General Conditions

Asisa Salud

Some of the rights limitation clauses included in the General Conditions shall not be applicable depending on the Particular Conditions established with the Policyholder.

ASISA SALUD GENERAL CONDITIONS

PRELIMINARY CLAUSE

This insurance contract is governed by the provisions of Law 50/1980, 8 October; on Insurance Contracts (Official State Bulletin 17 October); by the provisions of Law 20/2015, 14 July on the Regulation, Supervision and Solvency of Insurance and Reinsurance Companies (Official State Bulletin 15 July); by the provisions of Royal Decree 1060/2015, 20 November, on the Regulation, Supervision and Solvency of Insurance and Reinsurance Companies; and by the general conditions, schedule and special conditions of this contract and their annexes. Clauses limiting the rights of the insured which have not been specifically approved by the Policyholder shall not be valid, although mere transcriptions or references to statutory legal requirements shall not require his/her approval.

The General Directorate of Insurance and Pension Funds of the Spanish Ministry of the Economy and Competition is responsible for supervising the insurance business of ASISA, ASISTENCIA SANITARIA INTERPROVINCIAL DE SEGUROS, S.A.U.

DEFINITIONS

For the purposes of this contract the following definitions apply:

Accident: Bodily injury that derives from a cause that is violent, sudden, external and beyond the will of the Insured.

Insured: The individual for whom the insurance is established.

Insurer: ASISA, ASISTENCIA SANITARIA INTERPROVINCIAL DE SEGUROS, S.A.U., which assumes the risk contractually agreed. This document will also refer to the Insurer as "the Company".

Schedule: Document integral to the policy which specifies the aspects of the risk insured.

List of Doctors and Services: List of in-house or affiliated professionals and medical centres published by the Company in each province, with their addresses, telephone numbers and opening hours available in the Company's offices, at www.asisa.es and in the Asisa app. The Company's List of Doctors and Services covers for this purpose both the provinces where it operates directly and the provinces where it operates through agreements with other insurance companies. Besides professionals and medical centres, each province's List of Doctors and Services includes information and emergency services. The policy holder and the insureds are hereby informed and accept that the professionals and centres included in the List of Doctors and Services are fully independent and autonomous and exclusively responsible within the scope of their own medical provision. The information included in the List of Doctors and Services may be subject to change, therefore it is recommended that when faced with any contingency the Company is consulted.

Health Questionnaire: Declaration made by the policyholder and/or insured prior to the formalization of the policy which allows the insurer to value the risk which is the object of the insurance.

Address of the policyholder and the insured: The address listed in the Schedule of the policy.

Illness: Any alteration in the state of health of the insured person not caused by an accident, which has been diagnosed by a doctor and requires the provision of medical care, and whose first manifestations present themselves during the life of the policy.

Pre-Existing Illness: An illness suffered by the insured person prior to their effective inclusion (registration) in the policy.

Hospitalization: Denotes when a person is admitted to a hospital as a patient and remains admitted for a minimum of 24 hours.

Out Patient Care: Denotes when a person is admitted as a patient to a hospital outpatient care unit (medical, surgical and psychological) for a period of less than 24 hours, in order to receive a specific treatment or to be put under an anaesthetic.

Incontestability of the policy: Benefit included in the contract which arises from the year of its formalization or its inclusion of new insured persons, through which the Company assumes responsibility for coverage of any pre-existing illness, as long as the insured person is not aware of the illness or has not intentionally omitted it from the Health Questionnaire.

Participation of the Insured in the Cost of the Services (Co-payment): The amount the Policy Holder must pay to the Insurer in order to contribute to the financial cost of each medical service used by the Insured. This amount is different depending on the different types of medical services and/or medical specialties, and it may be updated annually.

Waiting Period: Period of time during which some of the provisions established in the Policy are not in force, and therefore are not covered. Waiting Periods established are calculated from the date of the Policy coming into effect.

Insurance Period: Period of time between the date of the policy coming into effect and the maturity of the policy, or between each extension.

Policy: The document that contains the regulatory conditions of the Insurance. The Health Questionnaire, the General Conditions, the Schedule that individualize the risk, and the Supplements, Annexes and Appendices that are issued to complement the policy or modify it, all form an integral part of the policy.

Service: Consists of the coverage of the medical care arising from the occurrence of the claim in the form established in these General Conditions.

Premium: The price of the Insurance. The invoice for the Premium will also contain legally applicable surcharges and taxes.

Insurance Claim: Event provided for in the policy that, once having occurred, gives rise to the Insurer being obliged to provide the Insured with medical care of the scope established in the Policy.

Medical Card: Document owned by ASISA, ASISTENCIA SANITARIA INTERPROVINCIAL DE SEGUROS, S.A.U. which is delivered to each customer The use of this card, which is personal and non-transferrable, is necessary to receive services covered by the policy.

Policyholder: The individual or legal entity who, together with the Insurer, signs this contract and assumes the obligations that derive from it, except those that by their nature must be met by the Insured.

Emergency: Situation produced by the sudden appearance of a medical condition which unexpectedly presents an extreme and serious risk to the life or physical integrity of the Insured, and which requires immediate and urgent medical attention.

CONDITIONS

ONE: OBJECT AND LIMITS OF THE INSURANCE

Within the limits and conditions stipulated in the Policy and through the application of the Premium and co-payments that in each case corresponds, the Insurer will put at the disposal of the Insured, within Spanish borders, a wide range of duly authorized medical professionals, centres and services, from whom the Insured may request medical and surgical care in those specialties and categories included

in the coverage of this Policy, **as long as this care involves diagnostic and treatment techniques recognized by standard medical practice at the time of signing the current contract.**

The Company reserves the right to include in the policy both diagnostic and treatment techniques already in existence at the time of signing the contract and new techniques which may arise in medical practice. It also reserves the right to revise the premium accordingly.

The Company will be responsible, as long as the provisions of this Policy are met, for the cost of the medical care that the aforementioned duly authorized medical professionals, centres and services provide to Insureds. In no case will optional cash damages be awarded as a replacement for the provision of medical care services included in the Policy.

In all cases, according to the provisions of Article 103 of the Law on Insurance Contracts, the Insurer is responsible for necessary urgent care, in accordance with the provisions of the conditions of the Policy.

TWO: DESCRIPTION OF THE SERVICES INSURED

The Company makes available to the Insured a "List of Doctors and Services" in which are listed Emergency Services, a list of doctors in different specialties, Registered Nurses/D.U.E., and other medical professionals and hospital centres. In case of displacement, also listed in the "List of Doctors and Services" is the national emergency network and the network of provincial offices of the Company.

1.- Emergency Service

In each provincial capital the Company provides the insured person with a twenty four hour a day emergency service for home and hospital care. The List of Doctors and Services that is delivered to the Insured includes telephone numbers where any service should be requested and the centres which should be attended in case of emergency.

2.- General Medicine

The Insured has a free choice of family doctor from among those included in the List of Doctors and Services. Care may be provided in the surgery or, when in the doctor's judgment circumstances require it, in the Insured's own home.

3.- Paediatrics

The paediatrician may be chosen freely from among those included in the List of Doctors and Services, for the care of Insureds up to 14 years of age. Care may be provided in the surgery or, when in the doctor's judgment circumstances require it, in the Insured's own home.

New born babies have the right to this medical care in the surgery or at home, charged to the mother's policy for **the first 30 days of their life only**. For this care to continue they must become Insureds within the aforementioned period.

4.- Specialized medicine

The Insured may have a free choice of medical specialist from those included in the List of Doctors and Services.

Existing medical specialties are the following:

- Allergology
- Anaesthesiology and resuscitation
- Anatomical Pathology

- Angiology and Vascular Surgery
- Cardiology
- Cardiovascular Surgery
- Clinical Analysis
- Clinical Neurophysiology
- Endocrinology and Nutrition
- Gastroenterology
- General and Gastroenterological Surgery. Proctology
- Geriatrics
- Haematology and Hemotherapy
- Internal medicine
- Medical Oncology
- Medical-surgical Dermatology and Venereology
- Nephrology
- Neurology
- Neurosurgery
- Nuclear medicine
- Obstetrics and Gynaecology
- Ophthalmology
- Oral and Maxillofacial Surgery
- Otorhinolaryngology
- Paediatric Surgery
- Plastic and Reconstructive Surgery
- Psychiatry
- Pulmonology
- Radiodiagnostics
- Radiotherapeutic Oncology
- Rehabilitation
- Rheumatology
- Stomatology and Dentistry
- Thoracic Surgery
- Traumatology and Orthopaedic Surgery
- Urology

When a specialty does not exist in a specific province, the Insured may make use of this service in any other province in which this specialty exists.

5.- Registered Nurse (D.U.E.)

This service may be provided in the surgery, or, if the Insured requires it, at home, subject to the orders of the doctor on the List of Doctors and Services who is treating the Insured.

6.- Podiatry

The podiatrist-chiropodist service may be provided only in the surgery, **and up to a limit of 6 sessions a year.**

7.- Diagnostic Methods

These must always be used subject to a written prescription from a doctor on the List of Doctors and Services.

Diagnostic methods include the following:

Clinical Analysis: hematology biochemistry, bacteriology and immunology, anatomical pathology cytology, karyotypes (*) and genetic studies solely when their specific purpose is to diagnose a specific disorder in affected patients pursuant to the corresponding clinical protocols and guidelines, and when signs or symptoms of that disorder are present. Also included are therapeutic targets, the determination of which is required in the specifications prepared by the relevant health authority for the administration of some medicines, and prenatal genetic screening using cell-free foetal DNA tests solely for the detection of fetal chromosomal aneuploidies 13, 18 and 21 and sex chromosome abnormalities when indicated according to the risk indices established by the Spanish Society of Gynaecology and Obstetrics (*).

Imaging diagnosis and Nuclear Medicine: Conventional radiology, vascular radiology (*), echography, mammography C.A.T. (Computerized Axial Tomography Scanner) (*), M.R.I. (Magnetic Resonance) (*), gammagraphic studies (*), P.E.T. (Positron Emission Tomography) (**exclusively for those oncological disorders for which the use of FDG is approved**, listed in Annex I of these General Conditions) (*).

Circulatory system: Electrocardiogram and Phonocardiogram. Echocardiogram, Doppler, Catheterization (*), Holter (E.C.G. and blood pressure), Stress Test, Cardiac Electrophysiological Studies (*).

Digestive system: Endoscopy, capsule endoscopy (solely for the diagnosis of internal bleeding of unknown or hidden origin).

Neurophysiology: Electroencephalogram, Echoencephalogram, Electronystagmography Electromyography, Nerve Conduction Velocity Test. Polysomnographic study for obstructive sleep apnea syndrome (*).

Obstetrics and Gynaecology: Laparoscopy Ultrasound, Monitoring, Amniocentesis (*), Karyotypes (*).

Ophthalmology: Retinography Fluorescein Angiography, OCT (Optical Coherence Tomography) (*), Campimetry Echography.

Podiatrics: includes Biomechanical Gait Analysis (*) subject to prescription by one of the Company's specialists in Orthopedic Surgery and Traumatology. Only 1 analysis covered during the term of the policy.

Urology: Urethra Cystoscopy Cystoscopy, Uroscopy Urodynamic Studies (*).

The doctor's written prescription for the above diagnostic methods must be endorsed and authorized by the Company prior to the methods being implemented for all these services except Clinical Analysis and conventional Radiology.

(*) For these Special Diagnostic Methods a Waiting Period of 6 months is established.

8.- Special Treatment Techniques (*)

These will always be performed following the prescription of a specialist doctor in the field from the List of Doctors and Services. The prescription will be accompanied by a report from the specialist doctor to be presented for the Company's corresponding authorization prior to the performance of the techniques.

These services include:

Aerosol, Ventilotherapy and Oxygen Therapy at home (through a single Oxygen source) - this medication being charged to the Insured. Home treatment through CPAP or BIPAP (mechanical devices generating positive pressure in the upper airways) for Obstructive Sleep Apnoea/Hypopnoea, Respiratory Distress and COPD is also included, as is titration polysomnography to adjust the device.

Circulatory System.- Cardiac catherization with or without angioplasty; therapeutic electrophysical cardiac study (atrioventricular conduction ablation, accessory pathways or ventricular tachycardias).

Laser Surgery.- for Otorhinolaryngology, Gynaecology, Proctology (for haemorrhoids, fistulas, anal and perianal fissures, condylomas and rectal polyps) and Ophthalmology (photocoagulation for retinal disorders). Also included is GreenLight laser surgery (KTP and HPS, diode, holmium or thulium) for the treatment of benign prostatic hyperplasia.

Extracorporeal Lithotrity.- For treatment of renal lithiasis.

Nuclear medicine.

Oncology.- Chemotherapy (includes the oncological chemotherapy medicines employed in intravenous or intravesical chemotherapy administered in outpatient Oncology Units); (**not covered are special forms of chemotherapy, such as Intra-Operative Chemotherapy or Intra-Peritoneal Chemotherapy**), Cobalt Therapy, Radiotherapy including Intensity Modulated Radiotherapy, and Brachytherapy for the treatment of prostate, gynaecological, genital and breast cancer (**not covered are Stereotactic Radiosurgery, Tomotherapy nor other special forms of Radiotherapy**).

Preparation for the birth.

Breast reconstruction, exclusively after mastectomy for malignancy (including breast prosthesis if necessary). In these cases, **contralateral breast symmetrisation** is also covered provided that it is performed in the same procedure as the reconstruction of the breast affected by the malignancy, or at most within 6 months of that reconstruction.

Interventional radiology.

Rehabilitation.- Physiotherapy, Electrotherapy Kinesiotherapy Magnetotherapy, Laser Therapy Speech Therapy.

Artificial kidney and peritoneal dialysis.- Haemodialysis for acute or chronic kidney failure.

Treatment of pain.

(*) For all these Special Treatment Techniques a Waiting Period of 6 months is established.

9.- Hospitalization (including Outpatient Care)

Hospitalization will always be carried out in the Company's own or affiliated centres included in the List of Doctors and Services, in an individual room with a bed for a companion, except where manifestly impossible.

Besides the services of the room and the maintenance of the patient, this Policy covers the costs of the operating theatre, anaesthetics, additional explorations, medication, transfusions and treatment of their process.

In all cases, the order for admission must be prescribed by a specialist doctor in the field on the List of Doctors and Services and previously authorized by the Company. There is no limit on the duration of the hospital stay and it will depend on whether according to the opinion of the doctor on the List of Doctors and Services, the technical necessity for the aforementioned stay persists. In no case will problems of a social type (difficulties of familial care in the home, etc.) be accepted as a reason for a stay.

These services include:

-Hospitalization for the birth: care at the time of birth or Caesarean section and postnatal care, assisted by an Obstetrician and Midwife. Also includes anaesthetic in normal births.

-Paediatric hospitalization.

* Care for the new born baby on the paediatrician's instructions, from the moment of birth itself.
* Hospitalization of the premature or pathological new born baby in a Specialized Centre (Neonatology Incubator).
* Hospitalization for reasons of surgical intervention or medical illness.

When the age of the child permits, and the Centre allows it, the patient may be accompanied.

Provided that the birth/caesarean has been covered by ASISA, hospitalisation of the newborn shall be charged to the mother's policy until at most 30 days of the date of his/her birth. For that care to continue the newborn must be insured with ASISA during that period, pursuant to Clause c) of General Condition Eight.

New born babies have the right to hospitalization charged to their mother's policy for the first 30 days of their life only, as long as the birth or the Caesarean section has been covered by the Company. For this care to continue they must become Insureds within the aforementioned period.

-Hospitalization for surgical reasons.

-Hospitalization for medical reasons (which do not require surgical intervention).

For treatment of acute processes that in the judgment of the specialist on the List of Doctors and Services may not be treated in the patient's home using the correct techniques, and therefore require admission.

-Psychiatric hospitalization.- For patients affected by acute and recoverable mental illnesses.

In these cases a bed for a companion is not included. A limit of 50 days Hospitalization per calendar year is established.

-Hospitalization in specialized units, such as the Intensive Care Unit (ICU) or the Coronary Unit.

In these cases a bed for a companion is not included.

For any Hospitalization a Waiting Period of 8 months is established (except in the situations of Emergencies or premature births).

10.- Outpatient surgery

Includes any diagnostic or therapeutic intervention carried out by a specialist doctor in an authorized centre which normally requires a treatment room. A Waiting Period of 6 months is established.

11.- Transport of Patients (Ambulance)

The ambulance service agreed with the Company will transfer the patient to the centre where they must be provided with the services that they need, or from that centre to their home, as long as a doctor on the List of Doctors and Services orders it in writing and special circumstances relating to physical

impossibility conspire to prevent them from using ordinary transport services (public services, taxi or private vehicle).

12.- Prostheses and Implants

The Company covers the cost of prescription, implantation, and materials of the internal surgical prostheses and implants listed below: Internal skeletal prostheses and the material for osteosynthesis (**excluding implants constituted by natural bone or natural bone substitutes**); cardiac valvular prostheses, valvular prostheses of the bypass type and coronary stents; single-chamber and dual-chamber pacemakers (**except devices for cardiac resynchronization and for auricular stimulation**); breast implants (**exclusively for mastectomy to remove tumours**); testicular prosthesis; and intraocular lenses for cataract treatment are excluded (**not covered are bifocal, varifocal, toric and corrective lenses of any type**).

Any other cost relating to prescription, implantation or to prosthetic products or materials for internal surgical implantation or for external use, or to any implantable, active synthetic, or biological non-autologous product, material or substance, not included in the previous list, is charged to the insured person. Platelet growth factors are not covered.

13.- Family Planning.

Includes consultation, vasectomy, tubal ligation and IUD insertion, including the cost of the device (hormonal IUD excluded). Diagnostic tests for sterility or infertility.

A Waiting Period of 6 months is established.

14.- Accidents at work and Compulsory Motor Vehicle Insurance.

Includes medical care required for accidents at work, professional accidents, and accidents covered by Compulsory Motor Vehicle Insurance, except those expressly excluded in the Schedule.

15.- Transplants

Covered by the Company are costs arising from carrying out bone marrow (both autologous and heterologous) and cornea transplants (**the cost of the cornea being charged to the Insured**).

The acquisition and transplant of organs may only be carried out according to the provisions of current medical legislation.

The Company does not take responsibility for the acquisition of organs to be transplanted.

16.- Second Opinion

The Insured has the right to the Second Medical Opinion service for certain clinical disorders and conditions listed in Annex II of these General Conditions.

17.- Psychotherapy

For the treatment of illnesses relating to mental health which have a psychological origin and are of a temporary nature (disorders relating to adaptation, stress, temporary depressive conditions, behaviour disorders, anorexia and bulimia). Subject to a prescription by one of the Company's team of psychiatric specialists.

Not covered by the company are psychological tests, psychopedagogy, group and couple psychology, outpatient narcolepsy care, and hypnosis.

A Waiting Period of 6 months is established, the maximum number of sessions covered by the Company being 20 sessions a calendar year for all the illnesses covered by this service, except for alimentary canal disorders, anorexia and bulimia, whose limit will be 40 sessions per calendar year.

18.- Preventive medicine.

Includes programmes in Paediatrics, Gynaecology, Cardiology, Urology, and Gastroenterology in accordance with generally accepted recommendations, which are listed in Annex III of these General Conditions.

THREE: SERVICES EXCLUDED

Excluded from the coverage of this insurance are:

1. The consequences of events resulting from armed conflict, whether following an official declaration of war or not, as well as declared epidemics.

2. The consequences of a direct or indirect relationship with explosions or chemical, biological, nuclear, or radioactive contamination, which should be covered by civil liability insurance for nuclear damage.

3. The consequences of events of an extraordinary or catastrophic character such as floods, tornados, earthquakes, collapses, etc.

4. Assistance resulting from the care of disorders, situations or processes previous to the agreement of the policy or present at the time of this contract, known and not declared in the health questionnaire that the Insured must sign, as well as the consequences or complications.

5. Assistance resulting from the care of disorders arising from the participation of the Insured, whether as a professional or enthusiast, in professional or sporting activities that involve a high level of danger, such as subterranean, subaquatic and aerial activities, those involving motor vehicles or boats, boxing, bullfighting, and anything else of a similar nature.

6. Plastic surgery for aesthetic reasons, as well as any diagnostic or therapeutic technique for aesthetic or cosmetic ends. Sex reassignment surgery. Bariatric surgery (surgical treatment for morbid obesity). Robotic surgery (with the Da Vinci robot or any other device).

7. Health checks, medical examinations and genetic tests, except in the cases expressly established under point 7 (Special Diagnostic Methods) of Clause Two of these General Conditions.

8. Homeopathy, organometry and acupuncture, as well as diagnostic techniques or experimental treatment which are not recognized by medical science nor have undergone clinical tests of any type.

9. Regarding the specialty of Dental Stomatology, fillings, prosthetics, periodontic treatments, orthodontics and endodontics are excluded, as well as preliminary tests for these treatments.

10. Regarding Psychiatry and Neuropsychiatry, psychological tests and psychoanalytical treatments and techniques, psychotherapy (except for that established in the psychotherapy service under point 17 of Clause Two of these General Conditions), hypnosis, sophrology and outpatient narcolepsy care, are excluded.

11. Regarding Obstetrics and Gynaecology, sterility treatment techniques, artificial fertilization, in vitro fertilization and hormonal IUD are excluded. Also voluntary termination of pregnancy is excluded, even when it fulfils the requirements of the current legislation.

12. Regarding Rehabilitation and functional recuperation, processes that require educational therapy are excluded, such as education for congenital language problems or special education in patients with psychological afflictions. Also excluded are maintenance and occupational therapies, as well as rehabilitation from chronic illnesses when injuries have been stabilized.

13. Implants made from natural bone or natural bone substitutes and platelet growth factors. Orthotics, as well as orthopaedic and anatomical products.

14. Medication, except in the case of hospitalization and oncological chemotherapy treatments intravenously or intravesically administered in Oncology Units on an Outpatient basis. Special forms of chemotherapy such as Intraoperative Chemotherapy or Intraperitoneal Chemotherapy are excluded. In all cases experimental treatments and/or treatments for compassionate reasons are considered to be excluded, as are those treatments conducted following instructions different from those authorized in the medication's specifications.

15. Laser treatments for myopia, hyperopia, astigmatism, and other refractive disorders, as well as laser surgery whichever organ is treated, except in the cases expressly recognized in point 8 (Special Treatment Techniques) of Clause Two of these General Conditions.

16. Stereotactic radiosurgery and other special radiotherapy techniques, except in the cases expressly established under point 8 (Special Treatment Techniques) of Clause Two of these General Conditions.

17. Explorations using Positron Emission Tomography (P.E.T.) (except for those disorders included in Annex I of these General Conditions).

18. All types of transplants are excluded, except bone marrow (autologous and heterologous) and cornea (the cost being at the insured person's expense).

19. All care arising from H.I.V. infection.

20. Excluded from the insurance coverage are those methods, procedures and techniques of diagnosis or treatment that are not recognized or not universal in standard medical practice, of an experimental character or under investigation.

21. Any diagnostic or therapeutic technique not expressly included in the coverage of the policy or recently incorporated in standard medical practice after the policy has been taken out will be considered to be excluded, unless the Company gives express notification of its inclusion.

22. Any care prescribed and/or provided by professionals or centres not affiliated to the Company.

FOUR: PROVISION AND USE OF THE SERVICES.

1. Right to assistance.

The exercise of the rights included in the Policy lies with the Insured, this exercise being personal and non-transferable. When requesting the appropriate services, the Insured must identify themselves by showing the accredited Company membership document (Magnetic Card), their National Identity Card (for persons obliged to possess one) and an acknowledgment of being up to date with payments.

Care will preferably be provided in the Province where the Insured lives.

The Company will not take responsibility for the cost of any service that is not prescribed and carried out by medical professionals on the List of Doctors and Services in centres or services owned by or affiliated to the Company. Services for Emergency reasons are excepted as long as they are submitted to the Company for authorization within a period of 7 days counted from the date on which they were provided.

2. Participation of the Insured

Participation of the Insured in the cost of the services is agreed for each consultation, session, treatment or service utilised through the use of the magnetic card, in accordance with the provisions of the particular and/or special conditions.

3. Freedom of choice of doctor

For the contracted care service the general principle of freedom of choice of doctors from those included on the Company's List of Doctors and Services applies. The Insured will be directed straight to the chosen doctor, except in cases in which, in accordance with the clauses of this contract, additional requirements are necessary.

4. Primary Care

The Insured has a free choice of Family Doctor Paediatrician and Registered Nurse (D.U.E./A.T.S.), although it is recommended that those they choose are the nearest to their home in order that care in the home and the surgery may be as quick and as comfortable as possible.

The family Paediatrician will attend to Insureds up to the age of 14.

The services of a Registered Nurse (D.U.E.) are provided in the same way as General Medicinal services, requiring a written order from the doctor issuing the prescription with instructions on whether care should be carried out at home or in the surgery, and for how long.

5. Care at home

A home visit may be requested up until five o'clock in the afternoon, or until the emergency home services begin work, if this occurs later, and is provided solely to those persons prevented from attending the surgery. After the hour indicated the Emergency Service should be used.

The services will be provided solely at the home address listed in the Policy and any change of address must be notified to the Company with minimum advance notice of 8 days. To maintain the rights to care, the new address must be situated within the Insurance Company's territorial scope.

Care at home by specialists may not be requested directly by the Insured, rather they will need a written prescription from a Doctor on the List of Doctors and Services.

6. Specialized care

Specialized care will be provided preferably in the Province where the Insured resides. When it is not possible to provide it in their Province, it will be provided preferably in the closest place to the home of the Insured, where the Insurance Company will provide these services, always respecting the freedom of choice of the Insured. Transport costs are always the responsibility of the Insured.

The Insured may directly attend the surgery of the Specialist, according to what is established in each case in the List of Doctors and Services and the Manual of Instructions for Insureds.

The information included in the List of Doctors and Services may be subject to change, therefore it is recommended that when facing any contingency the Company is consulted.

7. Emergency Services

Use of the Company's Emergency Services must be made by calling or directly attending the centre or centres established for this purpose, following the specific instructions that are included for each geographical area in the List of Doctors and Services made available to the Insured.

8. Care for displaced persons

The Company undertakes to facilitate the provision of health care for the Insured displaced to any province within Spanish borders, both in the capitals and the cities and towns in which there are affiliated Centres. For these purposes a list is supplied of Regional and Local Offices, as well as offices of affiliated Companies in the province in which the Company has no office, which the Insured must use to find the centres in which they may receive care charged to this Policy.

9. Travel assistance

The Insured resident in Spain will have Travel Assistance insurance coverage, both in Spain and abroad, the conditions of which are listed in Annex IV.

10. Diagnostic and Treatment Methods

As a general rule, any diagnostic or treatment method, to which this Policy gives the right, must be prescribed by a specialist doctor in the field on the List of Doctors and Services, in the document which has been recognized for this purpose.

The written prescription for certain diagnostic and treatment methods must be endorsed and authorized in advance by the Company. In the case of special treatment techniques, the aforementioned prescription must be accompanied by a report from the prescribing doctor for the Company's authorization, before they are practiced.

11. Hospitalization

In all cases, hospitalization must be prescribed by the specialist doctor in the field on the List of Doctors and Services who is going to treat the Insured person, through a document on which is listed the reason for admission, intervention or care to be carried out, and a prediction of the length of stay. This prescription must be presented to the Company offices for the corresponding advance authorization. The doctor's order must obligatorily be passed to a Centre owned by or affiliated to the company and the reason for admission must be included in the services covered by the Policy. Without these requirements the Company will neither authorize any admission, nor be responsible for any medical service, nor assume any other financial obligation.

In cases in which Hospitalization occurs urgently, a written prescription from a doctor on the List of Doctors and Services or the Centre's Admission Report will suffice, but the Insured, or where applicable their relatives, must notify the circumstance to the Company offices within a period of 7 days, obtaining the corresponding authorization in order to make it financially binding on the Insurance Company.

The Company will not be responsible for hospitalization costs in non-affiliated Centres, unless they have been incurred for reasons of Emergency. In these Emergency cases, the Insured, or where applicable their relatives, must notify and certify this circumstance to the Company within a maximum period of 7 days. It will be an essential requirement that Hospitalization occurs in the Centre closest to the place where the Emergency happened and that they are not treated in a Public Centre. As soon as it is possible, the Insured must be moved to one of the Company's own clinics or an affiliated clinic. In the case of urgent care in a Public Health Centre (belonging to the National Health System or incorporated into it), the Company will only assume responsibility for the cost arising in the event that the insured person is not registered under any Social Security scheme or does not have the right to public health coverage.

An Emergency situation is considered to justify the use of non-affiliated Centres when the Insured suffers a disorder the nature and symptoms of which make an imminent risk to life predictable should immediate therapeutic action not be obtained.

Admission authorizations to hospital centres provided by the Company will have a limit of days of stay related to the written forecast by the doctor who ordered the admission, or to the statistical average for each process estimated by the Company.

In order to obtain one or more extensions of the number of days of Hospitalization, the Insured must request them from the Company providing a new medical report in which the reasons for this extension and predictions of the number of days are indicated. In no case will problems of a social type (difficulties of family care in the home, for example) be accepted as a reason for a stay.

The duration of a patient's Hospitalization will be determined by the exclusive opinion of the doctor who attends to them, who may indicate and continue the treatment in the home of the Insured, if their hospitalization is no longer essential.

The Company reserves the right to modify the administrative organization and the care services, in order to improve its effectiveness and optimize the price-quality relationship of the services.

FIVE: DURATION OF THE INSURANCE

Insurance is stipulated for the period of time established in the Schedule of this Policy and on its maturity will be extended for periods not longer than one year, in accordance with Article 22 of the Law on Insurance Contracts. However, any of the parties may object to the extension through written notification of the other party provided in advance not less than one month before the conclusion of the current period of insurance in the event the policyholder objects to the extension, and not less than two months before the conclusion of the current period of insurance in the event the insurance company objects to this extension. The insurance company must notify the policyholder of any amendment to the insurance contract at least two months before the conclusion of the current period of insurance.

SIX: PAYMENT OF PREMIUMS

The Policyholder in accordance with Article 14 of the Law on Insurance Contracts, is obliged to pay the Premium, according to the provisions of the Schedule. The premiums the policyholder is bound to pay are annual, although payment in instalments may be agreed.

Any taxes and surcharges imposed on the policies and premiums are charged to the Policyholder whenever they can legally be passed on.

The first Premium, or an instalment thereof, is required, in accordance with Article 14 of the Law on Insurance Contracts, on the signing of the contract. If it has not been paid due to the fault of the Policyholder, the Insurer has the right to terminate the contract or to take administrative steps to demand payment based on the Policy and if it has not been paid before an insurance claim, the Insurer will be free of their obligation (Article 15 of the Law on Insurance Contracts).

In the case of missed payment of the second or subsequent Premiums or instalments thereof, the Insurer's coverage is suspended a month after its due date, and if the payment is not made within six months following its due date, the contract will be understood to have been cancelled. If the contract has not been terminated or cancelled in accordance with the above conditions, the coverage will take effect again within twenty four hours of the day in which the Policyholder pays the premium. In any case, when the contract is suspended the Insurer may only demand the payment of the Premium of the current Period of Insurance.

The Insurer and the Insured are only obligated by the invoices issued by the management or by their legally authorized representatives.

The contracting parties agree that the Insured covered by this policy participates in the costs of the services that they use. This participation is unique to each consultation, session, treatment or service utilized. The amount will be set annually by the Company. The provisions of this Clause SIX, in the case of missing payment of the second or successive premiums or instalments thereof, will be applied in the case of the non-payment of the cost of the participation of the insured person in the cost of services.

In accordance with the provisions of Article 94.1 of the Law on the Regulation, Supervision and Solvency of Insurance and Reinsurance Companies, the Insurer will set annually the Premiums to be applied

each year, adapting them to the variation in costs, to new services and to morbidity. These premiums will be notified to the Policyholder before the current period of insurance coverage matures.

In each period of extension the Premium will correspond to that determined by the Company in terms of the gender and the age of the insured person on the 31 December of the insured period which expires.

The aforementioned notification having been received, the policyholder may make use of the right established in Clause FIVE.

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

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

The Policyholder, or where applicable, the Insured, has the following obligations.

a) Declare to the Insurer before the formalization of the contract all the circumstances known to the Policyholder which may affect the valuation of risk on the Questionnaire submitted by him/her. The Policyholder is exempt from this obligation should ASISA fail to submit the Questionnaire to him/her or should the Questionnaire be submitted but the circumstances concerned which may affect assessment of the risk not be covered therein. It is essential that the information provided by the Policyholder/Insured is accurate and complete, as it constitutes the basis for the acceptance of this contract, of which the said Questionnaire forms part.

b) They must notify the Insurer of any change of the address designated in the policy within 8 days of the change having occurred.

c) They must reduce the consequences of the insurance claim by using any means available to them to recover quickly. Non-compliance with this obligation with the manifest intention of damaging or deceiving the Insurer will free the Insurer of any liability for all the services derived from the claim.

d) As established in Articles 43 and 82 of the Law on Insurance Contracts, they must provide the Insurer with all the information it requires to exercise the right of subrogation in the rights and actions that because of the care provided, and up to the limit of the cost of the care, may pertain to the Insured against the persons responsible for the illness or injury or against the persons or companies that legally or according to regulation must meet these costs of care.

e) Where expressly requested, the Policyholder and Insured are bound to provide ASISA with medical reports and/or the provider's estimates enabling ASISA to establish if the healthcare benefit requested is covered by the policy. ASISA shall not be required to guarantee the benefit requested whilst the aforementioned reports and/or estimates have not been provided when they have been expressly requested from the Insured. Once the information provided by the Insured is known, the insurer may reclaim from the Insured the cost of the coverage of any benefit it need not have borne.

f) Notify the Insurer should the card be lost, stolen or damaged as soon as possible, so that the Insurer can issue and send a new card to the insured's address identified in the policy and cancel the previous card. The Policyholder or Insured must return to ASISA the card corresponding to the insured removed from his/her policy.

EIGHT: RIGHTS OF THE POLICYHOLDER AND/OR INSURED

a) Within the period of a month after the delivery of the Policy, the Policyholder may demand that the Insurer rectifies any existing discrepancies between it and the insurance proposal or the agreed clauses,

according to the provisions of Article 8 of the Law on Insurance Contracts. This period having transpired without a complaint being made, the Policy will be as established.

b) The Policyholder or the Insured may during the life of the contract, make known to the insurer all circumstances that reduce the risk and are of such a nature that if they had been known by them at the time of drawing up the contract, would have completed it with more favourable conditions.

In such a case, when the period covered by the Premium ends, the amount of future Premiums should be reduced by a corresponding proportion, the Policyholder otherwise having the right to a termination of the contract and to a refund of the difference between the Premium paid, and that which would have been paid, from the time of the reduction of risk being made known.

c) The registration of the newborn as an ASISA insured can be requested without the waiting periods applicable in each case and without a Health Questionnaire evaluation, provided that the birth or caesarean has been covered by ASISA and the request is made within 30 days of his/her birth. For registrations requested outside that period, or for newborns resulting from births or caesareans not covered by the Company, the waiting periods established for each cover shall be applicable and the Health Questionnaire shall be required, with the possibility of rejection.

d) When the insurance contract is agreed using a distance selling technique, the Policyholder may terminate it unilaterally without penalty if an insurance claim covered by the contract has not occurred, in the 14 days following the signature of the policy or the receipt by the Policyholder of the contractual conditions and the statutory prior information (if this receipt is subsequent to the signing of the policy), through notifying the Company in writing to this end.

NINE: RIGHTS OF THE INSURER

Should ASISA ascertain that the Policyholder or the Insured has withheld or provided inaccurate information in the Health Questionnaire, it may rescind the contract by means of a notification addressed to the Policyholder within one month of becoming aware.

TEN: LOSS OF RIGHTS, INCONTESTABILITY OF THE CONTRACT AND NULLITY OF THE CONTRACT

1. The Insured loses the right to the guaranteed service:
   a) In the case where the Policyholder, or if applicable, the Insured, has held back or supplied inaccurate information at the time of declaring the risk (on completing the health questionnaire) before signing the Policy, as long as the Policyholder or, where applicable, the Insured, has acted in bad faith or was at serious fault (Article 10 of the Law on Insurance Contracts).
   b) If the guaranteed event ensues before they have paid the first Premium, except when agreed otherwise (Article 15 of the Law on Insurance Contracts).
   c) When the insurance claimed has been caused by the bad faith of the Insured (Article 19 of the Law on Insurance Contracts).
2. If a preliminary examination has been carried out or the full rights have been recognized, the Policy will be incontestable in terms of the state of health of the Insured, and the Insurance Company may not refuse services alleging the existence of pre-existing illnesses, unless in an express way and as a consequence of this examination some exception in the schedule of the Policy is made, or the Insured, acting in bad faith or at serious fault, has completed the health questionnaire by holding back or giving inexact information.

If a medical examination has not been carried out nor the full rights have been recognized, the Policy will be indisputable for a year from the conclusion of the contract, except when the Policyholder or the Insured has acted with bad faith in signing the health questionnaire.

3. The insurance contract will be null and void, except in cases established under the Law of Insurance Contracts, if at the time of formalizing the contract the event leading to an insurance claim has already taken place.

ELEVEN: NOTIFICATIONS

Notifications to the Insurance Company from the Policyholder, the Insured or their beneficiary, will be made to the head office indicated on the Policy. If they are made by the insurance agent who brokered the contract, they will have the same effects as if they had been made directly to the Company (Article 21 of the Law of Insurance Contracts and Article 12.1 of the Law of Mediation in Private Insurance).

Notifications from the Insurance Company to the Policyholder the Insured or their beneficiary will be sent to the physical address, e-mail address or telephone number provided by the Policyholder when making the insurance application, unless the Policyholder reports a change of address. The Policyholder authorizes ASISA to send any communication by electronic means whenever the law permits.

For the purposes of this insurance, a Claim is understood to have been notified when the Insured requests the provision of the service.

TWELVE: CLAIMS AND TIME LIMITS

Policyholders, Insureds, beneficiaries, Injured third parties or any rightful claimants, may make claims internally to the ASISA Provincial Office, for which purpose a claim form is available in the offices of the Insurance Company.

Notwithstanding any other jurisdiction which may be responsible, persons indicated in the above paragraph may make a claim to the ASISA Group's CUSTOMER SERVICES, in accordance with the regulation established in Order ECO/734/2004, for which purpose a claim form is available in the offices of the Insurance Company. The above is a pre-requisite for making a complaint and claim to the Complaints Service/General Directorate of Insurance and Pension Funds, should the necessity arise (Article 97 of the Law on the Regulation, Supervision and Solvency of Insurance and Reinsurance Companies).

Conflicts that may arise between Policy Holders, Insureds, beneficiaries, injured third parties or any rightful claimants with the Insurance Company, will be resolved by the judges and courts responsible (Article 97 of the Law on the Regulation, Supervision and Solvency of Insurance and Reinsurance Companies).

For the purposes of the current insurance contract, regardless of the above jurisdictions, the judge responsible for hearing the actions arising from the contract will be the judge with responsibility over the Insured's home address. In the case that their address is abroad, the Insured will designate an address in Spain for this purpose.

Actions arising from this insurance contract may be heard within a time limit of five years (Article 23 of the Law on Insurance Contracts).

THIRTEEN: SCOPE OF THE INSURANCE

The guarantees of this insurance are extended to all Spanish territory, except that established for the Travel Assistance service.

FOURTEEN: PROTECTION OF PERSONAL DATA

In compliance with Organic Law 15/1999 on the Protection of Personal Data, and for the purpose of carrying out, controlling and implementing the medical service guaranteed in the insurance contract, the insured person expressly consents to their personal data, including medical data, being processed by ASISA (Asistencia Sanitaria Interprovincial de Seguros, S.A. Sociedad Unipersonal), as well as to their data being communicated between the aforementioned company and the doctors, medical centres, hospitals, or other institutions or persons, identified as medical service providers either in the List of Doctors and Services produced by the Company or on its website www.asisa.es. The data must be appropriate, relevant, and not superfluous to the expressed objective relating to the insurance contract whose legal regulation obliges the insured person to inform the insurer of the reasons that justify the provision of the service, so that they may request such information from the medical service providers in order to carry out those aims relating to their health and the medical treatment that they are receiving.

Additionally their personal data, except health data, may be processed in order to send them publicity and commercial information, about the company, their activities, products, services, offers, special promotions etc., through different media, including email. The processing of data for these purposes will be continued while any business or contractual relationship with the Company lasts.

In the case that the data provided belongs to a third party, the provider guarantees that they have authorization for communicating it to the Company in the terms and for the purposes set out in the current clause.

In order to exercise rights of access, rectification, cancellation, and objection relating to the data, the insured person must contact the Company. In the case of objection to the processing and transfer of information set out in the above paragraph, the policy's services may not be performed during the period the objection lasts, because the insurance company would lack the necessary data for calculating indemnity and other purposes established in the insurance contract.

FIFTEEN: EXONERATION OF LIABILITY

The duly authorized medical professionals, centres and services that the Company puts at the disposal of the Insured and which they request, enjoy total autonomy independence, and liability for the provision of the medical service.

As a consequence, the Company in no case will be liable for acts and/or omissions of the aforementioned professionals or centres.

ANNEX I

PET/CAT COVERAGE: ONCOLOGICAL APPLICATIONS OF FLUDEOXYGLUCOSE (FDG)

Fludeoxyglucose (FDG) is to be used to obtain images through Positron Emission Tomography (PET) in the following oncological applications:

Diagnostics:

Characterization of the solitary pulmonary nodule.

Detection of a tumour of unknown origin evident, for example, through a cervical adenopathy or metastasis in the liver or bones.

Characterization of a pancreatic mass.

Classification:

Tumours of the head and neck, including guided assisted biopsy.

Primary lung cancer.

Locally advanced breast cancer.

Cancer of the oesophagus.

Pancreatic cancer.

Colorectal cancer especially recurrences Malignant lymphoma.

Malignant melanoma with a Breslow's depth factor of > 1.5 mm., or a metastasis in the lymphatic nodules in the initial diagnosis.

Monitoring of the response to treatment:

Malignant lymphoma.

Tumours of the head and neck

Detection in the case of reasonable suspicion of relapse:

Gliomas with a high degree of malignity (levels III or IV).

Tumours of the head and neck

Thyroid cancer (non-medullary): patients with an increase of serum thyroglobulin levels and radioactive iodine screening.

Primary lung cancer.

Breast cancer.

Pancreatic cancer.

Colorectal cancer

Ovarian cancer.

Malignant lymphoma.

Malignant melanoma.

ANNEX II

SECOND MEDICAL OPINION AND CONSULTATION WITH INTERNATIONAL EXPERTS

The insured person, or the Company's specialist who attends to them, may request a SECOND MEDICAL OPINION regarding both the diagnosis and the treatment of any of the processes or serious illnesses that are listed as follows:

1. Oncology.
2. Cardiac illness, including cardiac surgery and angioplasty.
3. Organ transplant.
4. Neurological and neurosurgical illnesses, including cerebral vascular accidents.
5. Complex orthopaedic surgery.
6. Congenital syndromes and malformations.
7. Degenerative and demyelinating illnesses of the nervous system.
8. Illnesses and problems derived from kidney failure.

The service may also be requested for other illnesses other than those listed, including those considered rare diseases or complex disorders, as long as the person making the request provides sufficient medical information (diagnostic and regarding treatment) capable of being submitted to internationally renowned experts.

To request this service they should call 910757195, where they will be instructed about the documentation of medical tests and reports that must be sent to the address indicated, together with a questionnaire that will be provided for them relating to the initial diagnosis established.

Experts of recognized international prestige in the corresponding illness will evaluate the diagnosis and treatment established, issuing the appropriate report within a period of five working days after the receipt of the necessary documentation.

This report will always be made on the basis of the medical history of the patient and the corresponding first diagnosis made by the doctors who attended to them.

Consultations, tests and/or treatments that are not carried out in accordance with the regulations and coverage of the medical care policy are not covered by the Company.

Patients who meet the above criteria will also be provided with two new services by calling the above mentioned telephone number.

MEDICAL GUIDANCE

This will permit you to resolve medical queries 24 hours a day through consultation with doctors. If you have arranged a Second Medical Opinion case, a doctor will be assigned to you who will be available to discuss over the telephone the progress of your case and resolve any queries which may arise.

The objective of this service is to complement medical care and resolve queries, never to replace the doctor treating you.

PSYCHOLOGICAL/EMOTIONAL SUPPORT

You will also have the possibility of requesting psychological support over the telephone relating to your illness or state of health. This service will consist of the arrangement of a telephone conference with one of our team's psychologists who will advise, guide and support you emotionally to help you overcome your adversity. The service will consist of a maximum of 5 telephone meetings.

ANNEX III

PREVENTIVE MEDICINE.

The specialties indicated below incorporate programmes which include a consultation with a specialist as well as the diagnostic tests indicated, as long as the specialist considers them necessary (in all cases, these tests must be prescribed and conducted by doctors on the Company's list).

Paediatrics: Covers medical examinations of new born babies (including detection of metabolic disorders as well as, if necessary, early diagnosis of hypoacusis through otoacoustic emissions or auditory evoked potentials) and regular medical examinations to monitor childhood development (from birth up to the age of 11).

Gynaecology: Annual gynaecological examination for prevention of cancer of the breast, uterus or cervix. Includes consultation and examination as well as diagnostic tests (for example, mammography, cytology, gynaecological echography) indicated by your Gynaecologist.

- In preventing breast cancer, it is recommended that a mammography is carried out every 2 years on women older than 50 (however, your Gynaecologist will indicate the frequency with which this examination should be conducted in your case).
- In preventing cervical cancer, it is recommended that a Pap smear test is conducted on women between 25 and 65 years of age. At first there should be 2 tests a year apart and then one every 3-5 years, according to the guidelines recommended by scientific institutions. According to your particular characteristics, your Gynaecologist may recommend that this examination is carried out more or less often than that indicated. These recommendations are not applicable to those how have not had sexual relations or those who have had a total hysterectomy.

Cardiology: Prevention of coronary risk in people older than 45 or patients with high cardiovascular risk factors (i.e. hypertension or dyslipidaemia). Includes consultation and examination by specialists, including the necessary tests (for example, ECG, basic blood and urine analysis, stress test), according to the recommendations of your Cardiologist.

The recommended frequency of these examinations varies with age and depends on whether there are coronary risk factors. Hence your Cardiologist will determine the appropriate frequency in your case.

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

Includes medical consultation and blood and urine tests (including the Prostate Specific Antigen Test), as well as other tests (such as echography and/or prostate biopsy) which the specialist considers appropriate. In general, an annual examination is recommended after 50 years of age, however, your Urologist will indicate the frequency and precise examinations in your case.

Gastroenterology: Prevention of colorectal cancer in people at risk (family or personal history). Includes consultation and physical examination, as well as diagnostic tests (for example, test for hidden blood in faeces or colonoscopy) which the specialist considers necessary in your case.

ANNEX IV

TRAVEL INSURANCE TERMS AND CONDITIONS

Individuals insured through the medical assistance policies of ASISA, Asistencia Sanitaria Interprovincial de Seguros, S.A.U., and resident in Spain, have the right to the coverage itemized below, coverage which may be provided directly by the company itself or by other companies with whom provision has been arranged. The conditions and limitations of this coverage are also itemized in accordance with the points listed below:

INSURED PERSON

An individual resident in Spain who is the holder of an Asisa travel insurance policy.

RELATIVE

The Insured's spouse or common-law spouse duly registered in the corresponding Official Register, or one of their parents, parents-in-law, children, grandparents, siblings, grandchildren, sons-in-law, daughters-in-law, brothers-in-law or sisters-in- law.

ACCIDENT

Bodily injury or material damage incurred during the life of the contract, which is violent, sudden, external and beyond the intentions of the Insured.

Regarding vehicles, a violent, sudden, external and involuntary event which causes damage to the vehicle covered will be considered an accident.

UNEXPECTED ILLNESS

Unless expressly specified, this contract will only cover an unexpected change in the state of health of an individual during the course of a journey covered by the policy when the diagnosis and confirmation is performed by a legally recognized doctor or dentist and when it requires medical attention.

SERIOUS ILLNESS

Any unexpected change in the state of health of an individual which leads to hospitalization and makes it impossible for the Insured to start the journey prevents them from continuing it on the scheduled date, or involves the risk of death.

TERRITORIAL SCOPE

The insurance will be valid throughout the world.

In all cases, those countries that during the journey are in a state of war insurrection or armed conflict of any type or nature, even when not officially declared, are excluded.

The insurance will be valid from a distance of more than 35 kilometres from the usual home of the insured person, except in the case of the Balearic Islands, the Canary Islands, Ceuta and Melilla, where the distance will be 15 kilometres.

TEMPORAL COVERAGE

The services defined below will be valid on an annual basis, as long as the time of the stay away from the usual place of residence as the result of a trip or journey is no longer than 90 consecutive days. This limitation does not apply when the journey is within Spanish borders.

GUARANTEES COVERED

1. Medical costs abroad

In the case of an illness or accident afflicting the Insured during the course of a journey abroad, the insurance company guarantees, during the life of the Contract and up to a maximum of €12,000 per insured person and trip, the expenses enumerated below:

- Designated medical fees of their choice.
- Medicines prescribed by a doctor or surgeon.
- Hospitalization costs.
- Costs of an ambulance ordered by a doctor for a local journey.

For these expenses to be reimbursed, the original corresponding invoice must be submitted accompanied by the complete medical report, including background, diagnosis and treatment, to permit the nature of the illness to be established.

In all cases dental costs are limited to €120 per person and trip.

2. Prolongation of a hotel stay as the result of an illness or accident

When the nature of the illness of accident does not require admission to a clinic or hospital, the insurance company will pay the costs arising from the prolongation of a hotel stay on the orders of a doctor up to €60 per day per person afflicted by the illness or accident.

3. Medical transfer of ill and injured persons

In the case of an illness or accident afflicting the Insured during the term of the Contract as a consequence of a journey from their usual place of residence, the insurance company will, as soon as it has been notified, organize the necessary contacts between its medical service and the doctors attending the Insured.

When the medical service of the insurance company orders the transfer of the Beneficiary to a better equipped or specialized hospital centre closer to their usual place of residence in Spain, the insurance company will take responsibility for this transfer under medical observation, arranging it, according to level of seriousness:

- By special medical plane.
- By medical helicopter.
- By regular scheduled flight.
- By sleeper train, first class.
- By ambulance.

When the insured person transferred or repatriated as the result of an illness or accident is less than 18 years old, a companion of the insured person will be transferred or repatriated at the expense of the insurance company.

If once the insured person has recovered they wish to continue their journey and their state of health permits it, the insurance company will be responsible for organizing their transfer to the destination of their journey as long as the cost of this journey is not higher that the cost of return to their usual place of residence. However, the costs arising from the condition suffered by the beneficiary will not be covered if the beneficiary takes the decision to continue to the destination of their journey.

4. Return of the insured person in the case of the death of a relative

In the case of the death in Spain during the journey covered by this policy of the insured person's spouse or common-law spouse, or one of their parents, children, grandparents, grandchildren, sons-in-law, daughters-in-law, brothers-in-law, sisters-in-law or siblings, once notified of the event the insurance company will arrange and provide a return ticket for the insured person on a regular scheduled flight (tourist class) or train (first class), or two return tickets when the insured person returns with a companion recorded in the schedule, to the place of burial in Spain.

5. Transport of mortal remains

In the case of the death of the Insured during the course of the journey covered by the Policy the insurance company will organize and take responsibility for the transport of the mortal remains to the place of their burial in Spain within the municipal boundaries of their usual place of residence in Spain, as well the costs of embalming, the statutory minimum casket and administrative formalities. In no event does the insurance company extend this coverage to funeral and burial costs.

If the deceased was accompanied by children or disabled persons, the insurance company will pay the transport costs of the family member who will accompany them on their return.

6. Accompaniment of mortal remains

If there is no one to accompany the transfer of the mortal remains of the deceased Insured, the insurance company will provide the person designated by the successors in interest with a return rail ticket (first class) or air ticket from Spain (tourist class) to accompany the body to the place of burial.

The insurance company will pay the costs of the stay of the accompanying person in hotel accommodation, subject to presentation of the corresponding invoices, up to €90 per day and up to a maximum of 3 days.

7. Transfer of a relative

If during the journey the insured person has to be hospitalized for more than five days (or three days in the case of children or disabled persons) and no direct relative is at their side, the insurance company will provide a ticket for a regular scheduled flight (tourist class) or rail return ticket (first class) for a family member or person designated by the family, who has their usual home in Spain, so that they can be with them.

If the Insured is hospitalized during a journey away from their usual place of residence, the insurance company will pay the costs of the stay in hotel accommodation, after presentation of the corresponding invoices, up to €60 per day and up to a maximum of 10 days.

8. Scheduled return of a companion in the case of a death or medical transfer of ill or injured persons.

When the Insured has been transferred either following an Unexpected Illness or Accident as the result of the "Medical transfer of ill or injured persons" service being applied, or following their death, and this circumstance prevents the Insured's companions from returning to their usual place of address by the initially scheduled means of transport, the insurance company will take responsibility for the transport of a companion to their usual place of residence or the place where the Insured transferred is hospitalized, by means of a scheduled flight (tourist class) or train (first class) ticket.

9. Accompaniment of children and disabled persons

If the insured persons are travelling with children or disabled persons and it becomes impossible to look after them as the result of an illness or accident covered by the policy or the insured persons are repatriated by the insurance company the insurance company will organize at its expense the return journey of a person resident in Spain designated by the insured person or their family or an attendant of

the insurance company to accompany the children or disabled persons in returning to their usual home in Spain as quickly as possible.

10. Sending of medicines

In the event that the Insured needs a medicine which cannot be acquired in the place in which they find themselves, the insurance company will take responsibility for tracing it and sending it by the quickest means subject to local legislation.

Cases where the production of the medicine has ceased and it is unavailable through Spanish distribution channels are excluded.

The Insured will have to reimburse the insurance company, on presentation of the invoice, for the cost of the medicine.

11. Tracing and locating luggage

In the event that the luggage of the insured person is delayed or lost, the insurance company will assist them in tracing and locating it, advising them on the procedure for submitting the corresponding report. If the luggage is located, the insurance company will send it to the insured person's usual address in Spain or on the journey as long as it can be accessed, when the presence of the owner is not necessary for its recovery in which case the necessary assistance and collaboration will be provided for them.

12. Sending of urgent messages

The insurance company, through its 24 hour service, will accept and transmit urgent messages from Insureds, as long as they do not have at their disposal other means to get them to their destination.

13. Civil Liability

The insurance guarantees on a first loss basis compensation of up to €4,000 for personal, material and/or consequential damages caused by the Insured to a third party which could be payable to them, in accordance with current legislation in the corresponding country, due to liability of a non-contractual nature.

Professional civil liability, liability arising from the use of vehicles, as well as liability arising from the use or ownership of explosive devices and weapons of any type or nature, is expressly excluded, as is compensation as a consequence of financial damages not arising from prior personal or material damage.

14. Information Service

The insurance company makes available to its insured persons a free and uninterrupted 24 hour service every day of the year to provide all types of tourist information on administrative formalities, medical precautions, travel conditions and local life, means of transport, accommodation, restaurants, etc., as well as vehicle-related information such as garages, petrol stations, insurance companies, etc.

15. Cash Advance

In case of need, the insurance company will advance funds to the Insured up to the limit of €9,000. The insurance company will request from the Insured some type of guarantee which will ensure the repayment of the advance. In all cases the amounts advanced must be repaid to the insurance company within a maximum period of 30 days.

16. Interpretation Service

The Insurance Company will provide the insured person with a telephone translation service in the main languages (English, French and German), and will provide contact with interpreters in the country in which the insured person finds themselves.

17. Medical guidance by telephone

This service consists of the resolution of queries of a medical nature which the Insured may have about the interpretation of clinical analysis, medicines, etc. In view of the details of the service request, the medical service of the insurance company will advise whatever is deemed appropriate and, if necessary will guide the Insured towards whichever medical resource it considers best. In no case will the medical guidance service make a diagnosis or prescribe any treatment.

For the most serious and urgent cases the insurance company may activate the necessary medical assistance services, prioritizing public emergency services, the costs occasioned as a consequence of this service being borne by the Beneficiary.

This service will be delivered at the request of the Insured between the hours of 9:00 to 21:00, every day.

18. Advice on probate.

The insurance company will comprehensively manage the extrajudicial testamentary process as well as provide preliminary advice to the Insured. This includes the following services:

a. Legal advice to the insured person about the execution of the will.
b. Design, drafting, preparation and, where applicable, intervention in the act of notarisation.
c. Personalised service to the Beneficiaries.
d. Permanent legal assistance telephone service on probate matters.
e. Obtaining of all the necessary certificates:
    - Death.
    - Birth.
    - Marriage or cohabitation.
    - Certificate that a person is alive.
    - Record of last will and testament.
f. National Institute of Social Security Procedures:
    - De-registration.
    - Death grant.
    - Registration of the spouse.
    - Registration of other beneficiaries.
g. Registration of the death in the Family Book.
h. Widows' and orphans' pension procedures.
i. Advice on non-litigious probate procedures.
    - Copy of the last will and testament.
    - Declaration of intestate heirs.
    - Opening of the will.
    - Determination of the estate.
    - Granting and division of the inheritance.
j. Processing of the payment receipt.

k. Settlement of inheritance tax and other tax obligations.

l. Management of the necessary registrations.

All the above services, with the exception of those indicated under letters a) and b), will also be provided to the Beneficiaries of the insured persons.

In the event that a conflict of interest occurs between the Insureds, the insurance company will limit its services to general telephone advice to all Insureds.

19. Administrative procedures for obtaining visas

At the Insured's request, the Insurance Company shall be responsible for processing the documentation necessary to requesting the corresponding visa. The Insured shall be responsible for consular fees, intermediaries (in the event they are necessary) and courier services.

Depending on the visa requested, both the documentation and fees required are different. Furthermore, the duration of the visa also differs depending on the country. In all cases an application form must be completed and the documentation presented.

- Types of visas in the different countries:
- Tourist visa
- Business visa
- Study visa
- Work visa
- Journalist's temporary visa
- Group visa
- Private travel visa
- Transit visa
- Special visa (for exceptional reasons)
- Courtesy visa
- Residence visa
- Work and residence visa
- Simple visa: permitting a single entry
- Multiple visa: permitting several entries over 6 months. (Hashemite Kingdom of Jordan)

20. Cancellation of Cards

In the event of the robbery, theft or loss of bank cards and other cards issued by third party companies in Spain, the Insurance Company shall perform all the procedures necessary to cancelling the said cards as quickly as possible.

The Insured must personally provide the following information: National Identity Card (DNI) number, type of card and issuing company.

In any event, the submission of the corresponding report to the competent bodies shall be necessary.

21. Blocking of mobile phones

In the event of notification by the Insured of the robbery or loss of his/her mobile phone, the Insurance

Company shall report the said circumstance to the corresponding operator and shall request that the phone be blocked.

In no event shall the Insurance Company be responsible for incorrect use.

EXCLUSIONS

Those claims which have not been notified in advance to the insurance company and those where the corresponding authorization has not been obtained are generally excluded, except in cases of material impossibility, duly certified, which in all cases are subject to the following exclusions:

1.- Preexisting or chronic illnesses, injuries or conditions, affecting the insured person before the signing of the Contract or its renewal or extension, as well as those that are manifested during the validity of the contract before the beginning of the journey with the exception of initial emergency care.

2.- Mental illnesses.

3.- Medical tests of a preventive character (checkups), thermal cures and aesthetic surgery.

4.- Cases in which the object of the journey is to receive medical treatment or a surgical operation abroad.

5.- Diagnosis, monitoring and treatment of pregnancy, voluntary termination and births during the first 150 days of gestation, unless it involves urgent care.

6.- Accidents at work or occupational illnesses.

7.- The participation of the insured person in bets, challenges or fights.

8.- The practice of sports in competition or motorized competition (race or rally), as well as the practice of such dangerous or risky activities as:

- Boxing, weightlifting, wrestling (in its different classes), martial arts, moun-taineering with access to glaciers, sledging, diving with breathing apparatus, potholing and ski-jumping.
- Aerial sports in general.
- Adventure sports, such as rafting, bungee jumping, hydrospeed, canyoning, etc.

9.- Acquired Immune Deficiency Syndrome, as well consequences derived from it.

10.- Suicide, suicide attempts or injuries self-inflicted by the insured person.

11.- Rescue of persons from mountains, caves, sea or desert.

12.- Illnesses or accidents deriving from the consumption of alcoholic drinks, narcotics, drugs or medicines, except those that have been prescribed by a doctor.

13.- Fraudulent actions by the Policy Holder, insured person or a successor in interest.

14.- Epidemics and/or infectious illnesses which appear suddenly and are rapidly spread throughout the population, as well as illness caused by atmospheric pollution.

15.- Wars, demonstrations, insurrections, tumultuous popular movements, acts of terrorism, sabotage and strikes, whether officially declared or not. The transmutation of the atomic nucleus, as well as radiation provoked by the artificial acceleration of atomic particles. Telluric movements, floods, and, in general, those that follow from the triggering of forces of nature. Any other phenomenon of an extraordinary character or event that by its magnitude or seriousness qualifies as a catastrophe or calamity.

Notwithstanding the above, the following situations are specifically excluded:

1.- The medical transfer of ill or injured persons due to conditions or injuries which could be treated "in situ".

2.- The costs of spectacles, lens and crutches, as well as the acquisition, implantation/substitution, extraction and/or repair of prostheses, anatomic and orthopedic parts of any type.

3.- Medical, surgical and pharmaceutical costs prescribed in Spain, even if as a consequence of illnesses or accidents occurring abroad, and those of an amount less than €6.

PROCEDURES IN THE EVENT OF A CLAIM:

The services defined above will be performed at the expressed request of the insured person using telephone number 34 915143611 or fax number 915149950.

The Insured will call the number indicated above, reversing the charges if desired, indicating their name and surnames, their ASISA medical insurance policy number, the place where they find themselves, their address and telephone number and the nature of their problem or the assistance they require, in order to guarantee the provision of the services with the utmost diligence 24 hours a day, including Sundays and holidays.

If events beyond their control prevent them from making this request, the Insured must make it immediately after the cause preventing them from doing so has disappeared.

ACKNOWLEDGEMENT OF THE DEBT

All the amounts paid by the insurance company or the cost of the services provided at the request of insured persons that by virtue of this contract are not the responsibility of the insurance company, constitute advances received by the insured persons that must be reimbursed to the insurance company within a maximum period of 30 days, counted from the date of the demand to this effect made to them by the insurance company.

In these cases, and in the cases of all those other services where the insurance company advances a payment on behalf of the insured persons, the insurance company reserves the right to request from the insured person a guarantee sufficient to cover it before initiating the provision of the service.

SUBROGATION

The insurance company is subrogated, up to the total of the cost of the services provided by it, in the rights and actions that have caused its intervention. When the claims made in the execution of the current contract are covered in total or in part by an insuring institution, by Social Security, or by any other institution or person, the insurance company will remain subrogated in the rights and actions of the insured person against the said company or institution. For this purpose, the insured person is obliged to actively collaborate with the insurance company, providing any help or handing over any document that could be considered necessary, without cost to the insured person.

In any case, when the return costs have been charged to the insurance company the insurance company will have the right to request from the insured person the presentation or delivery of the travel document (train ticket, plane ticket, etc.) held by them.