CASER SALUD ADAPTA
+ Sonrisa Esencial

Health and Dental Care Policy

General Conditions

CAJA DE SEGUROS REUNIDOS

Compañía de Seguros y Reaseguros, S.A.

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Pursuant to Article 3 of the Insurance Contracts Act 50/80 of 8 October, the clauses limiting the rights of the insured parties in the general conditions of the policy are highlighted in bold print.

This contract is subject to the Insurance Contracts Act 50/1980 of 8 October, and to Act 20/2015 of 14 July on the Classification, Supervision, and Solvency of Insurers and Underwriters and its implementation regulations.

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

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GENERAL CONDITIONS

PREAMBLE

This Insurance Contract is governed by the provisions of Law 50/1980 of 8 October on insurance contracts (Official Bulletin of 17 October 1980), Law 20/2015 of 14 July on the planning, supervision and solvency of insurance and reinsurance companies and its implementing regulation (Royal Decree 1060/2015 of 20 November) and by the provisions of the General, Specific and Special Conditions of this Contract. The insurance activities of the company are supervised by the Spanish Ministry for the Economy and Competition, through its Directorate-General of Insurance and Pension Funds.

By signing the form, the Specific Conditions or (where applicable) the Certificate of Insurance, the Policyholder accepts specifically the clauses restricting the rights of the Insured highlighted in bold font.

ARTICLE 1 - DEFINITIONS

For the purposes of this Contract, the terms below will have the following meanings:

ACCIDENT: Means an event resulting in physical injury suffered while the policy is in force caused by a violent, sudden, external event beyond the control of the Insured.

INSURED: Means the natural or legal person who is a beneficiary of the insurance policy and who assumes the obligations derived from the Contract except for those for which the Policyholder is responsible. Unless otherwise expressly stated in the Specific Conditions, the Policyholder and the Insured are one and the same person.

INSURER: Means the legal person who assumes the contractually agreed risk, in this case CAJA DE SEGUROS REUNIDOS, Compañía de Seguros y Reaseguros, S.A (hereinafter referred to as the Insurer).

SPECIAL HOME MEDICAL ASSISTANCE SERVICES: Means medical assistance provided to the Insured by the general practitioner or family doctor and a nursing assistant or registered nurse at the address stated in the Policy when the ill person is suffering from a condition that requires special care but not hospital admission. This service must always be authorised in advance by a practitioner of the Insurer.

NURSING ASSISTANT/REGISTERED NURSE: Means a healthcare professional who meets the legal requirements and has the training required to practice nursing.

SPECIFIC CONDITIONS: Means a document that forms part of the Policy that sets out and provides details of aspects of the risk covered.

HEALTH QUESTIONNAIRE: Means the document that the Policyholder and/or the Insured must complete accurately and in full, sign and return to the Insurer so that the Insurer has all the information it needs to evaluate the risk.

ILLNESS: Means any change in the state of health of the Insured that is not the result of an accident, diagnosed by a doctor, that requires medical assistance and the first signs of which become apparent during the term of the Policy.

CONGENITAL DISORDER, DEFECT, DISABILITY OR ABNORMALITY: Means a condition that exists at birth as a result of hereditary factors or medical conditions acquired during pregnancy up to the moment of the birth itself. The condition may manifest itself and be recognised immediately after birth or may be discovered later, at any time during the life of the Insured.

PRE-EXISTING ILLNESS: Means a condition suffered by the Insured prior to the effective date the Policy.

EXCESS OR COPAYMENT: Means an amount that the Policyholder must pay the Insurer for each health service used by them or the Insured parties in their policy. The amount can vary according to the type of health service and/or medical speciality provided. The amount of the Excess or Copayment, which is determined in the Specific Conditions, can be updated on an annual basis.

HOSPITAL: Means any institution legally authorised to provide medical or surgical treatment to outpatients or admitted patients for illnesses or injuries. These institutions will have a doctor permanently on duty, and will only admit persons who are ill or injured.

For the purposes of the Policy, hotels, asylums, nursing homes, hospices, spas, facilities that are primarily dedicated to the internment and/or treatment of drug addiction or alcoholism and similar institutions will not be considered hospitals.

HOSPITALISATION:

- General hospitalisation: Means a situation where a person is registered as a patient at a hospital and stays overnight there, or who has a mail meal there.

- Outpatient care: Means a situation where a person is registered as a patient at one of the units of the hospital (whether medical, surgical or psychiatric) to receive specific treatment or because they have been under anaesthetic, but without spending the night or having a main meal there.

SURGICAL OPERATION: Means any operation carried out through an incision or other means of internal entry by a surgeon. Said operation will normally take place in an operating theatre.

LIST OF MEDICAL PRACTITIONERS: Means the list of healthcare professionals and institutions belonging to or contracted by the Insurer in each province, with their addresses, telephone numbers and opening hours. In addition to healthcare professionals and institutions in the province, the list of medical practitioners for each province will include details of the information services and customer helplines that the Insured can call for the whole of Spain.

DOCTOR: Means a health professional duly authorised to practice medicine.

SPECIALIST DOCTOR OR SPECIALIST: Means a doctor who has the qualifications required to practice a legally recognised medical speciality.

WAITING PERIOD: Means the period that must pass before some of the cover included in the Policy comes into effect. This period is calculated in months, starting on the effective date of the Policy for each of the Insured parties.

INCONTESTABILITY PERIOD: Means the period, starting on the effective date of the Policy for each of the Insured parties, during which the Insurer may refuse to provide coverage or challenge the Contract on the grounds that the Insured has a Pre-Existing Illness that has not been declared on the Health Questionnaire. Once this period has elapsed, the Insurer may only refuse to provide cover is there has been an intentional concealment by the Insured.

POLICY: Means the document or documents that contain the clauses and pacts that regulate the Insurance Policy. The following form an integral and inseparable part of the Policy: the insurance application, the Health Questionnaire, the General Conditions, the Specific Conditions that specify the risks and the Particular Conditions (if any), as well as any supplementary documents or appendices that contain amendments agreed to during the term of the Contract.

SERVICE: Means the healthcare assistance provided as a result of a Claimable Event.

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

PROSTHESES, IMPLANTS AND GRAFTS: Means any element that replaces, whether temporarily or permanently, all or part of an organ, tissue, body fluid or limb (valves, artificial skin, intraocular implants, biological material, gels, synthetic or semi-synthetic fluids that replace bone or body fluids and drug reservoirs, among others).

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

CLAIMABLE EVENT: Means an event suffered by the Insured as a result of which he or she requires healthcare services covered in part or in full under the Policy.

CASER SALUD CARD: Means the health card issued to each party insured under the policy by the Insurer, and which is the property of the Insurer. This card may only be used by the holder, who should produce it to receive the services covered under the Policy.

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

EMERGENCY: Means a situation where the Insured requires immediate medical attention in order to avoid irreparable damage to their health.

ARTICLE 2 - PURPOSE OF THE INSURANCE

The Insurer promises to provide the Insured with the medical, surgical and hospital healthcare they require for illnesses and injuries that are covered by this insurance policy within Spain, subject to the limits and conditions stipulated in the Policy and payment of the Premium and Excesses applicable. All healthcare services will be provided by the medical practitioners with whom the Insurer has entered into an agreement at the time the Service is provided.

At all times, the Insurer will provide the necessary emergency assistance in accordance with the provisions of the Conditions of the Policy and the provisions of Article 103 of the Insurance Contracts Act.

No cash payments in lieu of healthcare services will be made under the terms of this Policy.

ARTICLE 3 - DESCRIPTION OF COVER

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

1. FAMILY MEDICINE

General medicine/Family doctor: Healthcare provided at the doctor's surgery or at home. Care at home will only be provided when the patient cannot travel due to medical reasons.

Paediatrics - Child care: Includes preventative and child development check-ups.

Nursing Assistant/Registered Nurse services: Healthcare provided at the doctor's surgery or at home. Care at home will only be provided when the patient cannot travel due to medical reasons and the visit has been authorised in advance by a doctor of the Insurer.

2. EMERGENCIES

If an Insured requires emergency healthcare, they should go to one of the 24-hour emergency healthcare centres on the list of contracted medical practitioners and medical centres of the Insurer. Emergency medical services will be provided at the home of the Insured by a GP and/or nursing assistant the Insurer when this is necessary as a result of the state of health of the patient.

3. SPECIALITIES

The Insured will be provided with specialist healthcare as an outpatient or as an admitted patient (according to the judgement of the doctor of the Insurer) for the following specialities:

3.1. Allergology. Vaccines will be paid for by the Insured.

3.2. Anaesthesiology and resuscitation.

3.3. Pathology. The determination of the following therapeutic targets in a preliminary study prior to personalised cancer treatment based on the type and stage of tumour is specifically included:

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

The Policy covers only the therapeutic targets listed in a drug's specifications and, depending on the therapeutic approach taken in each case, must be determined before the drug is administered. The drugs must be of proven clinical effectiveness and importance and sold in Spain. They must also be authorised and approved by the Spanish Agency of Medicines and Medical Devices.

3.4. Angiology and vascular surgery. The Policy covers symptomatic varicose vein surgery (classified as grades III to VI in accordance with the CEAP classification, which assesses and classifies venous insufficiency for the treatment or elimination of saphenous vein reflux) by means of endolaser for thermal ablation (endovascular laser), radio frequency (endovascular radio frequency fibre) or sclerotherapy. Treatment will be provided at the medical centres which have an agreement with the Insurer to this effect.

3.5. Digestive system.

3.6. Cardiology. This includes a cardiovascular risk prevention programme for people over 45 years of age.

3.7. Anal-rectal surgery. Proctology.

3.8. Cardiovascular surgery.

3.9. General surgery and surgery on the digestive system.

3.10. Maxilofacial surgery.

3.11. Paediatric surgery.

3.12. Plastic and reconstructive surgery. This insurance only covers breast reconstruction after surgery for breast neoplasms, provided that the surgery has been performed during the term of the Policy. Breast prostheses are included.

3.13. Thoracic surgery.

3.14. Medical-surgical dermatology and venereology.

3.15. Endocrinology and nutrition.

3.16. Geriatrics.

3.17. Haematology and hemotherapy. Autologous bone marrow transplants are included **only for the treatment of haematological tumours.**

3.18. Immunology.

3.19. Infectious and tropical diseases.

3.20. Internal medicine.

3.21. Nuclear medicine.

3.22. Nephrology.

3.23. Neonatology.

3.24. Pneumology.

3.25. Neurosurgery.

3.26. Clinical neurophysiology: This covers the neurophysiological intraoperative monitoring of the nervous system solely and exclusively for intracranial surgery and of the fusion or arthrodesis of three or more levels of the spinal column.

3.27. Neurology.

3.28. Obstetrics and gynecology.

a) **Preparation for birth:** This consists of a set of techniques that are practised to prepare the expectant mother physically and psychologically for birth. It is aimed at women who are in their second or third trimester of pregnancy.

b) **Pregnancy healthcare /monitoring:** The pregnancy is monitored by an obstetrician.

c) **Family planning**: This includes tubal ligation, hormonal contraception monitoring and the insertion and monitoring of IUDs. **The cost of the IUD is included, provided that it has been purchased at a chemist.** The Insurer will reimburse the Insured for 100% of the cost once the Insured has presented the prescription from the doctor and the corresponding invoice. **Hysteroscopic tubal occlusion, the insertion of Essure devices and other techniques are not covered.**

d) **Preventive medicine:** Annual gynaecological check-ups for the early detection of breast and cervical neoplasms. This cover also includes the study and diagnosis of infertility and sterility.

3.29. Ophthalmology. This includes laser photocoagulation and corneal transplants. The cost of the cornea to be transplanted is to be met by the Insured.

3.30. Medical oncology. This includes implantable port-a-cath reservoirs for intravenous perfusion used in chemotherapy.

3.31. Radiotherapeutic oncology. Except for radioembolisation with spheres, and limited exclusively to cancers and arteriovenous malformations.

3.32. Otorhinolaryngology. This includes radio frequency for the treatment of illnesses that affect the respiratory system.

3.33. Clinical psychology. This includes individual, short-term outpatient psychological treatment, prescribed by a psychiatrist on the list of medical practitioners of the Insurer, to treat conditions that can benefit from psychological treatment, **up to a maximum of 15 sessions per Insured per annum**.

A prescription from one of the specialists on list of medical practitioners of the Insurer and authorisation from the Insurer will be required prior to treatment.

3.34. Psychiatry.

3.35. Rehabilitation and physiotherapy. This includes **only outpatient treatment for problems with the musculoskeletal system**. Lymphatic drainage after breast cancer surgery performed during the term of the Policy is included.

A prescription from one of the specialists on list of medical practitioners of the Insurer and authorisation from the Insurer will be required prior to treatment.

3.36. Rheumatology.

3.37. Pain treatment. Port-a-cath implantable reservoirs are included.

3.38. Traumatology and orthopaedic surgery.

3.39. Urology. This includes vasectomies, the diagnosis (not treatment) of impotence and the study and diagnosis of infertility and sterility. It also includes the use of Holmium surgical lasers for endourological surgery, lithiasis, stenosis and tumours and the green-light laser (KTP and HPS) for the surgical treatment of benign prostatic hyperplasia. All treatment will be provided at centres that have prior agreements with the Insurer for this purpose.

4. METHODS OF DIAGNOSIS

Diagnostic tests will be only carried out **with a prior written prescription from a specialist on the list of medical practitioners of the Insurer**. This cover includes all the standard methods of diagnosis recognised in medical practice at the time the Policy is purchased. **Diagnostic studies and tests for research or scientific purposes and plastic surgery tests are not covered.** The contrast methods and radiopharmaceuticals used are included in the cover.

4.1. Clinical analyses: These include biochemical, haematological, microbiological, parasitological and cytopathological analyses, as well as those for surgical pathology.

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

4.3. Visceral and vascular interventional radiology.

4.4. Other:

a) **Nuclear medicine.** Radioactive isotopes and gammagraphy.
b) **Positron emission tomography (PET):** In cases of cancer and drug-resistant epilepsy.
c) **Endoscopies: If endoscopic capsules are used, only those used for the small intestine will be covered.**

4.5. Cardiological diagnostics: Electrocardiograms, stress tests, echocardiograms, conventional Holter monitor, Holter event monitor, Doppler, hemodynamic and electrophysiological studies and coronary CAT scans.

4.6. Clinical neurophysiology: Electroencephalograms, electromyography, cited potentials and polysomnography solely for studying obstructive sleep apnoea.

4.7. Triple screening, amniocentesis and foetal karyotyping in high-risk pregnancies.

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

4.9. Detection of sentinel lymph nodes in breast cancer and melanoma.

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

5. HOSPITALISATION

Insured parties will be admitted to a hospital either belonging to or contracted by the Insurer when a doctor at the hospital issues an admission order to this effect. The Insured will have their own room with a bathroom and a bed for a companion (unless this is clearly impossible), except for those cases which are expressly excluded. The Insurer will be responsible for operating theatre expenses, anaesthetic products and drugs used during both surgery and hospitalisation, as well as the materials required for post-operative care and board for the Insured whilst in hospital.

5.1. Medical hospitalisation (without surgery): The duration of the stay of the Insured in hospital will be decided by the doctor of the Insurer in charge of the healthcare. The Insured will remain in hospital until the doctor considers that they can be discharged. Outpatient care is included.

5.2. Paediatric hospitalisation: This includes conventional hospitalisation and incubator (the latter does not include a bed for a companion). **Hospitalisation of a premature or newborn baby at a specialist centre (neonatology), provided that the baby is included as an Insured in the Policy.**

5.3. Maternity hospitalisation: The Insured will be attended to by an obstetrician and a midwife. The cover includes anaesthesia (including epidural anaesthesia), **as well as a cot and incubator for the newborn, provided that the baby is included as an Insured in the Policy.**

5.4. Surgical hospitalisation: This includes outpatient care (major outpatient surgery).

5.5. Hospitalisation in the intensive care unit (ICU): The insured will be hospitalised in the appropriate facilities of a hospital designated by the Insurer when an admission order has been issued by a doctor at said hospital. The head of the intensive care unit will decide how long the insured will stay there. **Due to the nature of this type of hospitalisation, a bed for a companion is not included.**

5.6. Special home care: When the practitioner of the Insurer considers that the Insured requires hospital-type healthcare which is covered by the policy, but does not have to be admitted to hospital, medical and nursing care may be provided to the insured at the home that appears in the Policy.

Expenses incurred as a result of social care, accommodation and board costs, linen, food, medication, and healthcare materials are excluded, as are the general healthcare provided by GPs, nursing assistants and registered nurses and the round-the-clock presence of healthcare professionals in the home of the Insured.

6. PROSTHESES, GRAFTS AND IMPLANTS:

This cover includes fixed internal temporary or permanent prostheses, which should be provided by the suppliers designated by the insured and implanted during the term of the policy, such as cardiac valves **(except for valve endoprostheses (pulmonary and aortic), and METRACLIP and similar devices for percutaneous/transapical procedures using a catheter)**, vascular bypasses; pacemakers; stents; orthopaedic prostheses; osteosynthesis material; monofocal intraocular lenses for cataract surgery **(except toric and bitoric lenses)** breast prostheses following surgery for breast neoplasms (provided that the surgery was performed during the term of the Policy) **the contralateral prosthesis will not be covered unless it is for a neoplasm**, as well as auditory prostheses **(except cochlear implants, Carina implants and similar devices)**. Testicular prostheses will only be covered after cancer surgery. **Contralateral prosthesis will not be covered unless it is for a neoplasm**.

7. SPECIAL TREATMENTS

In all cases, **special treatments will only be carried out after the Insured has received a written prescription from one of the specialists on the list of medical practitioners of the Insurer** at a medical centre designated by the Insurer that specialises in the illness. **The Insured will require authorisation from the Insurer in order to receive treatment.**

- **Aerosol and ventilation therapy**: **All medication will be paid for by the Insured.**
- **Oxygen therapy:** This will be provided for both admitted patients and outpatients. Outpatient oxygen therapy is provided for patients who require oxygen treatment for at least 16 hours a day.
- **Dialysis (haemodialysis and peritoneal dialysis):** This only covers the treatment of acute renal failure on the days that it is necessary. **It does not include chronic conditions.**
- **Phoniatrics: Covered solely as rehabilitation after major larynx surgery**, for up to a maximum of 60 sessions.
- **Laser therapy:** This is only included for ophthalmological treatments, musculoskeletal rehabilitation, urology (in accordance with the terms of Article 3) and in varicose vein treatment (in accordance with the terms of Article 3).

- **Chemotherapy and radiotherapeutic oncology, except for radioembolisation with spheres and limited exclusively to cancers and arteriovenous malformations.** This patient will receive this treatment as an admitted patient or an an outpatient, except for intravesical BCG instillations for the treatment of superficial bladder cancer. These may be provided on an outpatient basis. **The Insurer will only pay for cytostatic drugs that are available in the domestic market, duly authorised by the Ministry of Health and used as per the instructions given in the technical data sheet of the product.**

Extracorporeal renal lithotripsy.

8. OTHER SERVICES

- **Ambulances:** The Insurance only covers **urban and intercity journeys for the Insured from his/her home to the hospital or vice versa, and only in the event of hospital admissions or emergency healthcare**. **An order from the doctor of the Insurer will be required, except in the event of an emergency.**

  Ambulance transfers will always be made using land ambulances, and will be provided when ordered in writing by the doctor when the Insured is physically unable to use ordinary transport services (public transport, taxi or own vehicle).

- **Podiatry:** Only podiatry services in a hospital (**limited to 6 sessions a year**) and biomechanical gait studies for children under 15.

ARTICLE 4 - EXCLUDED RISKS

a) Injuries the result of wars, uprisings, revolutions and terrorism; those caused by officially declared epidemics; those directly or indirectly related to radiation or a nuclear reaction; and those the result of natural disasters (earthquakes, floods and other seismic or meteorological phenomena).

b) Pharmaceuticals, radiopharmaceuticals and medicaments of all types prescribed when the Insured is not hospitalised, as well as vaccines of all types and parapharmaceuticals.

c) Healthcare arising from the consumption of alcohol or drugs of any type.

d) Healthcare for injuries that are the result of inebriation, fighting (except in cases of legitimate self-defence) or injuries the result of self-harm of suicide attempts.

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

f) Healthcare required for all types of illnesses, injuries or accidents and their long-term impacts or consequences, congenital defects or abnormalities and pre-existing conditions which were diagnosed prior to the effective date of the Policy for each Insured Party, as well as healthcare for symptoms that may constitute the onset of a medical condition and which appeared before such date, or for which the insured has undergone analyses, diagnostic tests or treatments of any kind prior to the effective date, unless such illnesses, injuries, accidents, symptoms, defects or abnormalities were declared by the Policyholder or Insured in the Health Questionnaire and the Insurer had specifically agreed to cover them in the Specific Conditions. This exclusion will not affect Insured Parties who have been covered by the Insurance Policy since birth, pursuant to point 1. e) of Article 10.

g) Alternative medicines. Treatments in asylums, residences, spas and similar institutions.

h) General preventative check-ups or examinations, except for those expressly included in point 3 of Article 3.

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

j) The following are expressly excluded from the insurance cover: surgical operations, filtrations, treatments, and any other form of medical intervention performed purely for cosmetic reasons. Illnesses, complications and special diagnostic and/or therapeutic tests directly related to or a consequence of the Insured having undergone a surgical operation, infiltration or treatment for purely cosmetic reasons are also excluded. In these cases, the Insurer will only cover tests needed for gynaecological check-ups.

k) Everything related to psychology, ambulatory monitoring for narcolepsy, sophrology, neuropsychological and psychometric tests, psychoanalytic psychotherapy, psychosocial rehabilitation or neuropsychiatry, psychoanalysis, hypnosis, group psychotherapy, psychological tests, rest cures and sleep therapy is specifically excluded from the cover, except for what is expressly included in point 3.34 of Article 3.

l) Organ and organ tissue transplants, except for autologous bone marrow and corneal transplants (the Insurer will not pay the cost of the cornea to be transplanted).

m) Healthcare for AIDS and diseases caused by the human immunodeficiency virus (HIV), as well as any type of treatment and healthcare for hepatitis C and its complications.

n) Hospital healthcare and treatment for social or family reasons, as well as hospital healthcare and treatment that can be replaced by healthcare and treatment at home or at an outpatient clinic.

o) The surgical correction of myopia, hypermetropy or astigmatism, presbyopia and any other refractive eye condition. In addition, intracorneal segment/ring implants are excluded. Crosslinking as a treatment for keratoconus is also expressly excluded.

p) All surgical and/or therapeutical techniques that use laser, other than those expressly included in point 7 of Article 3.

q) Transportation and travel expenses, except for the cost of an ambulance under the terms included in point 8 of Article 3. In addition, any transfers required for appointments, diagnostic or therapeutic tests, rehabilitation, physiotherapy, phoniatrics, psychology, radiotherapy, cancer treatment, surgery and all special treatments are excluded, irrespective of whether the treatment is provided as an admitted patient or an outpatient.

r) Chronic dialysis treatments.

s) Physiotherapy and rehabilitation when the Insured has recovered functional use of the affected part or has made the fullest possible recovery, or when it becomes occupational maintenance therapy (or does so in the opinion of the specialist in charge of the treatment). Educational therapy is excluded. Pelvic floor and lymphatic drainage rehabilitation are excluded except for that which is expressly included in point 3.35 of Article 3, as is rehabilitation required as a result of a neurological disorder.

t) Genetic tests to determine whether the Insured or their present or future descendants have a genetic predisposition to diseases caused by genetic alterations are excluded, with the sole exception of those expressly included in the cover, such as amniocentesis (except for the in situ hybridisation technique), karyotyping (except for karyotyping of foetal tissue) and the therapeutic targets described in Article 3. Genetic counselling, paternity and kinship testing, cancer gene-mapping and pharmacogenetics, whether for preventive or predictive purposes, are also excluded, as are massive gene sequencing, molecular karyotyping, comparative genomic hybridisation techniques, microarray platforms with automated interpretation of results and any other genetic and/or molecular biology testing requested for prognostic or diagnostic purposes.

u) Diagnostic and therapeutic procedures that have not been scientifically proven are excluded, as are those that appear after this Policy has been signed and which are not specified by the

Insurer. In addition, procedures that have not gained widespread acceptance and are not well-established in standard clinical practice, those which have been replaced by other available procedures, experimental procedures and procedures whose effectiveness in the prevention, treatment and curing of illnesses has not been clearly established are also excluded.

A diagnostic, surgical, or therapeutic procedure is considered to be safe and effective, for the purposes of this Policy when it has been approved by the European Medicines Agency and/or the Spanish Agency of Medicines and Medical Devices. A procedure is considered to have gained widespread acceptance and be well-established when it has been adopted as standard clinical practice at public hospitals that are not among the leading public hospitals.

v) All sleep disorder diagnosis methods are specifically excluded, except for those specified in point 4 of Article 3.

w) Metabolic and obesity surgery and the implanting/fitting of gastric bands and intragastric balloons.

x) Robotic surgery and neuromonitoring for any diagnostic, surgical or therapeutic procedures are excluded, except as specified for neurophysiology in point 3.26.

y) Implantable drug-delivery pumps and spinal stimulation electrodes are expressly excluded.

z) All types of orthopaedic material, orthotic devices, external fixators, biological or synthetic materials, grafts (except bone grafts), prostheses, dental osseointegrated implants and cochlear implants, valve endoprostheses (pulmonary and aortic), METRACLIP and similar devices for percutaneous/transapical procedures using a catheter are excluded, as are implantable pumps, penile and testicular prostheses (except after cancer surgery) intraocular multifocal lenses, and implantable automatic defibrillators. The infiltration of autologous growth factors (plasma rich in growth factors) and/or platelet concentrates and cellular components is also excluded.

aa) Breast reduction surgery is excluded.

bb) Cytoreductive surgery and intraperitoneal chemotherapy are excluded.

cc) Psychiatric hospitalisation is expressly excluded.

dd) Health and social care and/or palliative care are excluded.

ARTICLE 5 - HOW THE SERVICES ARE PROVIDED

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

New diagnostic and therapeutic procedures, and new technologies, will be included in the policy in accordance with medical principles once their effectiveness and safety has been proven, and they are available at the centres that the Insurer has entered into an agreement. Treatment provided by healthcare professionals, appointments, and diagnostic or therapeutic methods prescribed by a doctor will not be covered by this policy unless they are included in the healthcare services covered by this policy.

1. HEALTHCARE ADVICE AND GUIDANCE

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

2. FREE CHOICE OF DOCTORS

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

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

3. HOME VISITS

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

In the event of an emergency the insured should go to the 24/7 emergency health services centre established by the Insurer, or telephone the emergency helpline that is listed in the documentation given to insured parties.

4. COST-SHARING

In the case of healthcare services with a copayment amount, the insured will be required to pay a copayment for the service s/he has received. Caser will calculate the total amount of copays payable by the insured on the basis of the invoices it receives from the insured´s doctor. The copay amounts are listed in the specific conditions of the policy.

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

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

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

5. AUTHORISATION OF SERVICES

In general, hospitalisation, surgical operations, special treatments, rehabilitation and physiotherapy, psychological treatment, assisted reproduction treatment and diagnostic tests will require a written prescription from the Insurer's medical practitioner and prior express authorisation from the Insurer.

Documentation to be submitted for services that require authorisation:

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

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

In the event of an emergency the only authorisation required will be that of the Insurer's doctor, although the insured must obtain the Insurer´s authorisation within the seventy-two

hours following his/her hospitalisation or from the start of the healthcare service. The Insurer will be responsible for paying its share of the costs of the healthcare service up to the time when it challenges the doctor's authorisation on the grounds that the healthcare service or hospitalisation in question is not covered by the policy.

6. EMERGENCIES

In the event of an emergency the insured should telephone the emergency services, or by go directly to the 24/7 emergency health services centre of the Insurer. The address and telephone number of the emergency services centre are given in the Insurer´s list of medical practitioners.

7. TEMPORARY RELOCATIONS

The Insurer undertakes to provide healthcare to insured parties who are temporarily relocated away from their home throughout the whole of Spain. In this case they should use the healthcare services belonging to or contracted by the Insurer which are listed in the documentation given to insured parties.

8. HEALTHCARE IN MEDICAL FACILITIES NOT CONTRACTED BY THE INSURER

The Insurer is not liable for the fees of practitioners who are not on its medical practitioners list, nor for the costs of any hospitalisation or healthcare services they prescribe.

9. ACCREDITATION OF INSURED PARTIES

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

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

ARTICLE 6 - WAITING PERIODS

The healthcare services for which a specific period from the effective date of the Policy must pass before they are covered by the Insurer are:

Six (6)-month waiting period:

- Family planning.
- Cancer and cardiovascular treatments, lithotripsy and dialysis.
- Psychology.
- High-tech diagnostic tests.

Ten (10)-month waiting period:

- Surgery or hospital admissions (except in the event of a vital emergency), including assistance in deliveries/Caesarean sections. In the case of premature deliveries, had the approximate due date of the baby been after the end of the waiting period for this service.
- Prosthesis (to offset the cost of the prostheses, not of their implantation).

ARTICLE 7 - CONTRACT BASIS, LOSS OF RIGHTS, RESCISSION AND INCONTESTABILITY OF CONTRACT

1. The declarations made by the policyholder and insured in the questionnaire-insurance application regarding their state of health constitute the basis for the Insurer´s acceptance of the risk in this contract, and form an integral part of such contract.

2. The insured will lose the right to the insured healthcare services:

   a) In the event that s/he withholds or misrepresents information when completing the questionnaire about his/her state of health (Article 10 of the Act).

      The Insurer may rescind the policy through a statement addressed to the policyholder within a period of one month, as of the time it learns of said withholding or misrepresentation. As soon as the Insurer makes this statement it is entitled to keep the premiums corresponding to the period underway, unless there is wilful intent or gross negligence on its part.

      If a claimable event occurs before the Insurer has sent the statement referred to in the previous paragraph, the service provided to the insured shall be reduced in the same proportion as that existing between the premium agreed in the policy and the premium that would have been applied if the Insurer had been aware of the true nature of the risk. If there is wilful intent or gross negligence on the part of the policyholder or insured, the Insurer shall be released from its obligations to pay for any of the healthcare services.

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

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

3. However, the Insurer undertakes:

   a. In the event that the insured is being treated in hospital, not to terminate the policy until the insured has been discharged, unless s/he decides not to continue with the treatment.

   b. Not to challenge the renewal of insurance contracts in which there are insured parties who have certain serious illnesses, provided that the illness was first diagnosed when the policy was in force. The illnesses for which insured parties may be receiving treatment during the term of the contract, and which are covered, are as follows:

      · Active cancers.
      · Cardiac diseases which require surgical or interventional treatment.
      · Organ transplants.
      · The ongoing evolution or current after the immediate high of surgery orthopedic surgery complex
      · Degenerative and demyelinating diseases of the nervous system.
      · Acute renal failure.
      · Torpid chronic respiratory failure.
      · Chronic liver diseases (except alcoholic liver diseases).
      · Acute myocardial infarction with cardiac failure.
      · Macular degeneration.

   c. Not to challenge the renewal of insurance contracts in which there are insured parties who are over 65-years old when they can show that they have been an insured party for the last five years or more, and they have paid all of the insurance premiums.

The above undertakings given by the Insurer will not be applicable, or will cease to be valid, in the following circumstances:

a. The insured fails to comply with his/her obligations, or has withheld or misrepresented information when declaring the risk.
b. The policyholder fails to pay a premium, or does not accept an updated premium.
c. The policyholder does not accept the new conditions upon renewal of the contract.

4. The policyholder may cancel the contract when the list of medical practitioners for his/her province is changed by more than 50%, in which case s/he should formally notify the Insurer of his/her decision. This clause will not be applicable if the doctors are temporary replacements standing in for doctors who are officially off-work, are doctors who perform special surgical techniques, or dentists, analysts, electrologists and radiologists.

5. If any of the dates of birth of the insured parties in the application form filled in by the policyholder are inaccurate, the Insurer may only cancel the contract if the insured/s does/do not comply with the minimum or maximum age limits for applicants who want to enrol with the Company, on the effective date of the policy.

   If, as a result of an inaccurate declaration of the date of birth, the premium paid for an insured was less than that which should have been paid, the policyholder will be obliged to pay the Insurer the difference between the amount actually paid as the premium and the amount which, in accordance with the Insurer´s rates, should have been paid on the basis of the insured´s true age.

   However, if the premium paid was higher than that which should have been paid, the Insurer will be obliged to refund the policyholder the excess premium received, without interest.

ARTICLE 8 - INSURANCE TERM

This insurance policy is taken out for the period established in the specific conditions. Pursuant to Article 22 of the Insurance Contracts Act, it will be automatically renewed for annual periods at the end of each insurance period.

Notwithstanding the terms of Article 7.3.c, either of the parties may decide not to renew the contract, in which case they should notify the other party in writing of their decision. In this case the policyholder should notify the Insurer at least one month before the end of the insurance period underway, while the Insurer should notify the Policyholder at least two months before the end of the insurance period underway. The notification from the policyholder must be sent to the Insurer.

The Insurer may not terminate the policy while the insured is in hospital for treatment, and must wait until he/she has been discharged, unless the insured decides not to continue with such treatment.

With respect to each insured party, the insurance will be terminated:

1. Upon death.
2. When, if the policy includes family members who live with the policyholder, they move out of the policyholder´s home, in which case the Insurer must be notified of the change in the situation. If a family member takes out another insurance policy with the Insurer within one month, starting from when the above notice was sent, the Insurer undertakes to maintain all their acquired rights, provided they take out the same cover.

Minors may only be included in the insurance policy when their parents or legal guardians are also insured in the same policy, unless there is a specific agreement to the contrary.

The coverage taken out will not come into effect until the first premium has been paid.

ARTICLE 9 - PAYMENT OF PREMIUMS

Under Article 14 of the Act, the policyholder is obliged to pay the premiums.

1. The first premium or instalment thereof will be payable, pursuant to Article 15 of the Act, upon signing the contract. If it is not paid due to causes attributable to the policyholder, the Insurer shall be entitled to terminate the contract or initiate enforcement proceedings to demand payment of the outstanding premium, in accordance with the terms and conditions of the policy. **If the premium has not been paid prior to a claimable event the Insurer shall be released from its obligations,** unless there is an agreement otherwise.

2. In case of failure to pay the second or successive premiums or instalments thereof, the insured´s coverage will be suspended a month as from when the policy expired. If the Insurer does not request payment of the premium within the six (6) months subsequent to when the premium became due, the contract shall be considered to be terminated. If the contract has not been terminated or cancelled in accordance with the preceding conditions, the policy coverage will take effect again at midnight of the day on which the policyholder pays the premium. In any case, during the period that the contract is suspended, the Insurer may only request payment of the premium for the insurance period underway.

3. The Insurer will only be obliged to provide healthcare services when the insured parties have payment receipts issued by its legally authorised representatives.

   Premium payments made by the policyholder to the broker will not be considered to be payments to the Insurer, unless the broker gives the policyholder the premium payment receipt issued by the Insurer.

4. The bank account designated by the policyholder for payment of the premiums will be given in the specific conditions, and the following norm will apply. Premiums will be considered paid at renewal unless, having attempted collection during a period of thirty calendar days, there were insufficient funds in the policyholder's account.

ARTICLE 10 - OTHER OBLIGATIONS, DUTIES AND RIGHTS OF THE POLICYHOLDER AND INSURED PARTIES

1. The policyholder and, as applicable, the insured, have the following obligations:

a) To declare all the circumstances known to him/her that could affect the risk assessment when s/he completes the Insurer´s health questionnaire.

   S/he will be exempted from this obligation if the Insurer does not have him/her fill in the questionnaire or when, even if it does, the circumstances in question were not included in the questionnaire, even though they could have affected the risk assessment.

   The Insurer may rescind the policy through a statement addressed to the policyholder within a period of one month, as of the time it learns of any withholding or misrepresentation by the policyholder or insured. As soon as the Insurer makes this statement it is entitled to keep the premiums corresponding to the period underway, unless there is wilful intent or gross negligence on its part.

b) If a claimable event occurs before the Insurer has sent the statement referred to in the previous paragraph, the service provided to the insured shall be reduced in the same proportion as that existing between the premium agreed in the policy and the premium that would have been applied if the Insurer had been aware of the true nature of the risk. If there is wilful intent or gross negligence on the part of the policyholder, the Insurer shall be released from its obligations to pay for any healthcare services. While the contract is in force the policyholder or insured must notify the Insurer, as quickly as possible, of any circumstances that, pursuant to the health questionnaire s/he submitted, might aggravate a risk and are such that if the Insurer had been aware of them before

entering the contract it would not have signed the contract, or it would have established conditions less favourable to the policyholder.

c) To notify the Insurer of any change of address as soon as possible.

d) To notify the Insurer, as soon as possible, if any insured parties have to be removed from or added to the policy during the term of such policy. Any such additions or removals will come into effect on the first day of the month following that of the date of notification made by the policyholder. The removal of an insured from the policy during the term of the policy will be accepted when it is a consequence of: the death of the insured, a change of residence abroad, the separation of the couple, the emancipation of one of the insured, or in the event that one of the insured is to be provided with insurance as an employee benefit.

e) Newborn and recently adopted children may be included as additional insureds in the policy of their parents, and do not need to have a health questionnaire, nor will the terms established for waiting periods or pre-existing illnesses apply, provided the parents have been CASER insured parties for a **minimum of eight (8) months** and the application is made within a maximum period of 15 days, starting from the day s/he was born in the case of newborns, and from the day s/he was registered in the family book in the case of recently adopted children.

Once the 15 days have expired, newborns or recently adopted children will only be added to the policy if they meet the conditions established by the Insurer. In this case the ordinary waiting periods and exclusions will apply, and the Insurer will have the right to refuse applications.

The Insurer will provide healthcare services for newborns when they have been included in the policy as an insured party.

f) To mitigate the consequences of a claimable event, taking all the measures at his/her disposal to ensure s/he recovers rapidly. If the policyholder or insured fails to comply with this obligation with the clear intention of trying to harm or defraud the Insurer, it will be released from all its obligations arising from the claimable event.

g) To grant and facilitate the subrogation by the Insurer established in Article 82 of the Insurance Contracts Act.

2. The Caser Salud health card, which belongs to the Insurer and which it will give to each insured, is a document which may only be used by the insured. If it is lost, stolen, or damaged the policyholder or insured should notify the Insurer within a period of seventy-two (72) hours.

In these cases the Insurer will send a new card to the address of the insured party that appears in the policy, and cancel the lost, stolen, or damaged card.

Additionally, the policyholder and insured undertakes to return the card of any insured parties that are removed from the policy to the Insurer.

The Insurer will not be liable for any improper or fraudulent use of the Caser Salud health card.

3. If the content of this policy differs from the insurance proposal or from the agreed clauses, the policyholder may ask the Insurer to rectify the discrepancies within a period of one month, starting from when they received the policy, pursuant to Article 8 of the Insurance Contracts Act.

ARTICLE 11 - OTHER OBLIGATIONS OF THE INSURER

Apart from providing the contracted healthcare, the Insurer will give the policyholder the insurance policy or, as appropriate, the provisional cover or other document as described in Article 5 of the Insurance Contracts Act, as well as a copy of the health questionnaire and other documents signed by the policyholder.

The Insurer will also give the policyholder the Caser Salud health cards, which may only be used by the holder, for all the insured parties included in the policy.

On signing the policy the Insurer will give the policyholder a copy of the list of medical practitioners for the province where s/he lives, with the addresses and other necessary information of the 24/7 medical and surgical emergency centre or centres, the 24/7 outpatient clinic, the hospitals and medical clinics, and the addresses and surgery hours of the medical practitioners. It will also provide the addresses and other necessary information of the information services, and 24/7 emergency and outpatient services in all the capitals of the other provinces.

The Insurer may update the medical practitioners list annually, adding or removing medical practitioners, healthcare professionals, hospitals and any other institutions on the list, and these changes will come into effect on 1 January of each year. The policyholder and/or insured parties must use the services of the healthcare providers who are on the list when they request a healthcare service. To this end they may request an updated list of medical practitioners at the offices of the Insurer.

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

The Insurer may update the premiums and the copayments for the healthcare services annually, as stipulated in Point 4 of Article 5 of the general conditions.

These premium and copay updates include the adjustments needed to ensure that the premium rate is high enough. They are based on technical-actuarial calculations which take into account increases in healthcare prices, increases in healthcare service utilisation, the appearance of new technologies after the contract has been entered into and which are available under the terms of the policy, and other similar events.

The premiums to be paid by the policyholder will vary depending on the age of each one of the insured parties and the region where the home of the insured is located. The rates of the Insurer that are in force at the date of each renewal will be applied.

When the policyholder receives the notice informing him/her of the updated premiums and/or copayments for the following annual insurance period, s/he may choose between renewing the insurance contract, which means accepting the new financial terms, or cancelling the contract when it expires, in which case s/he should send written notice to the Insurer.

ARTICLE 13 - NOTICES

1. All notices to the Insurer should be sent to the address given in the policy.

2. Notices and premium payments made at the branches and offices of the Insurer, or to the insurance broker, will have the same effect as if they had been made directly to the Insurer.

ARTICLE 14 - LIMITATION OF RIGHTS

Any legal proceedings that may arise from this contract will become statute-barred after **five (5) years,** starting from the date on which they could have been initiated.

ARTICLE 15 - JURISDICTION

This contract is subject to Spanish jurisdiction and, within this, the judge competent to hear any legal action arising from this contract will be the judge of the court that corresponds to the domicile of the insured party in Spain.

This insurance contract is made up of the above general conditions, the specific conditions, the special conditions, if applicable, and the appendixes with the contractual amendments that have been agreed upon by the parties. They all form an integral and inseparable part of the contract.

SONRISA ESENCIAL DENTAL COVER

1. PURPOSE OF THE INSURANCE

Dental healthcare will be provided only by the medical practitioners who are listed in the Services Guide of the Insurer in force for the year in progress.

Under the terms of this cover, Insureds cannot choose to receive cash payments in lieu of the services provided under this Policy.

2. DESCRIPTION OF THE COVER

This section contains a description of the dental services agreed in the Policy at no cost to the Insured, as well as the services provided at special maximum rates applied to the same and additional odontostomatological cover.

These special rates and services provided free of charge attached to this contractual documentation as an appendix may be updated each year. Consult the latest rates and services on our website, *caser.es*

The services are organised a a function of the type of service and who they are intended for (adults or children), since Insureds under the age of 15 have a Child Dental Plan with dental services specially for children and with special benefits.

2.1. Child Dental Plan (children under 15)

Insureds below the age of 15 can access services available to adults, plus a list of services (at no cost to them) aimed at the prevention and treatment of dental issues unique to children. These issues can be consulted in the document attached to this document or on our website, *caser.es*, at any time.

2.2. For all Insureds:

Insureds under Caser Salud Dental can access to oral medicine service, either **for free** for the Insured or services with **special maximum prices.**

The list of services with **special maximum prices** described for this year is valid at the time the Contract is entered into, and may be updated annually. For this reason, one must consult said current prices on our website **caser.es**, which can be accessed at any time.

3. EXCLUDED RISKS

a) Injuries the result of wars, uprisings, revolutions and terrorism; those caused by officially declared epidemics; those directly or indirectly related to radiation or a nuclear reaction; and those the result of natural disasters (earthquakes, floods and other seismic or meteorological phenomena).

b) Healthcare arising from chronic alcoholism or the addition to drugs of any type.

c) Injuries that are the result of inebriation, fighting (except in cases of legitimate self-defence) or injuries the result of self-harm of suicide attempts.

d) Any other odontological service not expressly included in the Conditions of the Policy that describes the cover and the services rendered.

4. METHOD OF SERVICE PROVISION

When requesting care, the Insured must show the identification document provided to them by the Insurer for this purpose.

The Insurer is not liable for the fees of practitioners who are not on its medical practitioners list, nor for the costs of any healthcare treatment they may prescribe.

For the purposes of this policy, it will be understood that the Insurer has been informed of the Claimable Event when the Insured requests the services provided under the Policy.

All treatments and healthcare covered by the Insurance will be provided at an outpatient clinic. Therefore, hospitalisation and general anaesthesia are excluded.

If there are alternative treatments for a particular process, the decision and choice of treatment will be made by the Insured.

4.1. Structure and provision of the service

The Insurer provides its Insured with extensive list of oral medicine professionals, who have the most advanced diagnostic methods and treatments. The cover is valid for the whole of Spain, and consists of two types of cover:

- **Covered healthcare:** Services that the Insured can use free of charge.
- **Services provided at special rates:** Services paid for by the Insured that they can obtain at special rates. These services have **maximum prices** that are provided to the Insured so that they know what the maximum amounts are before requesting a quote. The maximum prices in force are available on casersalud.es at any time.

4.2. Using the services

- **Choice of professional**: The Insured may select the professional of their choice from those in their local area or from the list of professionals who appear in the Dental Services Guide.
- **Request for access to the Dentascan service and Maxilfacilal consultations:** If the Insured requires a Dentascan service, **the Insured must contact Caser on 902 432 250** to find out which centre is best-suited to address the condition in question and closest to the address of the Insured.
- **Access to the service:** In order to use the dental services and obtain special prices (when applicable), the Insured must present the health card which shows they are an Insured of **Caser Salud.**
- **Diagnoses and quotes:** Once they have made a diagnosis, the healthcare professional will give the Insured a quote based on the maximum recommended prices in force (for services with an added charge). This quote should be accepted by the Insured before the start of the treatment.
- **Treatment:** The Insured must accept the quote for any treatment with an added charge before treatment can begin.
- **Payment for treatments:** In the case of treatments that require the payment of special maximum prices, the Insured should pay the medical professional or Centre where the treatment is provided directly. The cost of treatments that are free of charge for the Insured will be billed directly by the practitioner to the Insurer.

5. SPECIAL PRICES

The **special maximum prices** available to the Insured are set only for the current year. Therefore, they may be updated by virtue of negotiation with suppliers for successive periods of one years if considered necessary.

These prices are paid by the Insured directly to the medical practitioner.

GLOSSARY OF DENTISTRY SERVICES TERMS

ALVEOLOPLASTY: Technique used to fill a tooth alveolus with hydroxylapatite following tooth extraction.

APEX FORMATION: Procedure used to encourage root formation in children's teeth.

APICOECTOMY: surgical procedure in which the tip of the tooth's root is removed via the bone and gum.

BRACKETS: orthodontic device or appliance that is attached to a tooth in order to fasten an arch wire. There are several types of brackets: metal, sapphire, ceramic, and plastic.

CAST CORE: system which permits the restoration of a dental crown. This is done by placing it on an osseointegrated implant, or the natural root of a tooth that has had root canal treatment, and subsequently placing an artificial crown on top. In post and core systems the post is placed on the implant or root while the core provides a base for the crown.

CAT SCAN Computerised Axial Tomography (CAT): which is a radiological diagnostic test that uses x-rays and computerised image processing. The computer reconstructs the x-rayed planes. When the images are processed they can be viewed as three-dimensional slices on a television screen or in a radiograph. This technique achieves very precise images of the inside of the body and its different organs, enabling more precise diagnoses.

CORE OR ANGLE RECONSTRUCTION WITH PINS OR POSTS: Reconstruction of an extremely deteriorated tooth, using posts or pins to reinforce the repair.

CROWN: artificial tooth cover made of metal, porcelain or porcelain fused to metal. Crowns are placed over teeth that have been weakened by caries, or badly damaged and restored with dental pins or posts.

CYST: Closed sac, with epithelial cover that usually contains a liquid. The origin may be infectious or residual. Almost all are benign and a pathological anatomy study should always be carried out.

DENTAL IMPLANTS: Small dental devices that are inserted in the upper and lower maxillas to help with the reconstruction of an oral cavity that has few or no teeth, and can be restored.

DENTASCAN: Computer program for CT scans that provide high resolution images of the upper and mandible and jaw and which, with axial plane slices, produces panoramic and transversal reconstructions.

ENDODONTIC RE-TREATMENT: Procedure in which root canal treatment is repeated on a tooth when the initial endodontic treatment has not had the expected result.

ENDODONTIC TREATMENT (ROOT CANAL): removal of nerve, whether alive or dead, from a tooth. The tooth can have one or several roots and depending on the number, the treatment will be single-root, dual-root or multi-root.

EPULIS: Small, red-violet benign tumour that develops at alveolus edge level of the gums at the expense of the tooth and the soft tissue.

FENESTRATION OF CANINE TEETH: Removal of bone and mucous around an impacted tooth for the purpose of releasing and accessing the tooth crown, allowing the orthodontist to fit a bracket and take this tooth to the dental arch.

FISSURE SEALING: Thin plastic film that is painted on the chewing surface of the back teeth (molars and premolars), to prevent tooth decay.

FLUORIDATION: Procedure used to deliver fluoride to the body to prevent tooth decay.

FRAENULUM: Mucous membrane fold that connects alveolus mucous with the upper lip or the tongue. (Can be labial or lingual).

GINGIVECTOMY: Surgical procedure to remove damaged gingival tissue (gums). Currently, it is used in treatment of: drug-induced hyperplasia (growth) of the gums, gum fibrosis, supra-osseous pockets in

difficult places. It is also used to improve access in restorative techniques that invade the sub-gingival area.

INTRAORAL RADIOGRAPHY: Exploratory technique consisting in the placement of different sized radiography plaques inside the mouth, which are imaged from the outside by an x-ray machine.

MAXILLARY SINUS LIFT: Surgical technique applied to increase the bone in the upper arch in order to achieve an appropriate osseous base in which to place bone-integrated implants, in cases where the thickness of the bone does not allow it.

MOUTH GUARD: appliance to immobilise teeth made of plastic or acrylic resin that is used in orthodontics as a stabiliser, as a means of inserting whitening substances into the mouth, and in periodontal treatments, as well as in temporomandibular joint pathology to relieve the symptoms of this joint and the effect on the teeth's chewing surfaces due to excessive jaw clenching or friction between the upper and lower teeth (bruxism).

OBTURATION: Filling.

ORTHODONTICS: Speciality within dentistry that includes all the techniques designed to improve positional defects in the patient's teeth, to achieve improved mechanical operation and satisfactory mouth aesthetics.

ORTHOPANTOMOGRAPHY: Panoramic dental radiography. Radiography of the maxillas that shows the osseous dental structures, as well as allowing certain presumptive diagnoses.

PERIODONTAL DIAGRAM: Measurement of tooth mobility.

PERIODONTAL FLAP SURGERY: Surgical technique applied to treat periodontal disease, designed to eliminate pockets, regenerate and gain insertion.

PERIODONTAL TREATMENTS: Branch of dentistry that deals with the diagnosis, prevention and treatment of periodontal (tissue surrounding the teeth, i.e. the gums and bone) diseases. Infection in these tissues due to lack of care destroys them, and the teeth become loose (periodontitis or pyorrhoea).

PREVENTIVE DENTISTRY: Subdiscipline of dentistry concerned with the prevention of disorders of the oral cavity, as well as the preservation of healthy teeth and gums.

PROSTHESIS: Replacement of a part of the body with an artificial element to restore the lost function.

PULPECTOMY: Partial removal of the nerve by removal the dental pulp, followed by tooth filling.

REPAIRS: Repairs to a damaged dental apparatus, which may be simple or require soldering.

RESIN: Filling material that matches the tooth colour, made from resin reinforced with silica or porcelain particles. It is used in dentistry as one of the several alternatives to dental amalgams.

ROOT SCALE AND POLISH: Treatment to remove and eliminate dental calculus or plaque from the tooth roots with selective instruments for each tooth.

SKELETAL: Partial removable prosthesis with a metal structure. A skeletal comprises retainers, a base of resin, large and small connectors and the teeth. The number of teeth determines the size of the skeletal.

SPACE MAINTAINERS: Fixed or removable devices designed to preserve the space left by one or several teeth until the permanent teeth come through.

TARTAR REMOVAL: Removal of bacterial plaque and tartar and dental calculus.

TELERADIOGRAPHY: Radiograph of the patient's cranium and mandible profile with the source of radiation distant from the patient and in which the rays of the beams are parallel. It is carried out with the photographic plaque outside the mouth and the x-ray equipment located at more than two metres from the patient's head, in order to maintain, as far as possible, its real dimensions.

TEMPOROMANDIBULAR JOINT (TMJ) PATHOLOGY: Painful or faulty TMJ movement. The TMJ is the joint that makes it possible to open and close the mouth and it is where the mandible joins the cranium's temporal bone, in front of the ear, on each side of the head.

VENEERS: Resin or porcelain facing attached to the front of a tooth or crown to give it a natural appearance.

VESTIBULOPLASTY: Surgical procedure designed to correct the height of the mouth vestibules (space between the lips and the gums).

WHITENING: Technique used to whiten extremely discoloured teeth.

WISDOM: Tooth definitive third molar.

ANNEX I: SECOND MEDICAL OPINION COVERAGE

1. Purpose of the service

The purpose of this cover is to provide the persons designated as insured parties with a second medical opinion, as described below.

The Second Medical Opinion service comprises an assessment of the diagnosis and treatment the insured is undergoing by recognised national and international experts in the field, who will then issue a report.

2. Insured parties

The policyholder and beneficiaries who are included in the policy when the service is requested and while the service is being provided will be considered to be insured parties.

3. Description

This healthcare service must be requested while the healthcare insurance contract is in force, and is as follows:

a) A second medical opinion for the illnesses listed in the **Illnesses for which the Second Medical Opinion service may be requested** section of this contract. The service consists of:

- Obtaining a second medical opinion from national and international highly-prestigious specialists.
- The insured will not have to travel, and will receive a reply within ten working days, starting from when s/he returns the completed second medical opinion request form, together with the corresponding documentation.
- Patient support, if considered appropriate, will be provided after the second medical opinion has been processed.

b) Selection of experts and hospitals:

- The insured will be advised as to the best national or international medical expert and hospital, and provided with a referral.
- The insured will be informed about the medical assistance that will be provided in national and international hospitals.

c) If the insured wants to contract medical services that are not included in the Insurer's list of medical practitioners and contracted centres, an expenses management service will be provided, which will:

- Manage appointments with national and international doctors who are not on the Insurer's list.
- Obtain quotes and estimated hospitalisation costs.
- Deal with the admission process to national and international hospitals.
- Coordinate patient transfers (reservations, air and land ambulance, translation services).

Under no circumstances will these services be provided without prior authorisation from the Insurer.

4. Illnesses for which the Second Medical Opinion service may be requested

The Second Medical Opinion service will be provided when the insured has already received a preliminary diagnosis for the following serious illnesses:

- Cancer.

- Cardiovascular diseases.
- Neurological and neurosurgical conditions, including strokes.
- Chronic kidney disease.
- Idiopathic Parkinson´s disease (paralysis agitans).
- Multiple sclerosis.
- Diabetes in children.
- Tropical diseases.

5. Other conditions

The services listed in this healthcare insurance policy will only be provided when the insured, or his/her doctor, requests the Second Medical Opinion service by calling the phone line set up for this purpose.

Once the telephone request has been made, the Insurer will send the insured a questionnaire which s/he should fill in and return, together with the medical/clinical records relating to his/her illness, laboratory tests, case history, x-rays, biopsies and any other medical documents s/he has about the preliminary diagnosis, as well as any complementary reports or tests that the Insurer may request, depending on the insured´s illness.

The Second Medical Opinion service includes the fees and expenses incurred directly from the medical consultancy and second diagnosis services described above, provided they have been requested in the way described above. **Any other expenses, costs and fees incurred from medical consultancy or treatment, tests, analyses, drafting of reports, x-rays and any other type of examination will be paid for by the insured if s/he decides to use the services of a medical practitioner or institution that is not in the Insurer's Services Guide, even when these are related to the illness or clinical condition for which the Second Medical Opinion was requested.**

6. Using the service

This service provides the insured with medical information, given by an expert, to supplement the information s/he has received from the doctor who is treating him/her. However, at no time will the doctor giving the second opinion offer an independent medical diagnosis or suggest therapeutic treatment.

In order to receive an accurate and reliable second medical opinion, via the Insurer, the information provided by the insured should be as true and accurate as possible.

The insured should not use the second medical opinion to substitute the doctor that is treating him/her, as any clinical decision requires person-specific information which can only be obtained by a clinical interview between doctor and patient.

7. Requesting a Second Medical Opinion

Insured parties who wish to request the Second Medical Opinion service should phone **901 33 22 33** and, when asked, must provide the information required to identify themselves to show they are entitled to use the service.

ANNEX II: TRAVEL ASSISTANCE ABROAD COVERAGE

The Insurer guarantees that the policyholder and other policy beneficiaries will be eligible for this supplementary cover for the term of the insurance period. It will be provided by CASAVI Asistencia en Viaje S.L. **with a maximum insured amount of €15,000 per insured and annual insurance year, at all times.** The following definitions will apply:

INSURED: the natural person, resident in Spain, who is the policyholder and other policy beneficiaries. None of the insured parties' rights will be modified or impaired if they travel separately.

RISK TO PEOPLE: this cover is valid in any country in the world, except for Spain.

VALIDITY: in order to use the services provided under the cover, the insured must have a home in Spain which is his/her habitual residence, and must not spend more than 90 days away from this home.

SERVICE PROVIDER: CASAVI Asistencia en Viaje, S.L., whose registered office is at Av/ de Burgos, 109, 28050, Madrid.

In order for the Insurer to comply with its obligations, it is essential that the insured immediately notify CASAVI Asistencia en Viaje, S.L., of the occurrence of a claimable event by calling the telephone number given in this document.

PARTIAL REIMBURSEMENT LIMITS

Notwithstanding the preceding section, any reimbursements paid by the Insurer will not exceed the limits that are established below for each type of cover:

Coverage

1. Repatriation of deceased insured party and their companions

In the event of the death of an insured party, the Insurer will organise and pay the costs of transferring the body to its place of burial in Spain. The Insurer will also pay for the return of any other insured parties who were with the deceased to their home.

Additionally, post-mortem treatment and preparation costs (such as embalming expenses and the mandatory casket for transferring the deceased), pursuant to the legal requirements, will be covered **up to a limit of €601.01**.

However, the cost of the burial coffin and the burial and ceremony expenses are not included in this cover.

2. Medical repatriation of the injured or sick from abroad

Depending on the urgency and seriousness of the case, and according to the medical criteria of the doctor in charge of the case, the Insurer will organise and pay for the transfer of the injured or sick insured party, under medical supervision if necessary, to a hospital in Spain close to his/her home, or to his/her home if hospitalisation is not necessary. If it is not possible to have the insured admitted to a hospital close to his/her home, the Company will pay the costs of transferring the insured to his/her home, when s/he is discharged from hospital.

Means of transport:

- Special ambulance aircraft for Europe and countries bordering the Mediterranean Sea.
- Commercial airline flights, train and ship.
- Ambulance.

If the insured is suffering from a benign condition or minor injury that does not call for repatriation, s/he will be taken by ambulance, or any other means of transport, to a place where s/he can receive suitable healthcare.

Under no circumstances will this service replace the emergency or assistance services of the country in question, nor will the Insurer accept such costs.

In all cases the decision as to whether or not to transfer the insured party will be taken by the doctor appointed to the case by the Insurer, in agreement with the doctor attending the insured and, as appropriate, his/her family.

Additionally, the Insurer will pay the travel expenses of up to two other insured parties who were travelling with the sick or injured insured party to take them to the place where they started their journey, or were due to end it, provided that these expenses do not exceed the travel expenses of returning them home.

3. Payment or reimbursement of medical, surgical, pharmaceutical and hospitalisation expenses abroad

Under this cover the Insurer will pay, **up to a limit of €15,000.00**, the expenses incurred by each insured outside Spain as a result of an accident or unforeseeable illness which occurs during a journey and the term of the insurance policy.

Emergency dental expenses are limited to €120.20.

The reimbursement of expenses will supplement any other amounts that the insured parties and their successors, either through Social Security payments or any employment insurance scheme they may belong to, are entitled to.

The insured therefore undertakes to take the steps necessary to recoup the expenses from the aforementioned entities, and to reimburse the Insurer any advance payments it has made.

4. Travel arrangements for a family member to accompany the insured if s/he is hospitalised abroad

If the condition of the injured or sick insured party means they cannot be repatriated, and they are hospitalised for more than five days in the place where they are, the Insurer will:

- Provide a family member, or another person chosen by the insured, with a return train (first class) or plane (tourist class) ticket so that they can accompany the insured in hospital.
- The Insurer will also pay the accommodation and meal expenses for the companion, provided they present the pertinent receipts, for an amount of **up to €66.11 per day, and for a maximum amount of €661.11.**

5. Extension of a hotel stay abroad

If, in the opinion of the doctor treating the insured and with the agreement of the Insurer's doctor, the sick or injured insured party cannot return home to Spain and must extend his/her stay in the hotel, the Insurer will pay the accommodation and meal expenses incurred due to the extended stay for an amount of **up to €66.11 per day, and for a maximum amount of €661.11.**

6. Sending medicines abroad

The Insurer will find and send any essential medicines which cannot be found in the country where the insured party is hospitalised.

The shipment of any medicines will be subject to the legislation of the country from which they are requested.

Nevertheless, the Insurer will cease to be liable if the Spanish Directorate of Pharmaceutical Products or the National Pharmaceutical Council reports that the required product is not available in the Spanish domestic market.

7. Transmission of urgent messages related to the insurance coverage

The Insurer will provide the insured parties with a 24-hour telephone helpline which they can call to send any urgent messages they need to send as a result of an incident that is covered by the travel assistance cover.

8. Repatriation or transfer of family members under the age of fifteen

If minors under the age of fifteen (15) travelling with the insured party are left alone and unable to continue their journey because the insured suffers an accident or illness covered by the policy, or has to be transferred, the Insurer will arrange for them to return home. In this case the Insurer will either pay for a family member to accompany the minor/s, or arrange for someone else to accompany them, if necessary. The means of transport and travel date will be chosen by the Insurer.

9. Interpreter in the event of accident or illness

If the insured has an accident or serious illness abroad which is covered by the policy, and needs the services of an interpreter, the Insurer will send an interpreter to help him/her as soon as possible.

The expenses covered by the Insurer will be limited to €30.05 per day, with a maximum of €180.30 per claim.

10. Advance payments for bail and legal expenses

If, as a result of judicial proceedings arising from a traffic accident which occurs outside the country of residence given in the policy, the insured party is required to post bail in a criminal case in order to be released, or has to pay a retainer fee to meet the legal defence costs, s/he may request an advance from the Insurer of **up to a maximum of €6,010.12 for the bail, and €601.01 for the legal expenses.** However, when requesting the advance the insured must give the Insurer a formal undertaking to reimburse the money advanced within sixty days**.**

In order to guarantee repayment of the advanced amount the Insurer reserves the right to require that a person in Spain, designated by the insured, gives a written undertaking before the advance is paid to reimburse the money paid through an acknowledgement of debt.

The legal defence of the insured party is specifically excluded from this cover.

11. Assistance with hospital admittance procedures

The Insurer will help arrange the insured´s admittance to hospital.

12. Deposits for hospitals

If, due to an accident or serious illness covered by the policy, the insured needs to be admitted to hospital, the Insurer will pay the costs of the deposit that the hospital may require from the insured before admitting him/her, **up to a maximum of €601.01**.

13. Cash advances in the event of accident, theft, or serious illness abroad

If the insured urgently needs cash because of an accident covered by the policy, theft of his/her possessions, or a serious illness, the Insurer will advance him/her **up to a maximum of €1,502.53.**

In order to guarantee repayment of the advanced amount the Insurer reserves the right to require that a person in Spain, designated by the insured, gives a written undertaking before the advance is paid to reimburse the money paid through an acknowledgement of debt.

Any advance payments made will be subject to the legislation of the country from which they are requested.

The insured undertakes to repay the money advanced by the Insurer within a period of 10 days, starting from the end of the journey and, in any case, within two months following the date on which the advance was paid.

14. Accompanying the body of the deceased

In the event that there is no-one to accompany the body of the deceased insured party, the Insurer will provide the person designated by his/her successors with a return train ticket (first class) or plane ticket (tourist class), so that they can accompany the body.

15. Accommodation expenses for the person accompanying the deceased

If, when the aforementioned cover has been requested, the companion has to extend their stay at the place where the insured died in order to deal with the formalities required to transfer the deceased´s body, the Insurer will pay their accommodation and meal expenses **up to a limit of €60.10/day and for a maximum of three days.**

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

If any of the insured parties have to cut short their journey while they are travelling due to the death of their spouse, an ascendant or descendant in first degree of kinship, or sibling, the Insurer will provide him/her with a return train ticket (first class) or return plane ticket (tourist class) so that s/he can travel to the place of burial of the family member in Spain and return to where s/he was before the event occurred, or with two tickets to his/her home if s/he is travelling with a companion who is also an insured party.

17. Assistance with locating and forwarding luggage

If the insured´s luggage is delayed or lost, the Insurer will help report the loss, participate in the search to find it, and make sure it is forwarded to the insured's home after it is found.

18. Shipping and/or forwarding property which has been left behind and/or stolen during the trip

The Insurer will arrange for and pay the costs of forwarding any possessions the insured has left behind in the place, or places, visited during the trip to the insured´s home.

GENERAL EXCLUSIONS TO THE TRAVEL ASSISTANCE ABROAD COVER

The following are excluded from this cover:

- **Any relapses of illnesses where the sufferer may suddenly get worse when the insured knew they suffered from the illness before starting out on the trip.**
- **Conditions for which the insured has a medical history that could be worsened by travelling.**
- **Pregnancy. Nevertheless, unforeseen complications will be covered up to the sixth month.**
- **In cases of serious dental problems, namely problems caused by infection, pain or trauma which require emergency treatment, the expenses will be limited to a maximum of €120.20 at all times.**
- **Sea, mountain, or desert rescue operations.**

- **Services required as a result of the practice of high-risk sports, such as mountaineering, climbing, motocross, gliding, hang-gliding, snowboard and similar sports.**
- **Accidents that occur while skiing.**
- **Expenses relating to a chronic illness, prostheses of any kind and thermal baths.**
- **Any medical expense below €9.02.**
- **Suicides, self-harming injuries and drug or alcohol poisoning.**
- **Under no circumstances will this service replace the emergency or assistance services of the country in question, nor will the Insurer pay the costs of such services.**
- **Illnesses caused by acquired immune deficiency syndrome (AIDS), as well as problems arising from alcoholism and drug-addition.**
- **Vaccinations and medical check-ups for previously-known illnesses.**
- **Thermal baths and UVA ray treatments.**
- **Physiotherapy and kinesiotherapy.**
- **Mental illnesses, psychoanalysis, and psychotherapy.**

ADDITIONAL CONDITIONS TO THE TRAVEL ASSISTANCE ABROAD COVER

1. This cover supplements the healthcare insurance policy, and will not be valid unless the insured has the latter.
2. The Insurer accepts no liability for delays or failures to comply with obligations when they are due to force majeure.
3. The Insurer will only pay the unforeseen travel expenses of the insured parties which they had not expected to incur (train tickets, plane tickets, tickets for sea crossings, petrol, etc.).
4. The travel assistance cover is provided by CASAVI Asistencia en Viaje, S.L., and it is responsible solely for the provision of the services.
5. **In order for the Insurer to comply with its obligations, it is essential that the insured immediately notify CASAVI Asistencia en Viaje, S.L. of the occurrence of a claimable event by calling the telephone number given in this document.**
6. **To use the services described above the insured should call the number below, and may reverse the charges if necessary:**

Assistance abroad:

34 91 595 50 49