Caser Salud Activa

Health Care Contract

General Terms and Conditions

CAJA DE SEGUROS REUNIDOS

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

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caser.es

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In accordance with the provisions of Article 3 of Law 50/80 of 8 October 1980 on Insurance Contracts, the limitation clauses of the rights of the Insured contained in the General Conditions of the contract are highlighted in bold print.

This contract is subject to Law 50/1980 of October, of Insurance Contracts, to Law 20/2015, of 14 July, on the Regulation, Supervision and Solvency of Insurance and Reinsurance Entities, and its development regulations.

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

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GENERAL CONDITIONS

INTRODUCTORY ARTICLE

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

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

ARTICLE 1 - DEFINITIONS THAT WE WILL USE IN YOUR CONTRACT

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

INSURED PERSON/BENEFICIARY: is the person who receives the corresponding benefit in the cases foreseen in the contract. Generally speaking, they have a common bond of personal, family or financial interest with the contract or policy holder

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

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

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

COMPREHENSIVE MEDICAL CARE: includes all the specialities and health benefits included in the health insurance: primary care, specialised care, complementary means of diagnosis and treatment of hospital care and surgery.

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

TELEMATIC MEDICAL CARE/TELEMEDICINE: medical care provided remotely using technology

NEONATAL CARE: any medical or surgical hospital process that affects a newborn during the first four weeks of life (28 days).

HEALTH CARE ABROAD: cover providing a solution to certain situations that may arise during a trip abroad, this cover will be included and limited in accordance with what is set out in this contract. The management team requires the Insured person to contact the Assistance Centre, which operates 24 hours a day, every day of the year.

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

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

MAJOR OUT-PATIENT SURGERY: any surgical procedure performed in the operating theatre, under general, local or regional anaesthesia or sedation, which requires postoperative care that is not very intensive and of short duration, and therefore does not require hospital admission and the patient can be discharged a few hours after surgery

MINOR OUT-PATIENT SURGERY: health care for processes that require simple and quick surgical procedures and generally with local anaesthesia.

ONCOLOGICAL SURGERY: surgical procedure following an oncological diagnosis.

NEURONAVIGATION ASSISTED SURGERY: computerised image digitalisation system to guide the surgeon in real time in complex or high-risk neurological procedures.

ROBOTIC SURGERY: surgical manoeuvres directed by the surgeon and performed by a robot. It incorporates a complex system of images, which allows them to be visualised in virtual reality and 3D among other computer advances.

CYTOSTATIC/CYTOTOXIC: drugs used as chemotherapy in oncology to stop cell multiplication. They act on cell mitosis through different actions on the DNA and RNA of the cells.

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

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

CONTRACT: document or documents containing the clauses and agreements regulating the relationship between the Contracting Party and the Insurer. The following form an integral and inseparable part of the contract: the Application for insurance, the Health Questionnaire, the General Conditions, the Particular Conditions that individualise the risk, if any, as well as the Supplements or Appendices that include, where applicable, the modifications agreed during the term of the contract.

COPAYMENT: share of the cost assumed and invoiced to the Contract Holder or Insured person for each health service used by the Insured included in the contract, and which shall coincide with that reported by the Insurer's providers. This amount may be updated annually and may vary depending on the types of health services and/or medical specialities used, which are determined in the Specific Conditions.

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

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

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

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

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

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

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

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

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

SURGICAL MEDICAL FEES: costs arising from surgery and/or hospitalisation. The following items are included in these costs: surgeon, his/her assistants, anaesthetists, midwife and medical staff required for the operation or medical care provided.

HOSPITAL: any establishment in which medical or surgical treatment of illness or bodily injury may lawfully be carried out, whether on an outpatient or inpatient basis. The said establishment shall be permanently attended by a doctor, and only ill or injured people shall be admitted to it.

For the purpose of the contract, hotels, nursing homes, retirement homes, spas, facilities primarily dedicated to the internment and/or treatment of drug addicts or alcoholics and similar institutions shall not be deemed to be hospitals.

GENERAL HOSPITALISATION: care provided in a hospital on an inpatient basis involving at least an overnight stay in hospital for the medical or surgical treatment of the Insured person as a patient.

DAY HOSPITALISATION: care in hospital units specifically designated, whether medical, surgical or psychiatric, in order to receive a specific treatment or for having been under anaesthesia, without the need for an overnight stay in hospital.

IMMUNOTHERAPY: a set of treatments aimed at making the cancer patient's immune system develop anti-tumour activity, either by stimulating the patient's immune system or through the direct administration of certain antibodies. Such as:

- **Monoclonal antibodies:** these are antibodies that are specific to a receptor on the tumour cell or to a factor that it needs for its growth.
- **Vaccines:** the body is exposed to an antigen (a protein or fragment of the pathogen or tumour cell) in such a way that it recognises it, and an immune response is produced.
- **Adoptive cell therapy:** A treatment procedure of great technical complexity that basically consists of extracting lymphocytes from the tumour or from the patient's blood and genetically modifying them so that they recognise tumour cells. They are cultured "in vitro" and re-administered to the patient.
- **Cytokines:** Cytokines are small molecules that immune system cells use to communicate with each other. This group includes interferon in patients with melanoma and interleukin in patients with renal cell carcinoma.
- **Immune control proteins:** these are drugs that act on the regulation of the immune system and allow the immune response to be controlled.
- **Other immunotherapies.**

SURGICAL PROCEDURE: any operation for diagnostic or therapeutic purposes, by incision or other approach, performed by a surgeon and normally requiring the use of an operating theatre.

BIOLOGICAL MATERIAL, BIOMATERIAL, BIOMATERIAL ORGANS: biological materials or organs which, implanted by any technique, replace, regenerate or complement an organ or its function.

OSTEOSYNTHESIS MATERIALS: pieces or elements of different nature, used for joining the ends of fractured bones or to join articular ends.

ORTHOPAEDIC MATERIALS: medical devices for external, permanent or temporary use, intended to modify the structural or functional conditions of the neuromuscular or skeletal system. Its insertion does not require surgery.

REGENERATIVE MEDICINE: therapies used for tissue, cellular or molecular regeneration, stem cell implants or transplants and tissue engineering.

DOCTOR: professional legally qualified and authorised to practice medicine.

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

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

OWN MEANS: doctors and centres included in the Insurer's Medical List that correspond to you according to the type of insurance taken out.

BIRTH: Birth of the newborn and expulsion of the placenta from the inside of the uterine cavity to the outside. A normal birth is one that occurs between 37 and 42 weeks from the date of the last menstrual cycle. A premature birth is one that occurs after the 20th week and before the 37th week of pregnancy. Births occurring after 42 weeks are considered post-term births.

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

DISPUTABILITY PERIOD: period of time, from the date the contract comes into force for each of the Insured parties included in it, during which the Insurer may refuse to cover benefits or contest the contract on the grounds of the existence of previous illnesses of the Insured person and which the latter has not declared in the Health Questionnaire. Once this period has elapsed, the Insurer's refusal must be based on the existence of fraudulent concealment on the part of the Insured.

BENEFIT: consists of health care derived from the illness.

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

PROSTHESIS, IMPLANTS AND SKIN GRAFTS: any element of any nature that temporarily or permanently replaces the absence of an organ, tissue, organic fluid, member or part of any of these.

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

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

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

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

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

INSURANCE APPLICATION: document in which the Contracting Party describes the risk that he/she wishes to insure, with all the circumstances known to him/her that may influence the assessment of said risk, the good faith of the Contracting Party being necessary.

SPECIAL AND COMPLEX MEDICAL TECHNOLOGY: medical applications of robotics, informatics and bioengineering in the fields of diagnosis and medical treatment. It is common for their use and implementation to be endorsed by reports from health technology assessment agencies (HTA).

BIOLOGIC TREATMENTS: A group of drugs that, within the systemic treatment of cancer, are designed to specifically block specific aspects of cell or tumour biology rather than destroying all rapidly reproducing cells. Such as:

- **Monoclonal antibodies against membrane receptors.**
- **Tyrosine kinase inhibitors.**
- **mTOR inhibitors.**
- **Antiangiogenic drugs**, which reduce the formation of new blood vessels from pre-existing vessels.
- **New hormonal agents.**

CELL THERAPY: The use of live cells processed ex vivo and reintroduced into a human organism for the purpose of curing, preventing or diagnosing disease.

Regenerative Medicine is the area of cell therapy concerned with the development and use of medical strategies to repair or restore damaged, diseased or metabolically deficient organs, tissues or cells. This replacement or repair of organic elements is done so through Cell Implants (modified ex vivo or not), or the insertion of Bioartificial Tissues or Organs, generated in-vitro or in-vivo, using Tissue Engineering techniques.

GENE THERAPY: process that allows the treatment of hereditary diseases, cancer, infections and other diseases by modifying the cellular genome. Gene therapy consists of inserting, by means of different vectors, genetic material into a target cell to obtain a therapeutic effect (synthesis of a protein of interest, compensate for a genetic deficit, stimulate the immune response against a tumour or resistance to infection produced by a virus, etc…).

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

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

URGENT EMERGENCY: is a clinical situation that requires immediate medical attention, given that a delay in this may result in a risk to the life of the Insured person.

ARTICLE 2 - PURPOSE OF THE INSURANCE

Within the limits and under the conditions stipulated in the contract and on payment of the premium and co-payments that may apply in each case, the Insurer undertakes to provide the Insured person, within Spain and through the professionals arranged by the Insurer at the time the service is provided, with medical, surgical and hospital care, in accordance with standard medical practice, for all kinds of illnesses or injuries included in the description of the cover provided in the contract.

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

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

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

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

ARTICLE 3 - DESCRIPTION OF COVERAGE

The specialities, health benefits and other services covered by this contract are as follows:

1. FAMILY MEDICINE

General Medicine: includes medical assistance at the surgery, prescription of basic means of diagnosis and home care. In the latter case, provided that the patient is unable to travel for medical reasons.

Paediatrics - Puericulture: includes preventive and child development examinations.

Nursing: At the surgery and at home. In the latter case provided that the patient is unable to travel for medical reasons and subject to a prescription from a doctor of the Insurer.

2. EMERGENCIES

Assistance in emergencies will be provided at the permanent A&E centres (24 hours) indicated in the list of professionals and health centres approved by the Insurer. Care will be provided at home whenever the condition of the patient warrants it and will be provided by a general practitioner and/or nurse of the Insurer in the places where the Insurer has arranged the service.

3. SPECIALITIES

Health care on an outpatient or inpatient basis (at the Insurer's doctor's discretion), in the specialities listed below:

3.1. Allergology. Vaccinations shall be at the Insured person's expense.

3.2. Anaesthesiology and Resuscitation. Including epidural anaesthesia.

3.3. Angiology and Vascular Surgery. Surgery for symptomatic varicose veins (grades III to VI) of the CEAP Classification is covered, which assesses and classifies venous insufficiency for the treatment or suppression of reflux in the saphenous axes, through the use of endolaser thermal ablation techniques (endovascular laser), by radio frequency (endovascular radio frequency fibre) or by sclerotherapy. **Treatment with foam and microfoam is excluded.**

3.4. Digestive system. Including the technique of endoscopic submucosal dissection.

3.5. Cardiology. It includes a cardiovascular risk prevention programme for people over 45 years of age.

3.6. Cardiovascular Surgery.

3.7. General and Digestive System Surgery. Including the use of lasers in proctology.

3.8. Maxillofacial Surgery.

3.9. Paediatric Surgery.

3.10. Plastic and Reconstructive Surgery. This only and exclusively includes breast reconstruction following breast surgery of neoplastic origin, provided that this has been carried out during the period of validity of the contract. The breast prosthesis is included.

3.11. Thoracic Surgery.

3.12. Medical-surgical dermatology and venereology.

3.13. Endocrinology and Nutrition.

3.14. Geriatrics.

3.15. Haematology and Haemotherapy. Autologous bone marrow transplantation is included, **exclusively for the treatment of haematological tumours.**

3.16. Internal Medicine. Includes costs incurred in the treatment of HIV/AIDS (Acquired Immune Deficiency Syndrome) infection and illnesses. **It guarantees up to a maximum of €6,000 per person insured for the entire duration of the policy.**

3.17. Nephrology. It includes dialysis in acute processes.

3.18. Neonatology. It includes assistance, administration of vaccinations, and performance of the necessary tests on the newborn. Medical care as a consequence of any disease or complication at birth will be included as long as **the newborn is discharged as an Insured and has such cover.**

3.19. Pneumology.

3.20. Neurosurgery. Including intracranial surgery assisted by neuronavigators.

3.21. Clinical Neurophysiology. Intraoperative neurophysiological monitoring of the nervous system is covered, solely and exclusively for intracranial surgery, fusion or arthrodesis of three or more levels of the spinal column and surgery of the face and neck that affects the facial nerve.

3.22. Neurology.

3.23. Obstetrics and Gynaecology.

a) **Preparation for childbirth:** includes a set of techniques that are applied so that the pregnant woman is physically and psychologically prepared for the moment of childbirth. Aimed at pregnant women from the second trimester of pregnancy.

b) **Pregnancy assistance/monitoring:** pregnancy monitoring by obstetrician.

c) **Family planning:** including tubal ligation, monitoring of hormonal contraceptive treatment and IUD implantation and monitoring. **The cost of the intrauterine device (IUD) will be reimbursed provided that it is purchased by the Insured person at a pharmacy,** on presentation of the corresponding medical prescription and invoice. **Hysteroscopic tubal occlusion, Essure type device implantation, or any other technique will not be covered.**

d) **Preventive medicine:** only includes gynaecological check-ups.

e) **Diagnosis of infertility and assisted reproduction:** providing treatment to the couple for infertility. Coverage includes the study, diagnosis (with the usual and protocolised complementary tests) and treatment of the couple's infertility, up to the **limit of 3 attempts of artificial insemination and 1 attempt of in vitro fertilisation for the couple,** including ICSI (sperm microinjection), if necessary.

The age limit for the application of the different techniques is set at 43 years for women. Treatment is excluded if the infertility has occurred voluntarily or if it is a consequence of the natural physiological process. It will be necessary that the diagnosis of sterility of one of the members of the couple has been confirmed.

Coverage limited to one successful birth during the term of the contract.

This guarantee does not include sperm FISH testing, sperm DNA fragmentation test, embryoscope, HBA Sperm Screening, vitrification, freezing/thawing and maintenance of embryos, oocytes, ovarian tissue and sperm, as well as the costs of oocyte donation and pre-implantation genetic diagnosis (PGD). Treatments with immunoglobulins are expressly excluded.

In order to receive this cover, both members of the couple must be insured and be beneficiaries of the same cover. A waiting period of 24 months is established for each member of the couple.

Treatment will be carried out in medical and hospital centres and by professionals appointed for this purpose by the Insurer, who will not necessarily be located in the same province in which the Insured person resides.

The application of assisted reproduction techniques shall comply with current legislation.

f) Postpartum care: After giving birth, assessment of the general condition of the mother and newborn will be provided. Advice will be offered on baby care, help and advice with breastfeeding, pelvic floor strengthening training, and answering any care questions. **The age limit of the newborn for the provision of the service will be 28 days. The service will be provided digitally.**

3.24. Odontostomatology. It only includes extractions in the surgery, stomatological treatment derived from these, simple intraoral X-rays and cleaning of the mouth (tartrectomy) once a year, **prescribed by an odontostomatologist from the Insurer's Medical List and all of this carried out in a dental or Odontostomatology surgery.**

In addition, a dental supplement is included with services at special prices, see the conditions in Annex I of this document.

3.25. Ophthalmology. Includes laser photocoagulation and corneal transplant, with the cost of the transplanted cornea assumed by the Insured person.

3.26. Medical Oncology. Implantable intravenous perfusion port-a-cath type reservoirs used in chemotherapy are included. It includes chemotherapy treatments in an oncology day hospital and inpatient treatment, if necessary, prescribed by an oncologist. **The Insurer will only pay for medication administered intravenously.**

3.27. Otorhinolaryngology. Radiofrequency is covered for the treatment of diseases related to the respiratory system.

3.28. Clinical Psychology. It includes, **up to a maximum of 20 sessions per Insured person and per insurance year,** individual and temporary psychological care, on an outpatient basis, the purpose of which is the treatment of processes that are susceptible to psychological intervention.

A prescription from a psychiatrist included in the Insurer's Medical List and authorisation from the Insurer will be required prior to the treatment being carried out.

3.29. Psychiatry.

3.30. Radiotherapy. Exclusively for oncological processes. It includes radiosurgery for malignant tumour processes, arteriovenous malformations and trigeminal neuralgia. **Excluding sphere radioembolisation and proton therapy.**

3.31. Rehabilitation and Physiotherapy. It is **included only on an outpatient basis**, for **the treatment of disorders of the locomotor system**, until the greatest possible functional recovery is achieved. It includes cardiac rehabilitation after acute myocardial infarction, through physical exercise and educational programs, individualised and supervised by professionals with a **maximum limit of 30 sessions**. This includes lymphatic drainage after oncological breast surgery during the term of the contract, and shock waves for chronic osteotendinous injuries. Also included is postpartum pelvic floor rehabilitation at the Insurer's approved centres, provided **that it is requested during the 6 months following natural childbirth**.

A prescription from a specialist doctor included in the Insurer's Medical List and authorisation from the Insurer will be required before it is carried out.

3.32. Rheumatology.

3.33. Treatment of pain. Implantable reservoirs (port-a-cath type) are included. Treatments carried out by units specialising in these techniques are covered, **with the limitations regarding the coverage of medication on an outpatient basis.**

3.34. Traumatology and Orthopaedic Surgery. Includes arthroscopic surgery and percutaneous treatment of hallux valgus.

3.35. Urology. It includes vasectomy, diagnosis of impotence **(not its treatment)**, as well as the study and diagnosis of infertility and sterility. Including the use of holmium surgical laser in endourological pathology, lithiasis, prostatic, stenotic or tumoral enucleation and green laser (KTP and HPS) **for the surgical treatment of benign prostatic hyperplasia**.

Includes prostate fusion biopsy for prostate cancer screening and robotic surgery for prostate cancer surgeries**.**

A prescription from a specialist doctor included in the Insurer's Medical List and authorisation from the Insurer will be required before it is carried out.

4. DIAGNOSTIC TESTS

Diagnostic tests shall in all cases be carried out **following a prescription from a specialist doctor included in the Insurer's Medical List**. It shall include the usual means of diagnosis recognised by medical practice when the contract is taken out. **Diagnostic studies or tests related to research or of a scientific nature will not be covered, nor will tests arising from cosmetic surgery.** The contrast medium and radiopharmaceuticals used are included in the coverage.

4.1. Clinical analysis. Biochemistry, haematology, microbiology and parasitology.

4.2. Pathological Anatomy and Cytopathology. The determination of the following therapeutic targets is expressly included as a study prior to a personalised oncological treatment and according to the type and stage of the tumour.

Therapeutic target	Tumour type/stage	Treatment
HER2	Breast Cancer	HER2 inhibitors
	Advanced (metastatic) gastric cancer	
eGFR	Lung Cancer	eGFR inhibitors
KRAS	Advanced (metastatic) colon cancer	Anti-monoclonal anti-EGFR
BRAF	Advanced (metastatic) melanoma	BRAF inhibitors
c-Kit	Gastrointestinal stromal tumours	c-Kit Inhibitors
ALK	Carcinoma of the lung	ALK inhibitors
N-RAS	Advanced (metastatic) melanoma	MEK inhibitors
ROS1	Non-small cell lung carcinoma	Tyrosine kinase inhibitors
PDL 1	Non-small cell lung carcinoma	Anti-monoclonal anti-PD1

Only therapeutic targets that are specified in the technical data sheet of the drug and whose determination is required as a step prior to the administration of said therapeutic target with regard to the therapeutic attitude of each case, and with demonstrated evidence and clinical relevance will be covered. Only those drugs marketed in Spain, and which have the corresponding indication and approval by the Spanish Agency of Medicines and Health Products will be considered.

4.3. Digital Dermatoscopy. In early diagnosis of melanoma in people with a family and/or personal history of melanoma, in dysplastic nevus syndrome and/or presence of multiple nevi / moles.

4.4. Sentinel lymph node detection. In breast pathology and melanoma.

4.5. Early detection of deafness in children. Includes consultation and examination, otoacoustic emissions and auditory evoked potentials of the brain stem.

4.6. Cardiological Diagnosis. Electrocardiogram, stress test, echocardiogram, blood pressure or heart rhythm holter, event holter, haemodynamic and electrophysiological studies, CT coronary angiography.

4.7. Gynaecological Diagnosis. Includes breast tomosynthesis and breast MRI.

4.8. Obstetric Diagnosis. It includes the "triple screening" (combined first trimester test), chorion biopsy and amniocentesis, with the obtaining of the chromosomal karyotype, for the diagnosis of foetal anomalies in pregnancies at risk.

Including non-invasive prenatal test for screening of foetal trisomies 13, 18 and 21 in case of changes in the combined screening (triple screening) in the first trimester **(high risk).**

4.9. Genetics. Only the genetic tests included in the following list are covered **provided that they are necessary and essential for the diagnosis and/or treatment of the patient with symptoms of the disease**, taking into account the recommendations of the Clinical Practice Guidelines in force at any given time:

- **Karyotyping of peripheral blood, bone marrow, amniotic fluid and chorionic villi.**
- **Thrombophilia panel (Factor II, V, XII and MTHFR).**
- **Haplotype HLA DQ2_DQ8 (Celiac).**
- **Haemochromatosis (C282Y, H63D, S65C mutation).**
- **Molecular Biology of pathogens (Hepatitis, HPV, HIV, STD).**
- **Oncohaematology, FISH/Rearrangements and JAK2 Mutation (V617F) studies.**
- **Genomic platforms in breast cancer according to their technical data sheet (Mamaprint, Oncotype and Prosigna).**
- **BRCA1 and BRCA2 sequencing only in the following cases:**
    - **Unaffected woman with a family history of breast cancer diagnosed before the age of 50 and/or ovarian cancer at any age.**
    - **Woman over 50 years old with breast cancer and with a family history of breast cancer diagnosed before the age of 50 and/or ovarian cancer at any age.**
    - **Woman under 50 years old with breast cancer.**
    - **Woman with ovarian cancer.**

- **Male with breast cancer.**

4.10. Nuclear Medicine. Includes radioactive isotopes for gammagraphic studies. PET (positron emission tomography) and PET-CT are included, **exclusively for cases of oncology and drug-resistant epilepsy** and with the radiotracers 18FDG, choline for prostate cancer and gallium for neuroendocrine tumours.

4.11. Clinical Neurophysiology. Electroencephalography, electromyography and evoked potentials. Polysomnography, **exclusively for the study of obstructive sleep apnea syndrome**.

4.12. Pneumology tests. Includes diagnostic and/or therapeutic fibrobronchoscopy and echobronchoscopy.

4.13. Digestive tests. Includes digestive endoscopies, diagnostic and/or therapeutic, digestive endoscopies, as well as capsule endoscopy for the diagnosis of haemorrhage and/or intestinal bleeding of unknown origin. It includes virtual colonoscopy, preventive colonoscopy for colon cancer and magnetic resonance enterography. Including hepatic elastography.

4.14. Radiodiagnosis.

- **Conventional radiology.** It includes the usual diagnostic techniques such as simple radiology (head, trunk, limbs, special skull and stomatological radiology) and special non-interventional radiology (digestive, urology and gynaecology).
- **Visceral and vascular interventional radiology.**
- **Ultrasound and Doppler echocardiography**
- **Computerised axial tomography (CT/Scanner).**
- **Magnetic resonance imaging (MRI).**
- **Bone densitometry.**

4.15. Urology. Includes multiparametric magnetic resonance imaging (MRI) of the prostate.

5. HOSPITALISATION:

Hospitalisation will be carried out in centres owned or arranged by the Insurer on the advice of one of the Insurer's doctors, with the patient occupying a single room with toilet and a visitor bed (unless it is manifestly impossible) except in the cases expressly excluded. The Insurer shall pay the costs of surgery, anaesthetic products and medicines used both during surgery and hospitalisation **(except for medication that is not authorised in Spain)**, as well as treatments and their material and the care of the patient while they are hospitalised.

5.1. Medical hospitalisation (without surgical procedure). The duration of hospitalisation will be determined by the Insurer's doctor in charge of the care until medical discharge.

5.2. Paediatric hospitalisation. It includes both conventional hospitalisation and incubator (in the latter case, a visitor bed is not included). **Hospitalisation of the premature child or pathological newborn in a specialised centre (Neonatology), provided that the child is included in the insurance policy.**

5.3. Maternity hospitalisation. Assisted by obstetrician and midwife. It includes epidural anaesthesia, **and the omni bed and incubator for the newborn, as long as the newborn is included in the insurance policy**.

5.4. Surgical hospitalisation. Major outpatient surgery is included.

5.5. Hospitalisation in the Intensive Care Unit (ICU). It shall be carried out in the centres designated by the Insurer, subject to the prescription of a doctor of the Insurer, in suitable facilities. The Head of the Intensive Care Unit will indicate the length of stay of the patient. **For hospitalisation in the ICU, a visitor bed is not included.**

5.6. Psychiatric hospitalisation. Exclusively for patients previously diagnosed by a specialist of the Insurer for the treatment of acute outbreaks of a reversible nature, as in-patients or in day hospitalisation, **with a limit of sixty days per contract year**. **For hospitalisation in the ICU, a visitor bed is not included.**

5.7. Special care at home. When the Insurer's doctor considers that the Insured requires hospital care covered in the contract and which does not require admission to a hospital, medical care and technical-healthcare services may be provided at the home of the Insured person as stated in the contract.

Excluded are expenses generated by social assistance, hospitality, linen, food, medication, healthcare material and non-specific care from the general practitioner, nursing, nor the continued stay of healthcare professionals in the Insured person's home.

6. PROSTHESES, IMPLANTS AND SKIN GRAFTS

Cover is provided for temporary or permanent fixed internal prostheses, which must be provided by the suppliers designated by the Insurer and implanted during the period of validity of the contract. **It comprises exclusively the following:**

a) **Cardiovascular**
   - Heart valves **(except for percutaneous and/or transapical procedures)**.
   - Medicalised or non-medicalised peripheral or coronary by-pass.
   - Pacemakers excluding any type of defibrillator and artificial heart.
   - Coronary stents.
   - Coils and/or embolisation material.

b) **Traumatological**
   - Hip, knee and other joint prostheses.
   - Materials required for spine fixation.
   - Disc and intervertebral interposition materials.
   - Necessary material for vertebroplasty-kyphoplasty.
   - Bone grafts from bone bank.

c) **Ophthalmology**

- Monofocal intraocular lenses for cataract correction **(except toric and bitoric)**.

d) Digestive

- Abdominal tights.
- Biliary stent.
- Oesophageal, duodenal and colonic endoprosthesis.

e) Others

- Breast prostheses and breast expanders post-surgery of neoplastic origin **(provided that the surgery has taken place during the contract period)**. **The prosthesis will not be covered in the contralateral breast unless it is affected by neoplasia.**
- Hearing aids, **only stapes in case of otosclerosis**.
- Testicular prosthesis **only in cases of oncological post-surgery**. **The prosthesis will not be covered in the contralateral testicle unless it is affected by neoplasia.**
- Cerebrospinal fluid diversion systems.
- Urological suspension systems.

In addition, only the biological and/or biomaterials and osteosynthesis material detailed below are covered:

- **Biological surgery:** Biomatrix or resorbable mesh to replace the dura mater in intracranial or tumoral spinal surgery, and the pericardium in cardiac surgery.
- **Suture anchors:** includes high-strength biomaterials (PPLA and PEEK) for ligament fixation of large joints (shoulder, knee, hip, elbow and ankle) in minimally invasive arthroscopic surgery of the extremities.
- **Dura mater**

7. TREATMENTS

In all cases, they will be carried out **following a prescription from a specialist doctor included in the Insurer's Medical List,** in the centres designated by the Insurer and related to the disease. **In order to undergo any of these treatments, authorisation from the Insurer will be required prior to the treatment being carried out.**

- **Aerosol-ventilation therapy. Medication shall in all cases be at the Insured's expense.**
- **Oxygen therapy.** Both in cases of admission to outpatient and inpatient centres. Outpatient oxygen therapy is included for those patients who require oxygen treatment for at least 16 hours per day.
- **Dialysis (haemodialysis and peritoneal dialysis).** Exclusively for the treatment of acute kidney failure.
- **Speech therapy.** In the case of rehabilitation after major laryngeal surgery, **up to a maximum of 60 sessions per contract year**. And for organic diseases related to the vocal cords (oedemas, nodules, polyps and cancer) **up to a maximum of 20 sessions per contract year**.

- **Laser therapy.** It is only included in ophthalmology treatments, musculoskeletal rehabilitation, urology (as established in Article 3), in the treatment of varicose veins (as established in Article 3) and the use of laser in proctology.
- **Chemotherapy and radiation oncology.** It will be provided on an inpatient or day-case basis, except for intravesical instillations of BCG for the treatment of superficial bladder carcinoma, which may be provided on an outpatient basis.

  The Insurer shall only be liable for the costs of specifically cytostatic drugs administered intravenously, which are issued on the domestic market and are duly authorised by the Ministry of Health, applied in accordance with the indications given in the product's technical data sheet. Likewise, the insurer will pay for medicines without anti-tumour effect that are administered simultaneously with cytostatics during the chemotherapy session, in order to avoid their adverse or side effects.

- **Renal extracorporeal lithotripsy.**

8. OTHER SERVICES

- **Ambulances:** the insurance covers **exclusively urban and interurban journeys of the Insured person from their home to the centre or vice versa and only for hospital admission or emergency care. A prescription from a doctor of the Insurer will be required, except in an emergency.**

  In all cases, transport will be by land and will be carried out whenever the doctor orders it in writing with a report indicating the need for assisted transport and only if there are special circumstances of physical impossibility that prevent the Insured from using ordinary transport services (public transport, taxi or own vehicle).

- **Podiatry:** includes chiropody, treatment of incarnate nail and/or papilloma at the surgery, and the biomechanical study of gait for children under 16 years of age.

9. HEALTH CARE ABROAD

The Insurer guarantees the Insured and the other Beneficiaries of the contract and during the term of the contract, the cover of this guarantee, **with a maximum of €15,000 per insured person and per insurance year.**

However, the partial reimbursement limits to be made by the Insurer shall not exceed the limits indicated in each of the covers provided.

With regard to the validity of the insurance and in order to be able to benefit from the guaranteed benefits, all of the following conditions must be met: an individual resident in Spain, holder of the contract and/or beneficiary who, from the start of the trip until its completion and within the period of validity of this cover, has suffered an illness or accident outside Spanish territory. **The trip or travel cannot exceed 90 days for this coverage to be valid.**

Travel shall be understood to be by public transport or private vehicle and must be duly justified by any means of proof (hotel reservation, airline reservation, etc.). The period of the trip that is the object of the cover includes from the moment when, within the dates contracted in the insurance policy, the client has left their usual place of residence in order to go on a trip or service contracted, until their return.

The Insured person undertakes to provide the Insurer with all the necessary documents requested in order to process the relevant formalities.

In order for the Insurer to assume its obligations, it is essential for the Insured person to contact the service provider immediately in the event of an incident to make a claim via the telephone number indicated in this document.

The exclusions specific to healthcare abroad are set out in Article 4, point 2.

9.1. GUARANTEES COVERED

1. Medical, surgical, pharmaceutical and hospitalisation expenses abroad

Under this cover the Insurer will pay, **up to a limit of €15,000,** the expenses incurred by each Insured person outside of Spain as a result of an accident or illness of an unforeseeable nature.

The reimbursement of expenses mentioned herein shall in all cases be complementary to other benefits to which both the Insured person and their successors are entitled, either through Social Security benefits or any other welfare scheme to which they may be affiliated.

In the event that any of the Insured parties should require emergency dental care, the Insurer will cover the costs arising from this **up to a maximum of €120.20.**

Under no circumstances shall expenses be covered that arise from medical or surgical treatments that are not necessary in the eyes of the Insurer's medical team or those which may be delayed until the Insured or Beneficiary returns home.

2. Hospitalisation fees

When due to an accident or illness covered by the Policy, during a trip abroad, the Insured person needs to be admitted to hospital, the Insurer will pay, up to a maximum limit of €601.01 of the amount demanded by the hospital in order to admit the Insured person.

3. Cash advance in case of serious illness abroad

If the Insured person or Beneficiary should urgently need cash as a result of a serious illness, the Insurer will provide an advance **up to a limit of €1,500.**

In order to guarantee this cash advance, the Insurer reserves the right to demand, prior to making the payment, that a person designated by the Insured in Spain takes responsibility for repayment of the amount in a reliable manner, by acknowledging the debt.

This advance is subject to the legislation of the country from which it is requested.

The Insured person undertakes to repay the amount advanced by the Insurer within 10 days of the end of the trip and, in any event, within two months of the date of the advance.

4. Medical repatriation of the wounded or sick from abroad

Depending on the urgency or seriousness of the case and the judgement of the treating doctor, the Insurer will pay for the transport of the Insured person or Beneficiary, even under medical supervision, if necessary, to a hospital in Spain close to their residence or to their own habitual residence when they do not need to be hospitalised. If the Insured person cannot be taken to a place close to their habitual residence, the Company will be responsible for the subsequent transfer to the Insured person or Beneficiary's residence.

In the event of benign illnesses or minor injuries that do not require medical repatriation, the Insurer will arrange for the transport of the Insured person by vehicle or ambulance to the place where the necessary medical care can be provided.

Under no circumstances shall the Insurer replace the emergency services of the country concerned, nor shall the Insurer be liable for the cost of such services.

In any event, the decision as to whether or not to carry out the transfer shall be taken by the doctor appointed by the Insurer in each case, in agreement with the doctor treating the Insured person and, if applicable, with their family.

The Insurer shall also pay the cost of transporting up to two people travelling with the Insured person or Beneficiary and who are also in that capacity, to their place of origin or destination, provided that the cost of this does not exceed the cost of returning home.

5. Repatriation of the deceased Insured person and accompanying persons

In the event of the death of an Insured person or Beneficiary, the Insurer organises and pays for the transport of the body from the place of death to the place of burial in Spain, as well as the return home of the other people accompanying the Insured or Beneficiary.

Also covered **up to a limit of €601.01** are the costs of a post-mortem and preparation of the body (such as embalming and the mandatory coffin for the transfer), in accordance with the legal requirements.

In any case, the cost of the actual coffin and the burial and ceremony expenses shall not be covered by the Insurer.

6. Accompaniment of mortal remains

If there is no one to travel home with the mortal remains of the deceased Insured person, the Insurer shall provide the person designated by the beneficiaries to travel with the body.

9.2. ADDITIONAL CONDITIONS TO THE HEALTH CARE COVERAGE ABROAD

1. The Insurer shall not be liable for delays or unfulfillment due to force majeure.
2. With regard to the travel expenses of the insured persons, **the Insurer will only cover the excess over the expenses normally expected by them (train tickets, plane tickets, sea crossings, fuel for the vehicle).**
3. **In order for the Insurer to carry out its obligations, the Insured person must notify the Insurer immediately of any claim via telephone which is operational** 24 hours a day, 365 days a year.

Healthcare assistance abroad:

34 91 595 50 49

ARTICLE 4 - EXCLUSIONS

1. HEALTH CARE

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

b) **General medical check-ups or examinations of a preventive nature, except for what is expressly included in point 3. of Article 3. Analyses or other examinations that are necessary for the issuing of certificates, reports and any type of document that does not have a clear health care function.**

c) **Physical damage resulting from war, riots, revolutions and terrorism, those caused by officially declared epidemics, those directly or indirectly related to radiation or nuclear reaction and those resulting from natural catastrophes (earthquakes, floods and other seismic or meteorological phenomena).**

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

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

f) Health care for all kinds of illnesses, injuries, previous states or health conditions, accidents and their sequelae, congenital or previous defects or deformities diagnosed before the date on which each Insured person is registered under the contract, as well as for any signs or symptoms that could be considered to be the start of any disease or which have previously required studies, diagnostic tests or treatments of any kind, unless such illnesses, injuries, accidents, symptoms, defects or deformities have been declared by the Contracting Party or Insured person in the health questionnaire and its cover is not expressly excluded in the Particular Conditions by the Insurer. This exclusion shall not affect the Insured persons added to the contract from birth in accordance with point 1. e) of Article 10.

g) Everything concerning Psychology, ambulatory narcolepsy, sophrology, neuropsychological and psychometric tests, psychoanalytic psychotherapy, as well as psychosocial or neuropsychiatric rehabilitation, psychoanalysis, hypnosis, group psychotherapy, psychological tests and rest and sleep cures, except for what is expressly included in point 3.28. of Article 3.

h) Travel expenses, except for the ambulance in the terms set out in point 8 of Article 3. Also excluded are required transfers, regardless of whether it is for outpatient or inpatient, for any consultation, diagnostic and therapeutic tests, rehabilitation treatments, physiotherapy, speech therapy, psychology, radiotherapy, oncology, surgery and all special treatments.

i) Voluntary termination of pregnancy, diagnostic tests related to such termination, any surgical procedure on the unborn child and the treatment (including surgery) of impotence.

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

k) Organ or tissue transplants, except for autologous bone marrow transplants and cornea transplants, except as expressly included in point 3.25. of Article 3.

l) Any genetic test requested for prognostic or preventive purposes is excluded, as well as genetic predisposition studies of the Insured person or their relatives. Also excluded from coverage are genetic counselling, genetic mapping, paternity or kinship tests, as well as anything else that is not explicitly included in point 4. of Article 3.

m) Hospital care and treatment for social or family reasons, palliative care, as well as care that can be replaced by home or outpatient care.

n) Health care in private centres that are not subsidised, and also that which is provided in hospitals, centres and other publicly owned establishments that are part of the Spanish National Health System and/or those that report to the Autonomous Communities, is also excluded. In any case the Insurer reserves the right to claim from the Insured person the recovery of the costs of care that it has had to pay to the public health system for the medical, surgical and hospital care provided.

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

p) Pharmaceuticals, medicines and auxiliary treatment aids of any kind, except for those administered to the Insured person during their stay (a minimum of 24 hours) in a hospital centre. Non-commercialised medicines in Spain are excluded. Vaccines are also excluded.

q) Diagnostic or therapeutic procedures whose safety and cost-effectiveness are not scientifically proven, or which appear after the signing of this contract and are not covered by the Insurer are excluded.
Procedures that are not universalised or not consolidated in routine clinical practice, those that have been replaced by other available procedures, procedures of an experimental nature or those whose effective contribution to the prevention, treatment or cure of diseases has not been sufficiently proven.
A diagnostic, surgical or therapeutic procedure is considered safe and effective for the purposes of this contract when it is approved by the European Medicines Agency and/or the Spanish Agency for Medicines and Medical Devices. A procedure is considered to be universalised and consolidated when it is performed in routine clinical practice in public hospitals that are not only referral hospitals.

r) Chemotherapy will only cover the cost of specifically cytostatic drugs as defined and detailed in Article 1, Definitions, "cytostatic". Expressly excluded from this are anti-tumour immunotherapy, monoclonal antibodies, gene therapy, endocrine or hormone therapy, enzyme and/or molecular inhibitors, anti-angiogenic drugs and sensitisers used in photodynamic therapy and radiation.

s) Physiotherapy and rehabilitation treatments when functional or the maximum possible recovery has been achieved, or when it becomes maintenance therapy, which in such a case would be indicated by the professional responsible for carrying out such treatments. In addition, the following are excluded: rehabilitation derived from neurological diseases, educational therapy, language education, special education for the mentally ill and early stimulation rehabilitation in cases of psychomotor developmental retardation. Cardiac rehabilitation, pelvic floor rehabilitation and lymphatic drainage are excluded except for what is expressly included in point 3.31. of Article 3. Rehabilitation in inpatients and at home is expressly excluded.

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

u) Any means of diagnosis for sleep disorders is expressly excluded, except for what is specifically included in point 4 of Article 3.

v) Metabolic and obesity surgery and the fitting/placement of gastric bands and intragastric balloons.

w) Robotic surgery is excluded, except for what is included in point 3.35 of Article 3. Likewise, neuromonitoring is excluded for any diagnostic, surgical or therapeutic procedure, except for what is included in point 3.21 of Article 3.

x) Implantable pumps for drug delivery and electrodes for spinal cord and brain stimulation are expressly excluded.

y) Parkinson's and epilepsy surgery.

z) Breast reduction surgery, prophylactic breast and gynecomastia surgery are excluded.

aa) Any prosthesis, implant, sanitary device, orthopaedic material, orthosis and external fixators not stated in item 6 of Article 3° are excluded. The cochlear implant and the carina implant or similar. Also excluded are heart valve stents, closure devices and vascular stents for congenital defects and other MitraClip type devices, atrial appendage closure devices, leaks or similar devices in percutaneous or transapical procedures. Penile prosthesis, multifocal intraocular lenses, toric and bitoric monofocal lenses. Infiltrations with autologous growth factors (plasma rich in growth factors) and/or platelet concentrates and cellular components are excluded.

bb) The following are expressly excluded: sealants, biological glues or adhesives, anti-adhesive or anti-adherent barrier gel, bone graft substitutes: bone cements and regenerative demineralised bone matrix, as well as any other biological or synthetic material not stated in point 6 of Article 3.

cc) Intraperitoneal chemotherapy is excluded.

dd) In the speciality of Odontostomatology, obturations, endodontics, placement of prostheses and osseointegrated dental implants, orthodontics, periodontics, as well as other dental treatments other than those included in point 3.24. of Article 3 are excluded.

ee) Treatments aimed at recovering the functionality of the mouth and dental area, such as orthognathic, pre-implantological and pre-prosthetic surgery.

ff) Surgical correction of myopia, hyperopia or astigmatism and presbyopia and any other ocular refractive disease. Intracorneal ring/segment implantation is also excluded. Cross-linking is expressly excluded as a treatment for keratoconus.

gg) All surgical and / or therapeutic techniques that use a laser, except for those expressly included in point 7. of Article 3.

hh) The hyperbaric chamber.

ii) Chronic dialysis treatments.

jj) Alternative medicines, treatments in nursing homes, residences, spas and the like.

kk) Water, home and alternative means of birth are excluded.

2. HEALTH CARE ABROAD

1) Claims that may arise directly or indirectly from previous illnesses, congenital, chronic or medical conditions under medical treatment prior to the start of the trip.

2) Voluntary termination of pregnancy, childbirth, except for emergencies and cases of unforeseeable complications up to the 29th week of pregnancy.

3) Accidents occurring in the event of war, pandemics, demonstrations and social movements, acts of terrorism and sabotage, strikes or any other case of force majeure, unless the Insured person proves that the accident is unrelated to such events.

4) Benefits from the practice of dangerous sports, such as mountaineering, climbing, motocross, gliding, hang-gliding, skiing, snowboarding and similar or those that require physical training.

5) Any expenses claimed when the insurance dates do not coincide with the actual dates of travel (both the day of departure and the return date must be taken into account).
6) Vaccinations and tests for previously known diseases.

7) Expenses relating to prostheses of any kind, physiotherapy and kinesiotherapy.

8) **The costs of implants, experimental surgeries and treatments whose safety and cost-effectiveness are not scientifically proven or are not recognised by official medical science in Spain. Psychological and aesthetic treatments, rehabilitation or preventive medicine.**

9) **Any type of medical fee or expense less than €9.02.**

10) **Suicides, self-harm and drug or alcohol intoxication.**

11) **Under no circumstances shall the Insurer replace the emergency services of the country concerned, nor shall it cover the cost of these services.**

12) **Mental illnesses, as well as psychoanalysis and psychotherapy.**

ARTICLE 5 - HOW SUPPORT WILL BE PROVIDED

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

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

1. CARE GUIDANCE

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

2. FREEDOM OF CHOICE OF DOCTORS

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

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

3. HOME VISITS

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

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

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

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

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

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

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

5. AUTHORISATION OF BENEFITS

In general, prior express authorisation from the Insurer with the prior written prescription of the Insurer's doctors will be required for hospitalisation, surgery, treatment, rehabilitation and physiotherapy treatments, psychology and assisted reproduction, as well as diagnostic tests.

Documentation to be submitted for those services that require authorisation:

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

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

In urgent cases, an order from the Insurer's doctor will be sufficient, but the Insured person must obtain confirmation from the Insurer within seventy-two (72) hours of admission to hospital or the start of the

medical care service. The Insurer shall remain financially bound until it expresses its objections to the doctor's order in the event that it considers that the contract does not cover the medical service or the hospitalisation.

6. EMERGENCIES

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

7. TEMPORARY TRIP

The Insurer undertakes to provide healthcare for the Insured person who is temporarily away from their habitual place of residence anywhere in Spain. **You will be able to choose between the Insurer's own or subsidised centres included in the Insurer's Medical List, in the town or city in Spain where you are located.**

If assistance is required outside the national territory, see Article 3 point 9 of health care abroad.

8. ASSISTANCE VIA MEANS NOT ARRANGED WITH THE INSURER

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

9. ACCREDITATION OF THE INSURED PERSON

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

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

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

The benefits that will need to have fulfilled the prior waiting periods in order to be covered by the Insurer are:

- **Six (6) months** for:
  - Family planning.
  - Surgical procedures and admissions.
  - Oncological, cardiovascular, lithotripsy and dialysis treatments.
- **Ten (10) months** for:
  - Hospitalisation and admission for assistance in childbirth/caesarean section. In the case of premature birth, if the estimated date of birth, for a full-term pregnancy, would have met the stipulated waiting period, this benefit will be paid out.
  - Postpartum pelvic floor rehabilitation.

    - Postpartum care.
- **Twenty-four (24)** months for:
    - Assisted reproduction.

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

1. The declarations made by the Contracting party and the Insured person regarding their state of health in the Application Questionnaire constitute the basis for acceptance of the risk under this contract and form an integral part thereof.
2. The Insured person loses the right to the guaranteed benefit:
    a) In case of withholding or providing inaccurate information when filling in the health status questionnaire (Article 10 of the Law).
    The Insurer may cancel the contract by means of a declaration addressed to the Contracting party within one month of the date on which the Insurer becomes aware that the Contracting party or the Insured person withheld or provided inaccurate information. Unless the Insurer is guilty of wilful misconduct or gross negligence, the Insurer shall be liable for the premiums for the current period at the time of making this declaration.

    If the incident occurs before the Insurer makes the declaration referred to in the previous paragraph, the Insured person's benefit shall be reduced in proportion to the difference between the agreed premium and the premium that would have been applied had the true nature of the risk been known. If there were fraud or gross negligence on the part of the Contracting party or the Insured person, the Insurer won't be liable for payment of the benefit.

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

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

3. However, the Insurer undertakes to:
    a) Not cancel the contract when the Insured person is undergoing hospital treatment until they are discharged from hospital unless they waive their right to continue such treatment.
    b) Not oppose the extension of insurance contracts of Insured persons in certain situations of serious illness, provided that the first diagnosis has occurred during the period of the contract. The following are illnesses with ongoing treatment within the contract:

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

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

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

a) The Insured person has failed to comply with their obligations, or they have withheld or provided inaccurate information when declaring the risk.
b) In the event of the Contracting party failing to pay for the premium or refusing to accept any updates to the policy.
c) The Contracting party does not agree to the terms of Renewal.

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

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

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

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

ARTICLE 8 - INSURANCE DURATION

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

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

The Insurer may not terminate the contract when the Insured person is undergoing hospital treatment until they are discharged from hospital unless they waive their right to continue with the treatment.

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

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

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

ARTICLE 9 - PAYMENT OF PREMIUMS

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

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

completion, unless collection is attempted within a period of thirty (30) calendar days and there are insufficient funds in the Contracting party's account, or the latter has ordered for it to be refunded.

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

1. The Contracting party and, where applicable, the Insured person have the following obligations:
    a) To declare to the Insurer, in accordance with the questionnaire that they must submit when taking out the policy, all circumstances known to them that may affect the assessment of the risk.
    They shall be exempt from this obligation if the Insurer does not request that they fill in and submit a questionnaire or when, even if they do submit the questionnaire, it concerns circumstances which, although they may affect the assessment of the risk, are not included in it.
    The Insurer may terminate the contract by means of a declaration addressed to the Contracting party within one month (1) from the date on which the Insurer becomes aware that the Contracting party or Insured person has withheld or given inaccurate information. Unless the Insurer is guilty of wilful misconduct or gross negligence, the Insurer shall be liable for the premiums for the current period at the time when they make this declaration.
    b) If the incident occurs before the Insurer makes the declaration referred to in the previous paragraph, the Insured person's benefit shall be reduced in proportion to the difference between the agreed premium and the premium that would have been applied had the true nature of the risk been known. If there were fraud or gross negligence on the part of the Contracting party, the Insurer shall no longer be liable for payment of the benefit. To notify the Insurer, during the course of the contract and as soon as possible, of all circumstances which, according to the questionnaire on the state of health of the Insured person previously submitted, affect the risk and are of such a nature that, if they had been known to the Insurer at the time the contract was finalised, they would not have done so or would have finalised it under more onerous conditions.
    c) Notify the Insurer as soon as possible of the change of address.
    d) To notify the Insurer as soon as possible of any additions or partial cancellations of Insured parties that occur during the term of the contract, taking effect on the first day of the month following the date of the notification made by the Contracting party. The following cases of partial cancellation will be accepted: the day on which the Insured person dies, a change of residence outside Spanish territory, separation of the couple or emancipation of one of the Insured persons or in the event of the payment of insurance to one of the Insured persons as a corporate social benefit.
    e) Newborn children and newly adopted children may be registered as Insured parties, without having to submit health questionnaires and without waiting periods, in the parents' contract provided that they have been insured with CASER for **at least eight (8) months**, and the registration is requested within a

maximum period of 15 days from their birth, in the case of newborn children, or from their registration in the family book, in the case of newly adopted children, by means of the corresponding insurance application.

Otherwise, the admission of the newborn or adopted child will be subject to compliance with the conditions established by the Insurer, and the ordinary waiting periods, the corresponding exclusions or the refusal of insurance may be applicable.

In any case, the Insurer shall cover healthcare for the newborn or adopted child provided that they are registered as an Insured party.

f) Minimise the consequences of the incident, using the means at their disposal for a prompt recovery. Failure to comply with this duty, with the sole intention of harming or deceiving the Insurer, shall release the Insurer from paying out any benefit deriving from the claim.
g) To grant and facilitate the subrogation in favour of the Insurer established in Article 82 of the Insurance Contract Law.
h) Minors may only be included in the insurance policy in the event that the person or persons who have parental authority or guardianship over them is the Contracting party, unless otherwise agreed.

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

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

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

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

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

ARTICLE 11 - OTHER OBLIGATIONS OF THE INSURER

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

It will also facilitate:

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

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

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

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

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

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

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

ARTICLE 13 - COMMUNICATIONS

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

ARTICLE 14 - VALIDITY

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

ARTICLE 15 - JURISDICTION

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

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

COMPLEMENTARY GUARANTEES TO THE HEALTH CARE INSURANCE

ANNEX I: DENTAL CARE COVERAGE

1. Purpose

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

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

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

2. Coverage Description

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

The list of services established with maximum amounts (excesses) described for the present financial year may be updated annually based on the price modifications of the suppliers and/or if deemed necessary. The updated guarantees and maximum amounts can be consulted on our website caser.es and/or on the Caser Salud App.

3. Excluded risks

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

4. How services are provided

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

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

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

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

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

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

5. STRUCTURE AND OPERATION OF THE SERVICE

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

1. **Care guarantee** list of services which the insured person may use for free.
2. **Services with maximum amounts**: services to be paid for by the Insured person that can be obtained at special prices. These services are identified as **maximum amounts** (excesses) available to the Insured person so that they can be known prior to requesting quotes.

6. ACCESSING THE SERVICES

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

GLOSSARY OF TERMS - DENTAL SERVICES

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

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

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

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

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

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

PERIODONTAL FLAP SURGERY: surgical procedure for the treatment of periodontal disease. The objectives of this procedure are: to reduce pocket depth, regenerate and prevent attachment loss.

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

REPAIR: repair of damaged braces, which may be simple or require soldering of the braces.

WISDOM TOOTH: third permanent molar. Wisdom tooth.

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

3D SCANNER: computer program for computer tomographs that provides high resolution images of the maxilla and mandible, and that from axial plane slices, performs panoramic and transversal reconstructions.

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

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

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

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

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

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

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

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

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

DENTAL IMPLANTS: small dental devices that are inserted into the upper and lower jaws to help repair an oral cavity that has few or no teeth that can be restored.

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

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

FILLING: dental filling.

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

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

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

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

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

ODONTOGRAM: measurement of tooth mobility.

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

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

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

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

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

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

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

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

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

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

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

ANNEX II: SECOND MEDICAL OPINION COVERAGE

1. Purpose

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

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

2. Insured persons

The status of the Insured persons will be held by the persons, contract holders and Beneficiaries at the time of applying for cover and during the entire period of cover.

3. Description

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

a) Second Medical Opinion on the diseases described in this contract in the section on **illnesses subject to Second Medical Opinion**. The service consists of:

  - Second Medical Opinion with specialists of the highest national and international prestige.
  - Without the need to travel and with a response within ten working days, counting from the date on which the Insured person sends the completed Second Medical Opinion request form and the corresponding documentation.
  - Support for the patient, if he/she deems it appropriate, after the Second Medical Opinion has been processed.

b) Selection of experts and hospitals:

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

c) In those cases in which the Insured person considers it appropriate to receive medical services outside the list of professionals and centres arranged by the Insurer, an Expense Management service shall be provided which shall consist of:

  - Management of appointments with national and international doctors outside the Insurer's list.
  - Obtaining budgets and estimated costs of hospitalisation.
  - Admission procedures in national and international hospitals.
  - Coordination of the patient's transfer (reservations, air and land ambulance and translation service).

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

4. Illnesses subject to Second Medical Opinion

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

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

5. Other conditions

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

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

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

6. Use of the service

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

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

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

7. Request for Second Medical Opinion

Requests for Second Medical Opinion services can be made by calling **91 590 96 40**. The Insured person must provide the identification details requested in order to accredit their right to the service.

INSURED PARTY'S DEFENCE SERVICE

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

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

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

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

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

5. The resolutions will take into account the obligations and rights set out in the General, Particular and Special Conditions of the contracts, the regulations governing insurance activity and the rules on transparency and protection of financial services customers (Insurance Contract Law, redrafted text of the Law on the Regulation and Supervision of Private Insurances, redrafted text of the Law on Pension Plans and Funds, Law on Financial System Reform Measures, Law on Alternative Dispute Resolution in Consumer Affairs, Order ECC/2502/2012,

regulating the procedure for the submission of claims to the Claims Service of the Directorate-General of Insurance and Pension Funds among others, Order ECO 734/2004, of 11 March, on the customer services of financial entities, redrafted text of the General Law for the Defence of Consumers and Users and other complementary laws).