MEDICAL CENTRE: In-house medical centre for digital health care.

PARTICULAR CONDITIONS: A document which is an integral part of the contract in which the aspects of the risk of being insured are specified.

CONTRACTING PARTY/POLICY HOLDER: the individual or legal entity that, together with the Insurer, signs this contract and to whom the obligations deriving from it correspond, except for those that due to their nature must be fulfilled by the Insured or Beneficiary.

CONTRACT: document or documents containing the clauses and agreements regulating the relationship between the Contracting Party and the Insurer. The following form an integral and inseparable part of the contract: the Insurance Application, the Health Questionnaire, the General Conditions, the Particular Conditions that individualise the risk, if any, as well as the Supplements

or Appendices that include, where applicable, the modifications agreed during the term of the contract.

CO-PAYMENT: participation assumed and invoiced to the Contracting Party or Insured for each health service used by the Insured included in the contract, and which shall coincide with that reported by the Insurer's providers. This amount may be updated annually and may vary depending on the types of health services and/or medical specialities used, which are determined in the Particular Conditions.

MEDICAL TEAM: this is the complete list of professionals and own or contracted health centres defined by the Insurer.

HEALTH QUESTIONNAIRE: A form with questions on the state of health, provided by the means of the Insurer, in which all the necessary information that must be known by the Insurer for the assessment of the risk is declared and which each of the Insured parties must sign and declare completely and accurately.

PREVIOUS PAIN: is a health condition, not necessarily pathological, that exists prior to the moment of taking out or registering for insurance, regardless of whether or not there is a medical diagnosis.

ILLNESS: any change in the Insured's health that is not the result of an accident, diagnosed by a doctor during the term of the insurance policy, which makes the provision of medical care necessary.

ILLNESS, INJURY, DISABILITY OR BIRTH DEFECTS: is that which exists at the moment of birth, as a consequence of hereditary factors or conditions acquired during pregnancy up to the moment of birth. A congenital condition may manifest itself and be recognised immediately after birth, or be discovered later, at any time during the life of the Insured.

PREVIOUS ILLNESS: illness of the Insured prior to the start date of their contract, whether or not diagnosed at the start of the contract.

NURSE: professional legally qualified and authorised to carry out nursing activities.

FORCE MAJEURE: an event or occurrence beyond the control of the Insured which cannot be prevented or foreseen and which makes it impossible to comply with the obligation.

CLINICAL PRACTICE GUIDELINES: a set of recommendations based on the available scientific evidence that provide information and guidance to health personnel on the prevention and treatment of diseases.

DOCTOR: professional legally qualified and authorised to practice medicine.

SPECIALIST DOCTOR: doctor who has the necessary qualifications to practise in one of the legally recognised medical specialities.

EXTERNAL MEANS: doctors and centres not included in the Insurer's Medical List that corresponds to the type of insurance taken out.

IN-NETWORK/OWN MEANS: doctors and centres included in the Insurer's Medical List that corresponds to the type of insurance taken out.

WAITING PERIOD: interval of time during which some of the cover included in the contract is not yet effective. This period shall be calculated in months from the date the contract comes into force for each of the Insured parties included in it.

DISPUTABILITY PERIOD: period of time, from the date the contract comes into force for each of the Insured parties included in it, during which the Insurer may refuse to cover benefits or contest the contract on the grounds of the existence of previous illnesses of the Insured and which the

latter has not declared in the Health Questionnaire. Once this period has elapsed, the Insurer's refusal must be based on the existence of fraudulent concealment on the part of the Insured.

SERVICE PLATFORM: Online portal *-casermasbeneficios.es-* (owned by Caser Servicios de Salud S.A.U, a Caser Group company), for the acquisition of health, prevention and wellness services.

BENEFIT: consists of health care derived from the illness.

PREMIUM: this is the price of the insurance. The premium receipt shall also include the legally applicable surcharges, taxes and fees. The insurance premium is annual, even if payment is paid in instalments.

USUAL DIAGNOSTIC TESTS: a test prescribed by a doctor of the medical staff, during the act of consultation, and whose performance does not require highly complex equipment or specific interpretation by a specialist.

HIGH-TECH DIAGNOSTIC TESTS: this test requires for its performance a sanitary or hospital environment with technological equipment and specialised professional for the interpretation of the results due to its complexity. The health infrastructure where it is carried out must have sufficient personnel and equipment to deal with any complications.

CLINICAL PSYCHOLOGY: speciality of Psychology, which deals with the treatment and rehabilitation of anomalies and disorders of human behaviour.

PSYCHOTHERAPY: treatment given to a person suffering from a psychic conflict, under the indication or diagnosis of a psychiatrist.

REHABILITATION AND PHYSIOTHERAPY: all acts carried out by a rehabilitation doctor or physiotherapist in a specific rehabilitation centre, aimed at restoring the functionality of those parts of the locomotive system affected by the consequences of an illness or accident.

NEUROLOGICAL REHABILITATION: a set of specific physical therapies (also called neurological physiotherapy), prescribed by a neurologist or rehabilitation doctor, and carried out by a physiotherapist in a suitable rehabilitation centre, aimed at restoring, as far as possible, normal mobility to those patients who have suffered a sensory-motor disorder resulting from severe acquired brain damage.

INCIDENT: event whose consequences make it necessary to use health services that are totally or partially covered by the contract.

INSURANCE APPLICATION: document in which the Contracting Party describes the risk that they wish to insure, with all the circumstances known to them that may influence the assessment of said risk, the good faith of the Contracting Party being necessary.

HEALTH CARD: a document, property of the Insurer, which is issued to each Insured and/or Beneficiary included in the contract and whose use, personal and non-transferable, is necessary to receive the benefits covered by the contract.

EMERGENCY: assistance which, given the Insured's clinical or medical condition, must be provided immediately in a medical centre or at the patient's home.

LIFE-THREATENING EMERGENCY: a clinical situation that requires immediate medical attention, given that a delay could pose a risk to the life of the Insured.

ARTICLE 2 - PURPOSE OF THE INSURANCE

Within the limits and under the conditions stipulated in the contract and on payment of the premium and co-payments that may apply in each case, the Insurer undertakes to provide the

Insured, within the national territory and with the professionals arranged by the Insurer at the time the service is provided, medical assistance in outpatient consultations in different specialities, as well as the means of diagnosis and therapeutic acts, according to the usual medical practice, in all kinds of illnesses or injuries included in the description of the cover of the contract.

Therefore, hospital care or surgical interventions are not covered.

In addition, diagnostic and therapeutic advances that are made in medical science after the start date of this contract may become part of the cover of this contract provided that they are safe, effective, universal and consolidated at each renewal of this contract. The Insurer shall explicitly communicate the techniques or treatments that will be included in the cover of the contract for the following period.

The Insurer accepts no liability for expenses or services arising in public or private centres not contracted by the Insurer and which are not included in the corresponding Medical List, according to the type of treatment contracted, regardless of the prescribing or performing doctor.

In any case the Insurer assumes the necessary urgent assistance in accordance with the provisions of the terms and conditions of the contract and in application of the provisions of Article 103 of the Insurance Contract Act.

No cash compensation may be granted under this insurance in lieu of health care benefits.

ARTICLE 3 - DESCRIPTION OF COVER

It includes outpatient health care services, covering the specialities, tests, treatments and other services detailed in this contract. **For diagnostic tests and treatments, a prescription from a doctor included in the Insurer's Medical List will be required.**

SPECIALTIES, TESTS AND TREATMENTS

1. **Primary care:**
    - **Family medicine:** includes medical care provided during consultation. Includes consultation, follow-ups, prescription of basic diagnostic tests and home visits. Home visits are provided only when the patient cannot travel due to medical reasons.
    - **Nursing:** In consultation and at home. Home visits are provided only when the patient cannot travel due to medical reasons and subject to a prescription from a doctor of the Insurer. Follow-up appointments are also included.
2. **Emergencies:**
    - **Home emergency:** emergency medical assistance and nursing service at home. After an assessment by Caser's emergency service and only at the home indicated in the policy's Particular Conditions, provided that Caser has arranged home services in the town where the Insured resides and when the illness prevents the Insured from attending the consultation with the designated professional or nurse.
    - **Outpatient emergency:** urgent medical assistance during office hours at outpatient centres, excluding hospitals, arranged by the Insurer. The assistance will be provided in those towns in which Caser has arranged the provision of such service and which appear in the corresponding section of the medical list, not being guaranteed the 24-hour emergency service.
      Hospital emergencies are excluded.

3. **Allergology.** Consultations, follow-ups and tests in office. **Immunotherapy treatments and vaccines are excluded.**
4. **Clinical tests.** Including clinical determinations of haematology, biochemistry, immunology, microbiology and hormone testing. **Genetic determinations are excluded.**
5. **Angiology and Vascular Surgery.** Includes consultations, follow-ups and Doppler ultrasound.
6. **Digestive System.** Includes consultations, follow-ups and abdominal ultrasound. **Fibroscan is excluded.**
7. **Cardiology.** Includes consultations, follow-ups and the following tests: echocardiogram, electrocardiogram, stress test, and Holter monitoring (blood pressure and arrhythmias).
8. **General and Digestive System Surgery.** Includes consultations, follow-ups and abdominal ultrasound. **Fibroscan is excluded.**
9. **Maxillofacial Surgery.** Includes consultations and follow-ups.
10. **Medical-surgical dermatology and venereology.** Includes consultations, follow-ups, tests during consultation. Additionally, treatments include cryotherapy, electrocoagulation of superficial lesions, and digital dermatoscopy for early melanoma diagnosis in individuals with a family and/or personal history of melanoma, dysplastic nevus syndrome, and/or multiple nevi/moles **(including one per year).**
11. **Endocrinology and Nutrition.** Includes consultations, follow-ups and ultrasound.
12. **Geriatrics.** Includes consultations and follow-ups.
13. **Haematology and Haemotherapy.** Includes consultations and follow-ups.
14. **Speech therapy (Logophoniatrics).** In the case of rehabilitation after major laryngeal surgery**, up to a maximum of 60 sessions per contract year**. And for organic diseases related to the vocal cords (oedemas, nodules, polyps and cancer) **up to a maximum of 20 sessions per contract year**.
15. **Internal Medicine.** Includes consultations and follow-ups.
16. **Nephrology.** Includes consultations, follow-ups and the following tests: ultrasound and blood pressure Holter monitoring.
17. **Pneumology.** Includes consultations, follow-ups, and pulmonary function tests during consultation.
18. **Neurosurgery.** Includes consultations and follow-ups.
19. **Clinical Neurophysiology.** Includes the following tests during consultation: evoked potentials, electroencephalogram, and electromyogram.
20. **Neurology.** Includes consultations, revisions and the following tests during consultation: evoked potentials, electroencephalogram, electromyogram and Doppler ultrasound of supra-aortic trunks.
21. **Gynaecology.** Includes consultations, follow-ups and tests during consultation: mammography, gynaecological ultrasound and cytology.
22. **Odontostomatology.** Only includes extractions in consultation, dental care resulting from these extractions, simple intraoral X-rays and cleaning of the mouth (tartrectomy) once a year, as prescribed by a dentist from the Insurer's Medical List and all of this carried out in consultation or dental office. In addition, a dental supplement is included with services at special prices, see the conditions in Annex I of this document.

23. **Ophthalmology.** Includes consultations, follow-ups and diagnostic tests during consultation.
24. **Medical Oncology.** Includes consultations and follow-ups.
25. **Otorhinolaryngology.** Includes consultations, follow-ups and the following diagnostic tests during consultations: audiometry and fibroscopy.
26. **Oxygen therapy, ventilation therapy, aerosol therapy.**
27. **Podiatry.** Includes chiropody, treatment of ingrown toenails and/or papillomas in a podiatrist's office, **limited to 6 sessions per year**.
28. **Clinical Psychology.** It includes, **up to a maximum of 15 sessions per Insured and per insurance year,** individual and temporary psychological care, on an outpatient basis, the purpose of which is the treatment of processes that are susceptible to psychological intervention.
29. **Psychiatry.** Includes consultations and follow-ups.
30. **Radiodiagnosis.**
    - Standard and special radiology (digestive, urology and gynaecology).
    - Ultrasound and Doppler ultrasound
    - Bone densitometry.
    - CT scans.
    - Resonance Imaging (MRI).

    Standard contrast media and radiopharmaceuticals used are included.

    The following tests are excluded: Interventional radiology, virtual colonoscopy, coronary CT scan, entero-MRI, arthro-MRI, cardiac MRI, MR cholangiography and MR angiography.
31. **Rehabilitation and Physiotherapy.** Included only on an outpatient and out-of-hospital basis, for the treatment of non-surgical disorders of the locomotor system, until the greatest possible functional recovery is achieved.
32. **Rheumatology.** Includes consultations and follow-ups.
33. **Treatment of pain.** Includes consultations, follow-ups, and the following treatments: infiltrations and blocks performed in consultation by units specialised in these techniques, **excluding medication**.
34. **Traumatology and Orthopaedic Surgery.** Includes consultations and follow-ups.
35. **Urology.** Includes consultations, follow-ups and the following tests during consultation: urological ultrasound, urodynamic studies and uroflowmetry. **Prostate fusion biopsy is excluded.**

ARTICLE 4 - EXCLUSIONS

1. HEALTH CARE

a) **General medical check-ups or examinations of a preventive nature, except for what is expressly included in the contract. Analyses or other examinations that are necessary for the issuing of certificates, reports and any type of document that does not have a clear health care function.**

b) **Physical damage resulting from war, riots, revolutions and terrorism, those caused by officially declared epidemics, those directly or indirectly related to radiation or nuclear reaction and**

those resulting from natural catastrophes (earthquakes, floods and other seismic or meteorological phenomena).

c) Health care due to the consumption of alcohol, drugs of any kind or intoxication due to the abuse of psychotropic drugs, narcotics or hallucinogens.

d) Health care for injuries caused by drunkenness, fights (except in the case of legitimate self-defence), self-harm or suicide attempts and illnesses or accidents suffered due to serious fault, imprudence or negligence on the part of the Insured.

e) Health care required as a result of injuries sustained while taking part in bets and competitions, the practice of high-risk activities such as bullfighting and bull running, the practice of dangerous sports such as scuba diving, horseback riding, caving, boxing, martial arts, climbing, rugby, motor vehicle sports, quad biking, paragliding, aerial activities not authorised for public passenger transport, sailing or white water activities, bungee jumping, canyoning, skiing, snowboarding, surfing and any other manifestly dangerous activity; as well as those sustained from the professional practice of any sport.

f) Health care provided in hospitals, whether outpatient, day hospital or hospitalisation, as well as therapeutic and surgical interventions, except for the cases expressly indicated in Article 3.

g) Hospital emergencies.

h) Arthroscopies, laparoscopies and surgical biopsies, endoscopies, catheterisms, vascular hemodynamic and interventional radiology. Prosthesis of any nature, osteosynthesis material, biological or synthetic materials, anatomical and orthopaedic pieces.

i) Everything concerning psychology, ambulatory narcolepsy, sophrology, neuropsychological and psychometric tests, psychoanalytic psychotherapy, as well as psychosocial or neuropsychiatric rehabilitation, psychoanalysis, hypnosis, group psychotherapy, psychological tests and rest and sleep cures, except for what is expressly included in point 28 of Article 3.

j) Travel and transfer expenses, including ambulances.

k) Treatment for sterility or infertility, voluntary termination of pregnancy in any case, diagnostic tests related to such termination, any surgical procedure on the unborn child and the treatment (including surgery) of impotence.

l) Surgical procedures, infiltrations and treatments, as well as any other type of procedure whose purpose is a change of sex or which has an aesthetic character are expressly excluded. Also expressly excluded is any disease, complication or need for special diagnostic and/or therapeutic tests that are directly related to or are the result of the Insured having undergone a procedure, infiltration or treatment of an aesthetic nature. Only in these cases will the necessary tests for the gynaecological examination be paid for.

m) Any genetic test requested for prognostic or preventive purposes is excluded, as well as genetic predisposition studies of the Insured or their relatives. Also excluded from cover are genetic counselling, genetic mapping, paternity or kinship tests, as well as anything else that is not explicitly included in the contract.

n) Any assistance or treatment for social or family reasons, palliative care, as well as care that can be replaced by home or outpatient care.

o) Health care in non-contracted private centres, as well as services rendered in hospitals, centres and other publicly owned establishments that are part of the Spanish National Health System and/or those that depend on the Autonomous Communities, is also excluded. In any case the Insurer reserves the right to claim from the Insured the recovery of the costs of care that it has had to pay to the public health system for the medical-surgical and hospital care provided.

p) Regenerative medicine, biological medicine, immunotherapy, biological therapies, gene therapy and direct-acting antivirals, as well as the applications of all of them. In addition, all types of experimental treatments, compassionate use, orphan drugs, and those in clinical trials in all their phases are excluded.

q) Pharmaceutical products, medicines and auxiliary means of cure of any kind. Non-commercialised medicines in Spain are excluded. Vaccines are also excluded.

r) Excluded are all those diagnostic procedures or diagnostic, surgical or therapeutic techniques that appear after the signing of this policy not contemplated by the Insurer, unless the Insurer, in compliance with the provisions of Article 126.2 of Royal Decree 1060/2015 of 20 November on the regulation of supervision and solvency of insurance and reinsurance companies, has notified the Insured in writing of their inclusion in the insured covers, under the terms and within the limits established in said notification.
Also excluded are those therapeutic methods, surgical techniques or diagnostic tests performed as part of clinical trials, or which, due to their lack of safety or efficacy, are not used in routine clinical practice. All those that are not approved by the European Medicines Agency and/or the Spanish Agency for Medicines and Health Products, as well as by the Health Technology Assessment Agencies dependent on the health services of the Autonomous Regions or the Ministry of Health, will be considered as such. Also excluded from cover will be those therapeutic methods, surgical techniques or diagnostic tests that have been clearly surpassed by others available.

s) Physiotherapy and rehabilitation treatments when functional or the maximum possible recovery has been achieved, or when it becomes maintenance therapy, which in such a case would be indicated by the professional responsible for carrying out such treatments. In addition, the following are excluded: rehabilitation derived from neurological diseases, educational therapy, language education, special education for the mentally ill and early stimulation rehabilitation in cases of psychomotor developmental retardation. Cardiac rehabilitation, pelvic floor rehabilitation and lymphatic drainage are excluded. Rehabilitation for hospitalised patients is expressly excluded.

t) Alternative and complementary therapies such as acupuncture, naturopathy, homeopathy, chiromassage, mesotherapy, osteopathy, hydrotherapy and pressotherapy are excluded.

u) Any means of diagnosis for sleep disorders is expressly excluded.

v) In the speciality of odontostomatology, obturations, endodontics, placement of prostheses and osteointegrated dental implants, orthodontics, periodontics, as well as other dental treatments other than those included in point 22 of Article 3 are excluded.

w) All surgical and/or therapeutic techniques using lasers.

x) Dialysis treatments.

y) Alternative medicines, treatments in nursing homes, residences, spas and similar establishments.

z) Ozone therapy treatments are expressly excluded.

aa) Diagnostic studies or tests related to research or of a scientific nature shall not be covered.

ARTICLE 5 - HOW SERVICES WILL BE PROVIDED

The healthcare covered by the contract shall be provided in all towns and cities where the Insurer has its own or contracted healthcare centres. When some of the services included in the contract are not available in any of these places, they shall be provided in another town where they are available, with the Insured being able to choose where.

The incorporation of new diagnostic and therapeutic procedures and new technologies in the contract shall be carried out in accordance with the principles of medicine once their effectiveness and safety have been demonstrated and there is sufficient availability in the agreed means. Treatment, consultations, diagnostic or therapeutic means prescribed or ordered by a doctor will not be covered by this contract as long as they are not included in the benefits covered by this contract.

1. CARE GUIDANCE

The Insurer has a Care Guidance Service whose purpose is to facilitate access to care services for Insured parties, informing them of the procedures to be followed and facilitating these procedures to the greatest extent possible.

2. FREEDOM OF CHOICE OF DOCTORS

Insured parties may go freely and directly to the primary care professionals and specialists who form part of the Insurer's current Medical List, as applicable at any given time.

The Insurer recommends that each Insured has a family doctor who is responsible for family care. Each Insured may choose their family doctor and nurse from the doctors on the Insurer's Medical List.

3. HOME VISITS

Home visits by the family doctor or nurse will be made after prior notification by telephone to the doctor within the time frame stated by the doctor. **The home visit will only take place at the address stated in the contract.** For any modifications, the Insurer must be notified at least 8 days before any service is required.

In cases of emergency, the Insured should go to the permanent emergency services set up by the Insurer, or contact the telephone service included for this purpose in the documentation provided to Insured parties.

4. INSURED'S SHARE OF THE COST OF SERVICES (CO-PAYMENTS)

In the event of sharing the cost of the benefit, the Contracting Party or Insured shall pay the corresponding amount for each medical service used by the Insured Persons included in the contract, i.e. each of the benefits reported and invoiced by the providers to the Insurer. The amount of the co-payment or participation is set out in the Particular Conditions.

For this purpose, the Insurer shall periodically provide the Contracting Party with a comprehensive statement of the services used by the Insured parties included in the contract, together with the amount of the co-payments corresponding to them.

The resulting total amount shall be collected by direct debit from the bank account designated by the Contracting Party for the payment of the premium.

The amount of the co-payments may be updated by the Insurer in accordance with the provisions of Article 12.

5. BENEFIT AUTHORISATION

In general, prior express authorisation from the Insurer with the prior written prescription of the contracted professionals for treatments, rehabilitation and physiotherapy treatments, psychology, as well as for diagnostic tests, will be required for assistance.

Documentation to be submitted for those services that require authorisation:

For medical care that requires express authorisation from the Insurer, the Insured must provide, at their request, the medical report stating the personal medical and surgical history, the date of onset and the development time of the symptoms and/or date of diagnosis, tests and treatments carried out to date.

The Insured must obtain prior confirmation of the benefit from the Insurer, who will grant this confirmation unless it is understood that it is a benefit not covered by the contract or related to or preparatory to a benefit that is not covered. Once written confirmation has been granted, the Insurer shall be financially bound to the prescribing or performing doctor.

6. EMERGENCIES

The emergency service must be requested by telephone or by going directly to one of the outpatient Emergency Centres established by the Insurer, whose information is included in the Medical List.

7. TEMPORARY RELOCATIONS

The Insurer undertakes to provide healthcare for the Insured who is temporarily displaced from their habitual place of residence anywhere in Spain. **The Insured may choose between the Insurer's own or contracted centres included in the Insurer's Medical List, in the town or city in Spain where they are located.**

8. ASSISTANCE VIA MEANS NOT ARRANGED WITH THE INSURER

Assistance via means not arranged by the Insurer is not covered by this policy. The Insurer accepts no liability for the fees of medical centres and professionals outside its Medical List, nor for any type of cost or service provided or prescribed by them.

9. ACCREDITATION OF THE INSURED

When requesting care services, the Insured must present their individual health card which the Insurer will give them for this purpose. The Insured must sign the receipt justifying the service received.

When the doctor or the centre providing the service deems it appropriate, they may also request the National Identity Card from the persons obliged to have it.

ARTICLE 6 - PERIODS DURING WHICH CERTAIN COVER CANNOT YET BE BENEFITTED FROM (WAITING PERIOD)

- The benefits that require the completion of the waiting periods prior to being covered by the Insurer are:

Five (5) months for:
-High-tech diagnostic tests.

ARTICLE 7 - BASIS, LOSS OF RIGHTS, TERMINATION AND INDISPUTABILITY OF THE CONTRACT

1. The Insured loses the right to the guaranteed benefit:

   a) If the incident whose risk cover is guaranteed, occurs before the premium has been paid, unless otherwise agreed (Article 15 of the Insurance Contract Act).

   b) When the incident was caused by bad faith on the part of the Insured (Article 19 of the Insurance Contract Act).

2. However, the Insurer undertakes to:

   a) Not cancel the contract when the Insured is undergoing hospital treatment until they are discharged from hospital, unless they waive their right to continue such treatment.

   b) Not oppose the extension of insurance contracts of Insured persons in certain situations of serious illness, provided that the first diagnosis has occurred during the period of the contract. The following are illnesses with ongoing treatment within the contract:

      - Active oncological processes.
      - Cardiac diseases requiring surgical or interventional treatment.
      - Organ transplants.
      - Complex orthopaedic surgery in the evolving stage.
      - Degenerative and demyelinating diseases of the nervous system.
      - Acute kidney failure.
      - Chronic slow-progressing respiratory failure.
      - Chronic liver diseases (excluding those of alcoholic origin).
      - Acute myocardial infarction with heart failure.
      - Macular degeneration.

Not all are necessarily covered in the Health 60+ product. Consult the General, Special and Particular Conditions of your contract.

   c) Not oppose the extension of insurance contracts with Contracting parties over 65 years of age, when they have been with the company (without failure to pay for the premium) for 5 years or more.

The above commitments shall not apply or shall be without effect in those cases in which:

a) The Insured has failed to comply with their obligations or they have withheld or provided inaccurate information when declaring the risk.
b) If the premium is not paid or the Contracting party refuses to accept its update.
c) The Contracting party does not agree to the terms of Renewal.

3. The Contracting Party may terminate the contract when the list of medical professionals corresponding to their province changes by more than 50% in the last 12 months from the start of the contract and must notify the Insurer of this decision by any credible means. This rule does not apply in the case of temporary replacements for justified reasons, or in the case of doctors of special surgical techniques, as well as dentists, analysts and radiologists.

4. If the Contracting Party, when taking out the insurance, has incorrectly stated the birth year of one or more of the Insured persons, the Insurer may only cancel the contract if the true age of the Insured when the contact comes into force exceeds the admission limits or underwriting policies established by the Insurer.

   In the event that, as a result of an inaccurate declaration of the birth year, the premium paid is less than what should have been paid, the Contracting party shall be obliged to pay the Insurer the difference between the premiums actually paid to the Insurer and those which, in accordance with the tariffs, they should have paid according to their true age.

   If, on the other hand, the premium paid is higher than that which should have been paid, the Insurer shall be obliged to reimburse the Contracting Party for the excess premiums received without interest.

ARTICLE 8 - INSURANCE DURATION

Upon expiry, it shall be tacitly extended for one-year periods. The insurance is renewable annually and is contracted for the period stipulated in the Particular Conditions. Upon expiry, it shall be tacitly extended for one-year periods.

However, in addition to the provisions of Article 7.3. of these Conditions, either party may object to the extension of the contract by giving written notice to the other party not less than one month before the end of the current insurance period if it is the Contracting party, and two months if it is the Insurer. The Insurer must be notified by the Contracting Party.

With regard to each Insured person, the insurance policy will be cancelled:

1. Due to death.
2. If the contract includes family members who live with the Contracting party, when they cease to live habitually in the latter's home, which must be notified to the Insurer. If these persons take out a new insurance policy with the Insurer within one month of the aforementioned notification, the Insurer will honour all the rights they have acquired, provided that they take out the same cover.

The covers taken out will not be valid until the first premium has been paid.

ARTICLE 9 - PAYMENT OF PREMIUMS

In accordance with Article 14 of the Insurance Contract Act, the Contracting party is obliged to pay the premium.

1. The first premium or part thereof shall be due in accordance with Article 15 of the Insurance Contract Act, once the contract has been signed. If it has not been paid due to the fault of the Contracting Party, the Insurer has the right to terminate the contract or to demand payment of the premium due by way of enforcement procedure according to the contract. **In any case, if the premium has not been paid before the incident occurs, the Insurer shall be released from its obligation,** unless otherwise agreed.
2. In the event of non-payment of the second or successive premiums or fractions thereof, cover shall be suspended one month after the date of termination of the contract, and if the Insurer does not demand payment within six (6) months following the said date of termination, the contract shall be deemed to be terminated. If the contract has not been rescinded or cancelled in accordance with the above conditions, the cover shall take effect 24 hours after the day on which the Contracting Party pays the premium. In any case, when the contract is suspended, the Insurer may only demand payment of the premium for the current period.

3. The Insurer is only obliged by virtue of the receipts issued by its legally authorised representatives.

   Payment of the premium amount made by the Contracting party to the Broker shall not be deemed to have been made to the Insurer unless, in return, the Broker shall deliver to the Contracting party the original of the premium receipt issued by the Insurer.

4. The Particular Conditions shall establish the Contracting party's designated bank account for the payment of the insurance premium, and the following rule shall apply: the premium shall be deemed to have been paid on completion, unless collection is attempted within a period of thirty (30) calendar days and there are insufficient funds in the Contracting party's account.

ARTICLE 10 - OTHER OBLIGATIONS, DUTIES AND RIGHTS OF THE INSURANCE CONTRACTING PARTY OR THE INSURED

1. The Contracting party and, where applicable, the Insured, have the following obligations:

   a) To notify the Insurer as soon as possible of the change of address.
   b) To notify the Insurer as soon as possible of any additions or partial cancellations of Insured parties that occur during the term of the contract, taking effect on the first day of the month following the date of the notification made by the Contracting party. The following cases of partial cancellation will be accepted: the day on which the Insured dies, a change of residence outside Spanish territory, separation of the couple or emancipation of one of the Insured persons or in the event of the payment of insurance to one of the Insured persons as a corporate social benefit.
   c) To minimise the consequences of the incident, using the means at their disposal for a prompt recovery. Failure to comply with this duty, with the sole intention of harming or deceiving the Insurer, shall release the Insurer from paying out any benefit deriving from the claim.
   d) To grant and facilitate the subrogation in favour of the Insurer established in Article 82 of the Insurance Contract Act.

2. The health card, which is the property of the Insurer and which it will provide to each Insured person, is a document for personal and non-transferable use. In the event of loss, theft or damage, the Contracting party and the Insured are obliged to notify the Insurer within a maximum period of seventy-two (72) hours.

   In such cases, the Insurer shall issue and send a new card to the Insured's address stated in the contract, cancelling the lost, stolen or damaged card.

   In addition, the Contracting party and the Insured undertake to return to the Insurer the card corresponding to the Insured who has cancelled the contract.

   The Insurer accepts no responsibility for improper or fraudulent use of the health card.

3. Within one month (1) of the delivery of the contract, the Contracting party may request the Insurer to rectify any discrepancies between the contract and the insurance proposal or the agreed clauses, in accordance with Article 8 of the Insurance Contract Act.

ARTICLE 11 - OTHER OBLIGATIONS OF THE INSURER

In addition to providing the agreed assistance, the Insurer shall send the contract to the Contracting party or, where appropriate, the provisional cover document.

It will also facilitate:

1. The health card of the corresponding Insured person, a personal and non-transferable document, which confirms their identity and gives them the right to receive care.

2. Medical List with the list of professionals, centres and health services that will provide care. The Medical List may be updated by the Insurer and the Insurer undertakes to publish the updated information on its corporate website.

ARTICLE 12 - ANNUAL UPDATE OF THE ECONOMIC CONDITIONS OF THE CONTRACT

The Insurer may annually update the cost of the premiums and the amount corresponding to the co-payment or the Insured's share of the cost of the services referred to in point 4 of Article 5 of these General Conditions.

These updates of premiums and co-payments will incorporate the necessary adjustments to guarantee that the premium rate is sufficient and are based on the technical-actuarial calculations made and based on the increase in the cost of health services, the increase in the frequency of the benefits covered by the contract, the incorporation of technological innovations used subsequently for the perfection of the contract and which are included in the guaranteed cover, or other events of similar characteristics.

The premiums to be paid by the Contracting party will vary according to the age of each of the Insured persons and the geographical area corresponding to the place of residence of the benefit, applying the rates that the Insurer has in force on the date of each renewal.

On receiving notification of these updates to premiums and/or co-payments for the following year, the Contracting party may choose between extending the Insurance Contract, which implies accepting the new financial conditions, or terminating it at the end of the current year by sending a letter addressed to the Insurer within the periods established in the Insurance Contract Act.

ARTICLE 13 - COMMUNICATIONS

1. Notifications to the Insurer shall be made to the address, e-mail address or telephone number indicated in the contract.
2. Notifications and payment of premiums made to the contract broker shall have the same effect as if they had been made directly to the Insurer.

ARTICLE 14 - LIMITATION

The actions deriving from this contract will expire after **five (5)** years as of the date on which they may be exercised.

ARTICLE 15 - JURISDICTION

This contract is subject to Spanish legal jurisdiction and, within this jurisdiction, the competent judge for hearing any actions arising from it shall be that of the Insured's residence in Spain.

This insurance contract comprises inseparably the above General Conditions, the Particular Conditions, the Special Conditions, if any, and the appendices containing the amendments thereto agreed upon by the parties.

COMPLEMENTARY GUARANTEES TO THE HEALTH CARE INSURANCE

ANNEX I: DENTAL CARE COVER

1. Purpose

In addition to the health care cover that is the purpose of the contract, the Insurer undertakes to provide the Insured with outpatient dental care included in this complementary cover, either free of charge or with the maximum amounts (excesses) stipulated in the corresponding guarantees.

The assistance will be provided exclusively by the professionals who appear on the dental medical list for the current year in question.

No optional cash compensation may be granted under this insurance in lieu of the benefits covered by this cover.

2. Cover Description

This cover refers to the set of stomatological procedures, both at no cost to the Insured and the services established with maximum amounts (excesses) valid for the current financial year, to which the Insured may have access.

The list of services established with maximum amounts (excesses) described for the present financial year may be updated annually based on the price modifications of the suppliers and/or if deemed necessary. The guarantees and maximum amounts may be consulted in an updated manner in the digital media enabled for this purpose.

3. Excluded risks

a) **Physical damage resulting from war, riots, revolutions and terrorism, those caused by officially declared epidemics, those directly or indirectly related to radiation or nuclear reaction and those resulting from natural catastrophes (earthquakes, floods and other seismic or meteorological phenomena).**
b) **Assistance derived from the consumption of alcohol, drugs of any kind, fights (except in the case of legitimate self-defence), injuries, self-harm or suicide attempts.**
c) **Any other dental services not expressly included in the Contract Conditions describing the cover and services provided.**

4. How services are provided

All services covered under this supplemental guarantee are free of charge.

When requesting assistance, the Insured must present the health card, which the Insurer will give them for this purpose. When the professional or centre providing the service deems it appropriate, they may also require the National Identity Card from the persons obliged to have it.

The Insurer accepts no liability for the fees of doctors from outside its approved Medical List, nor for the cost of any medical treatment that they may prescribe.

For the purpose of this insurance, the incident is deemed to have been reported when the Insured person requests the benefits included in this cover.

All treatments and procedures covered will be carried out exclusively on an outpatient basis, excluding hospitalisation and general anaesthesia.

If there are alternative treatments for the same process, the decision and choice of treatment shall be made by the Insured.

5. Structure and operation of the service

The Insurer offers its Insured parties a wide range of stomatology professionals, equipped with the most advanced diagnostic and treatment resources, with national cover for the provision of the service, in accordance with two modalities:

1. **Care guarantee** list of services which the Insured may use for free.

2. **Services with maximum amounts**: services to be paid for by the Insured that can be obtained at special prices. These services are identified as **maximum amounts** (excesses) available to the Insured so that they can be known prior to requesting quotes in the means provided for this purpose.

6. Access to services

- **Choice of professional:** the selection and access to the professional is free, within those included in the dental medical list.
- **Access to the service provision:** in order to use the dental services and the application of the special prices (if applicable) it is essential to present the health card which identifies you as an insured person.
- **Carrying out the diagnosis and quote:** once the appropriate diagnosis has been made, the healthcare professional will draw up a quote in accordance with the maximum recommended prices at the time (in the case of services with associated costs), which must be accepted by the Insured before starting the treatment.
- **Treatment:** in order to start treatment, it will be essential for the Insured to accept the quote for those treatments with an associated cost.
- **Payment for treatments:** in the case of treatments with an associated cost, the Insured shall pay the amount corresponding to the services provided directly to the Professional or Centre.

GLOSSARY OF DENTAL SERVICE TERMS

ALVEOLOPLASTY: technique by means of which a tooth socket is filled with hydroxyapatite after tooth extraction.

APICECTOMY: surgical removal of the tip of a tooth root through the bone and gum.

APICOFORMATION: procedure that stimulates the formation of the root of the teeth in children.

WHITENING: a technique that lightens the colour of highly pigmented teeth.

BRACES: An orthodontic bracket or device that is attached to a tooth for the purpose of attaching an archwire. The braces can be metal, sapphire, ceramic or plastic.

VENEERS: resin or porcelain surface placed on the front of a tooth or crown to give it a natural look.

PERIODONTAL FLAP SURGERY: surgical procedure for the treatment of periodontal disease. The objectives of this procedure are: eliminating pockets, regenerating, and gaining insertion..

COMPOSITE FILLINGS: tooth-coloured filling materials made of resin reinforced with silica or ceramic particles. They are used in dentistry as one of several alternatives to dental amalgams.

REPAIR: repair of damaged dental appliance, which may be simple or require welding.

WISDOM TOOTH: third permanent molar.

CROWN: artificial covering of a tooth with metal, porcelain, or porcelain fused to metal. Crowns cover severely damaged teeth or those weakened by decay and are rebuilt with pins or posts.

3D SCANNER: computer programme for CT scanners that allows to obtain high resolution images of the upper jaw and lower jaw. It turns axial plane sections into panoramic and transversal reconstructions.

MAXILLARY SINUS ELEVATION: surgical procedure that allows bone grafting in the upper arch, with the aim of obtaining an adequate bone base on which to place osteointegrated implants, in those cases where the thickness of the bone does not allow it.

ENDODONTICS: removal of the nerve, dead or alive, from a tooth. The part may have one or more roots. Depending on the number of roots of the tooth, the endodontics will be single-rooted, double-rooted or multi-rooted.

EPULIS: small, benign, purplish-red tumour that develops at the level of the alveolar ridge of the gums at the expense of the bone or soft tissue.

SKELETAL: partial removable prosthesis whose structure is metallic. Skeletal dentures have retainers, a resin base, major and minor connectors, and teeth. The number of teeth determines the size of the skeletal.

FENESTRATION OF CANINE TEETH: removal of the bone and mucosa around an impacted tooth in order to free and make the crown of the tooth visible, allowing the orthodontist to place a brace and bring this tooth into the arch.

SPLINT: dental immobilisation device, made of plastic material or acrylic resin, which is used in orthodontics as a stabiliser, as a vehicle to carry whitening substances into the mouth, in periodontal treatments, as well as a tool that allows the rest of teeth with mobility and in treatments of temporomandibular joint pathology, to relieve the symptoms of this joint and the consequences on the chewing surfaces of the teeth caused by excessive clenching or rubbing between the upper and lower teeth (bruxism).

FLUORIDATION: procedure by which we provide fluoride to prevent tooth decay.

FRENUM: fold of mucous membrane connecting the upper lip or tongue to the alveolar mucosa. (Can be labial or lingual).

GINGIVECTOMY: a surgical procedure in which damaged gum (gingival) tissue is removed. It is currently used for the treatment of: hyperplasia (growth) of the gum due to medication, fibrosis of the gum, supraosseous pockets in difficult places. Also used to improve access in restorative techniques that invade the subgingival space.

DENTAL IMPLANTS: small dental devices inserted into the upper and lower jawbones to help rehabilitate a dental cavity with few or no teeth, making it possible to restore function.

SPACE MAINTAINERS: devices, fixed or removable, aimed at preserving the space left by one or more teeth, until the eruption of the permanent successor.

CAST POST: part that allows a dental crown to be repaired by placing it on an osteointegrated implant or a natural root with endodontics, making the subsequent placement of an artificial crown necessary. The cast posts have a part called a pin for the implant and the root and another post for the crown.

FILLING: dental filling.

PREVENTIVE DENTISTRY: subdiscipline of dentistry that deals with the prevention of disorders of the oral cavity, as well as the maintenance of healthy teeth and gums.

ORTHODONTICS: a speciality within stomatology that includes all the techniques aimed at improving the positional defects of the patient's teeth, to achieve better mechanical function and satisfactory oral aesthetics.

ORTHOPANTOMOGRAPHY: Panoramic dental X-ray. X-rays of the jaws allow visualisation of both bone and dental structures as well as to make certain presumptive diagnoses.

TEMPOROMANDIBULAR JOINT PATHOLOGY (TMJ): painful or defective function of the TMJ. The TMJ is the joint that makes it possible to open and close the mouth. It is the joint where the jaw articulates with the temporal bone of the skull, in front of the ear and on each side of the head.

PERIODONTICS: branch of dentistry that deals with the diagnosis, prevention and treatment of periodontal diseases (tissue surrounding the tooth, which are the gums and bone). When these tissues become infected due to lack of care, they are destroyed and leave the tooth almost without support (periodontitis or pyorrhea).

PERIODONTOGRAM: measurement of tooth mobility.

PROSTHESIS: substitution, using an artificial element, of a part of the body rehabilitating the lost function.

PULPOTOMY: partial removal of the nerve, by removing the dental pulp and subsequent filling of the tooth.

CYST: a sac without an opening or outlet, lined with epithelium and usually containing fluid. The origin may be infectious or residual. The vast majority are benign, and a pathological anatomy study should always be performed.

INTRAORAL X-RAY: exploratory technique consisting of placing radiographic plates inside the mouth, of different sizes, which are recorded from the outside by an X-ray machine.

ROOT PLANNING AND SCALING: treatment aimed at removing and eliminating tartar and plaque from the roots of the teeth with selective instruments for each tooth.

RECONSTRUCTION OF POSTS OR ANGLES WITH PINS OR POSTS: reconstruction of a badly damaged tooth, using pins or posts to strengthen the repair.

RE-ENDODONTICS: procedure by which root canal treatment is performed again on a tooth where the initial endodontic treatment has not given the expected result.

FISSURE SEALANTS: thin plastic film that is painted on the chewing surfaces of the back teeth (molars and premolars) to prevent the formation of cavities.

TARTRECTOMY/CLEANING: elimination of bacterial plaque and tartar or dental calculus.

TELERADIOGRAPHY: x-ray (of the patient's craniomandibular profile) with the radiation source positioned away from the subject and in which the beams are parallel. It is performed by placing the photographic plate outside the mouth and with the X-Ray machine more than two metres away from the patient's skull. The aim is to preserve the real dimensions of it as much as possible.

VESTIBULOPLASTY: surgical procedure aimed at correcting the height of the buccal vestibules (the space between the lip and the gum).

COMPLEMENTARY GUARANTEES TO THE HEALTH CARE INSURANCE

ANNEX II SECOND MEDICAL OPINION COVER

1. Purpose

The purpose of this cover is to guarantee the Insured persons a Second Medical Opinion as defined below.

The Second Medical Opinion shall consist of the assessment, by experts of recognised national and international prestige of the illness in question, of the diagnosis and treatment that the Insured person is following in the process or illness from which they are suffering, issuing the corresponding report for this matter.

2. Insured persons:

The individuals who hold the contract and its Beneficiaries will be considered Insured persons at the time of the cover request and throughout the entire duration of the contract.

3. Description

This cover must be requested during the period of validity of this Health Care insurance contract and in accordance with the definitions detailed below:

a) Second Medical Opinion on the diseases described in this contract in the section on **illnesses subject to Second Medical Opinion**. The service consists of:
   - Second Medical Opinion with specialists of the highest national and international prestige.
   - Without the need to travel and with a response within ten working days, counting from the date on which the Insured sends the completed Second Medical Opinion request form and the corresponding documentation.
   - Support for the patient, if they deem it appropriate, after the Second Medical Opinion has been processed.

b) Selection of experts and hospitals:
   - Selection and referral of national and international medical experts and hospitals.
   - Advice regarding the medical care you will receive in national and international hospitals.

c) In those cases in which the Insured considers it appropriate to receive medical services outside the list of professionals and centres arranged by the Insurer, an Expense Management service shall be provided which shall consist of:
   - Management of appointments with national and international doctors outside the Insurer's list.
   - Obtaining budgets and estimated costs of hospitalisation.
   - Admission procedures in national and international hospitals.
   - Coordination of the patient's transfer (reservations, air and land ambulance and translation service).

Under no circumstances shall these services be provided without the prior authorisation of the Insurer.

4. Illnesses subject to Second Medical Opinion

The Second Medical Opinion may be provided in cases where the Insured has a first diagnosis of the following serious illnesses:

- Cancer.
- Cardiovascular diseases.
- Neurological and neurosurgical diseases, including stroke.
- Chronic kidney failure.
- Idiopathic Parkinson's disease (paralysis agitans).
- Multiple sclerosis.
- Tropical diseases.

5. Other conditions

The services included in this Health Care insurance contract shall only be provided when the Insured or the Insurer's doctor attending them requests a Second Medical Opinion via the telephone number set up specifically for this purpose.

Once the request has been made by telephone, the Insurer will provide the Insured with a questionnaire, which will be returned duly completed, together with the medical/clinical history relating to the case, the laboratory tests, medical reports, X-rays, biopsies and other medical documents available to the Insured that correspond to the first diagnosis established, as well as any reports and complementary tests that the Insurer may request depending on the illness.

The Second Medical Opinion service includes the fees and expenses derived directly from the provision of the medical consultation services and second diagnoses indicated above, provided that these have been requested in the aforementioned manner. **Any other expenses, costs and fees arising from medical consultations or treatments, tests and analyses, reports, X-rays and other types of examinations shall be covered by the Insured if they are carried out by means other than the Insurer's medical teams, even if they are related to the illness or medical condition for which the Second Medical Opinion has been requested.**

6. Use of the service

This service offers medical information to complement, from a qualified medical expert, the information that the Insured receives from their attending doctor and is never intended to reach a medical diagnosis or a therapeutic decision on its own.

The response obtained through the Insurer shall be conditional upon the truthfulness and accuracy of the data provided.

The answer the Insured receives should not be used to substitute their attending doctor, as reaching any medical decision requires a personalisation that only the actual clinical interview can provide.

7. Request for Second Medical Opinion

Requests for Second Medical Opinion services can be made by calling 91 590 96 40.

The Insured must provide the identification details requested in order to accredit their right to the service.

COMPLEMENTARY GUARANTEES TO THE HEALTH CARE INSURANCE

ANNEX III: ADDITIONAL COVERS 60+

HOME HELP

1. Purpose and description of cover:

The Insured persons of this insurance contract shall be entitled to a total of up to 37 hours per year for the services included and detailed below, provided that the Insured has been or is hospitalised with overnight stay for a period of more than 72 hours, has a medical leave or prescription certifying the need for immobilisation due to convalescence for a period of more than 5 days at home.

In order to access this guarantee, the Insured must provide the Insurer with a medical report or medical leave certifying that they have a medical condition.

The following are the services included and the hours for each of them:

- Home help: a total of 30 hours per Insured per year for the services detailed below, provided that these tasks can be performed by an assistant:

- **Physical care and personal attention.** This service includes the following basic tasks: personal care and attention consisting of bathing and hygiene, assistance with lying down and getting up, monitoring and tracking of nutrition, shopping, and meal preparation.
- **Accompaniment.** For performing errands, administrative procedures, shopping, and visits.
- **Night-time Assistance and Supervision.** Monitoring, personal attention, and care during the

night.

- Physiotherapy: a total of 7 hours per year by a general physiotherapist for the treatment of painful conditions and/or functional impairments using physical methods to maintain and improve body mobility, aiming to enhance the individual's quality of life. Physiotherapy for trauma, rheumatology, sports, geriatrics, neurology, respiratory conditions, or lymphatic drainage.

2. General characteristics:

The service will be provided wherever the Insured may need it (home, hospital, etc.) and anywhere in Spain, provided that the local circumstances, transportation availability and other characteristics allow it.

The hours of service corresponding to the same claim shall be distributed over a maximum period of one month and the minimum shall be 2 consecutive hours of service.

3. Access to services:

For the provision of the service, the Insured shall contact the Insurer through the means provided for such purpose, from where they shall be asked for their National Identity Document Number for identification purposes.

Once identified, the entity will send them the following documentation, which must be sent to us prior to the start of the service:

- Socio-health record that will include the most relevant aspects of the user (medical history, medication, allergies, contact relatives...), as well as the place where the service will be provided.
- Medical recommendation form for the 24-hour home surveillance service, detailing: the place of service, the profile of the service to be provided, as well as the desired start and end date. It must be completed and stamped by a doctor attesting to the need for the Service(s).

MEDICAL GUIDANCE

1. Purpose and description of cover:

The Insured persons included in this contract will have access to care coordination. This is a medical guidance and coordination service for appropriate referral of the patient to specialists and prescription of tests and medications.

2. Access to the service:

The insured shall contact the insurer through the means provided for such purpose.

ANNUAL CHECK-UP

1. Purpose and description of cover:

The Insured will be covered for an annual preventive check-up that includes: consultation, general analysis, electrocardiogram, consultation of results and diagnostic guidance.

2. Access to the service:

To request the service, the insured must contact the insurer through the designated channels for such purpose, by means of the previously mentioned care coordination service.

The insured will be referred to the contracted medical centres determined by the Insurer.

INSURED PARTY'S DEFENCE SERVICE

1. CAJA DE SEGUROS REUNIDOS, Compañía de Seguros y Reaseguros, S.A. (CASER) offers its customers its Insured party's Defence Service (Complaints and Claims) at Avenida de Burgos, nº 109, 28050 Madrid, and via the email address: *defensa-Asegurado@caser.es*

2. This Service will attend to and resolve, in accordance with the current regulations, within a maximum period of two months from their submission, the complaints and claims made, directly or through accredited representation, by all natural or legal persons, insurance users and participants or beneficiaries of occupational pension plans and associates of CASER, when these refer to their legally recognised interests and rights related to their insurance and pension plan operations, whether they derive from the contracts themselves, from the regulations on transparency and customer protection or from good practice and usage, in particular the principle of equity.

   The complaint or claim may be submitted in person or by accredited representation at any of the Company's offices open to the public or at the office of the Insured party's Defence Service on Avenida de Burgos 109, 28050 - Madrid, by post or online, provided that they can be read, printed and stored, in which case it must comply with the provisions of Law 59/2003 of 19 December on Electronic Signatures.

3. If the admission of the claims or complaints is refused, or if the request is totally or partially rejected, or if a period of one month has elapsed from the date of its submission to the Insured's Defence Service without it having been resolved, the interested party may submit their claim or complaint to the Claims Service of the Directorate-General for Insurance and Pension Funds (Paseo de la Castellana, nº44, 28046 Madrid), a body that will act as an alternative dispute resolution body in consumer matters, in accordance with the First Additional Provision of Law 7/2017, of 2 November. The website address of the Directorate-General of Insurance is provided for this purpose, www.dgsfp.mineco.es/reclamaciones/ where the claimant can find information

on the procedure, requirements and means to file a claim or complaint. It may also be submitted to the competent courts.

4. Both at the CASER offices, and on its website www.caser.es our customers, users or injured parties, will find at their disposal a claim form model, as well as the Entity's Regulation for the Defence of the Insured persons, which governs the activity and the operation of this Service and the features and requirements for submitting and resolving complaints and claims. Likewise, from this web page, you can file a complaint or claim.

5. The resolutions will take into account the obligations and rights set out in the General, Particular and Special Conditions of the contracts, the regulations governing insurance activity and the rules on transparency and protection of financial services customers (Insurance Contract Law, redrafted text of the Law on the Regulation and Supervision of Private Insurances, redrafted text of the Law on Pension Plans and Funds, Law on Financial System Reform Measures, Law on Alternative Dispute Resolution in Consumer Affairs, Order ECC/2502/2012, regulating the procedure for the submission of claims to the Claims Service of the Directorate-General of Insurance and Pension Funds among others, Order ECO 734/2004, of 11 March, on the customer services of financial entities, redrafted text of the General Law for the Defence of Consumers and Users and other complementary laws).