AGRUPACIÓN SANITARIA SEGUROS, S.A.

Company founded in 1935

ASSSA
INSURANCE

GENERAL CONDITIONS

AME HEALTH PROTECTION

Your health in good hands

EDITION - E21AT01

REGISTERED ADDRESS AND HEAD OFFICES

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Registered in the Companies Register of Alicante, Volume 2.643, Book 0, Folio 119, Section 8, Page A-76181. 2nd entry, CIF/VAT NR. A-28005312

Registered in the Insurance Companies Register of the DGSFP with the code C-0437

HEALTH INSURANCE POLICY

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1. Preliminary clause

This Insurance Contract is governed by the provisions of Law 50/1980, of October 8, on the Insurance Contract (BOE – Spanish Official State Gazette - of October 17, 1980), by Law 20/2015, of July 14, on the management, supervision and solvency of insurance and reinsurance entities (BOE July 15, 2015); and by its development regulations in the drafting of Royal Decree 1060/2015 of November 20, on the management, supervision and solvency of insurance and reinsurance entities (BOE December 2, 2015); by the rules of the complementary provisions that are applicable to it and by what is agreed in these General Terms and Conditions and in the Particular Conditions of this contract, without the limiting clauses of the rights of the Insured that are not specially accepted by them, having validity, as an additional agreement to the Particular Conditions.

Mere transcripts or references of mandatory legal precepts or the rules on delimitation or definition of the covered risk will not require such acceptance.

The Insurance Contract is composed of these General Terms and Conditions, Particular Conditions, Special Conditions, if any, and all Annexes that, signed by the parties, may have modified the original conditions.

In accordance with the provisions of Articles 122 and 126 of Royal Decree 1060/2015, of November 20, on the management, supervision and solvency of insurance and reinsurance entities, you are hereby informed that Agrupación Sanitaria Seguros, SA, is a public limited company with registered office at Avenida Alfonso X El Sabio, 14, Alicante, subject to Spanish law and under the supervision and control of the General Directorate of Insurance and Pension Funds, under the Ministry of Economy and Competitiveness, with address at Paseo de la Castellana number 44, Madrid, 28046 and with website www.dgsfp.mineco.es

2. Object of insurance

Within the limits and conditions stipulated in the policy and by paying the premium and franchise that in each case corresponds, ASSSA will provide the Insured, within the national territory and in the cities in which it has medical staff, the medical, surgical and hospital assistance that is appropriate in all kinds of illnesses or injuries included in the description of the policy coverage (clause 3).

In any case and in accordance with article 103 of the Insurance Contract Law, ASSSA will take on the necessary assistance of an urgent nature, in accordance with the provisions of the General Terms and Conditions of the Policy and within the services covered by it.

In no case may optional compensation in cash be granted to replace the provision of medical care services.

3. Description of coverage

3.1. Primary health care

• GENERAL MEDICINE

Medical assistance with indication and prescription of tests and basic diagnostic methods.

• PAEDIATRICS AND CHILDCARE

Cover for medical assistance for children up to 14 years of age with indication and prescription of tests and basic diagnostic methods. Cover includes preventive controls and development monitoring for children. Basic clinical tests of blood, urine and conventional simple radiology are included.

• NURSING SERVICE (Injectables and treatments)

Service provided by Healthcare Technical Assistant or Nursing University Graduate in consulting room or at home, with the prior written request of the ASSSA doctor.

3.2. Emergency service

• PERMANENT EMERGENCY ASSISTANCE

Emergency medical care will be provided in the permanent emergency centres that appear in the list of medical care providers. General Medicine and Nursing medical care will be provided at home whenever the patient's condition requires it.

• AMBULANCE

To be provided in case of urgent need and as long as there are special circumstances of physical impossibility that prevent other transport services (private car, taxi, bus, etc.) being used for land transfer from the place where the Insured is located to the corresponding ASSSA approved centres. In all cases, a written prescription from an ASSSA doctor with a report indicating the need for assisted transfer will be required.

3.3. Medical Specialities

The coverage includes visits to doctors and the Insured may freely choose the specialist doctor from among those listed in the ASSSA medical directory, but always in private consultation or in a clinic where the Insured is an in-patient.

The guaranteed specialities are:

- **ALLERGOLOGY.**
- **ANAESTHESIOLOGY AND RESUSCITATION. In surgical interventions covered by the policy.** Including Epidural Anaesthesia.
- **PATHOLOGICAL ANATOMY.**
- **ANGIOLOGY AND VASCULAR SURGERY.**
- **DIGESTIVE SYSTEM.**
- **CARDIOLOGY.**
- **CARDIOVASCULAR SURGERY.**
- **GENERAL SURGERY AND DIGESTIVE SYSTEM SURGERY.**
- **MAXILLOFACIAL SURGERY.**
- **PAEDIATRIC SURGERY.**
- **PLASTIC AND RECONSTRUCTIVE SURGERY.** Including breast reconstruction after radical mastectomy derived from an oncological process.
- **THORACIC SURGERY.** Including sympathectomy for hyperhidrosis (treatment of excessive sweating).
- **DERMATOLOGY.**
- **ENDOCRINOLOGY.**
- **GYNAECOLOGY.** Includes annual gynaecological check-up.
- **HAEMATOLOGY.**
- **INTERNAL MEDICINE.**
- **NEPHROLOGY.**
- **PULMONOLOGY.**
- **NEUROSURGERY.**
- **NEUROLOGY.**
- **ODONTO-STOMATOLOGY.** Includes annual dental cleaning, extractions and stomatological treatments derived from these and simple radiology of the oral cavity.
- **OPHTHALMOLOGY.** Includes laser photocoagulation (yag and argon) and cornea transplant. **The cornea to be transplanted is payable by the Insured.**
- **MEDICAL ONCOLOGY.** Includes examination of the sentinel node in breast cancer.
- **OTORHINOLARYNGOLOGY.**
- **PSYCHIATRY.**
- **RHEUMATOLOGY.**
- **TRAUMATOLOGY AND ORTHOPAEDIC SURGERY.**
- **UROLOGY.**

3.4. Diagnostic methods

To be carried out in all cases with a prior written prescription by an approved doctor in one of the health centres designated by the Entity. The contrast media used are included in the coverage **up to a maximum of €100 per test.**

- **BASIC DIAGNOSTIC METHODS:**
  - **Clinical Analysis, Biochemistry, Haematology, Microbiology and Parasitology. The Food Sensitivity Test is excluded.**
  - **Pathological Anatomy and Cytopathology.** Includes Immunohistochemistry, Hormone Receptors, and Tumour Markers.
  - **Simple Conventional Radiology.**

- **OTHER DIAGNOSTIC METHODS:**
  - **Radiodiagnosis.** Includes Bone Densitometry, Ultrasound **(except Obstetric 3D or 4D Ultrasound)**, Mammography, Angiography, Digital Arteriography and Non-Interventional Radiology.
  - **Complex analytics.**
  - **Nuclear Medicine.** Radioactive isotopes and Gammagraphy.
  - **Conventional Magnetic Resonance Imaging (MRI).**
  - **Conventional Computed Axial Tomography (CAT/SCANNER) and Multiple Detector Tomography (DMD) exclusively for coronary system pathologies.**
  - **Digestive Endoscopy. Capsule endoscopy and digital endoscopy excluded.**
  - **Diagnostic and/or therapeutic fibrobronchoscopies.**
  - **Cardiology diagnosis:** Electrocardiogram, Stress Test, Echocardiogram, Holter, Map, Doppler, Coronary Tomography, cardiac SPECT and Haemodynamics.
  - **Clinical Neurophysiology:** Electroencephalography and Electromyography.
  - **Otoacoustic emissions** or neonatal hearing screening for the early detection of hearing loss.
  - **Optical coherence tomography (OCT)** in ophthalmological diagnosis, according to commonly accepted clinical practice protocols.
  - **Polysomnography for the study of obstructive sleep apnoea syndrome at home.**
  - **Diagnostic Tests of Sterility:** Seminogram, Hysterosalpingography and Constitutional Karyotype (peripheral blood).

- **HIGH-TECH DIAGNOSTICS.**
  - **Multislice computed tomography angiography** (CT Angiography), Angioresonance (AngioRM) and Bile Duct Resonance.
  - **Fibroscan or elastography:** exclusively to assess the evolution of the degree of hepatic fibrosis in chronic liver disease. **Limited to one per insured per year.**
  - **Positron emission tomography (PET)** alone or combined with conventional computed tomography (PET-CT).

3.5. Preventive medicine

The preventive medicine programmes listed below must be carried out by an approved doctor in one of the health centres designated by the Entity.

- **GYNAECOLOGICAL CHECK-UP**
  - **Annual check-up** including consultation, colposcopy, cytology, ultrasound and mammography, according to commonly accepted protocols.
  - **HPV test** for early detection of cervical cancer according to commonly accepted protocols.
- **CARDIOLOGICAL CHECK-UP**
  - **Annual check-up** including consultation, cardiovascular examination, electrocardiogram, analysis and, if applicable, stress test and echocardiogram.
- **DERMATOLOGICAL PREVENTION PLAN**
  - **Consultation and check** of changes in size, colour and shape of dysplastic or atypical nevus. **Epiluminescence is excluded.**
- **UROLOGICAL CHECK-UP**
  - **Annual check-up** including consultation, renal and vesicoprostatic ultrasound, PSA (prostate specific antigen), transrectal ultrasound and/or prostate biopsy, if applicable.
- **COLORECTAL CANCER PREVENTION PLAN**
  - **Medical consultation and physical examination.**
  - **Specific test** to detect occult blood in faeces.
  - **Colonoscopy if necessary according to medical criteria and in a population at risk with a history.**
- **DENTISTRY**
  - **Dental consultation** and oral health examination.
  - **Annual dental scaling and cleaning.**

3.6. Therapeutic treatment

To be carried out in all cases with a prior written prescription by an approved doctor in one of the health centres designated by the Entity.

- **OUTPATIENT AND HOME OXYGEN THERAPY.**
- **REHABILITATION AND PHYSIOTHERAPY.** For the treatment of acute traumatic processes, due to intervention and/or trauma (not chronic pain) provided that they have been contracted after the effective date of the contract. To be provided on an outpatient basis. Must be overseen by a doctor, assisted by physiotherapists and carried out in a suitable centre for this purpose and included in the current list of approved centres.

- **CARDIOLOGICAL REHABILITATION.** Following coronary and/or vascular heart surgery.
- **ORTHOPTICS.** Will be provided as a consequence of the appearance of strabismus.
- **PROSTATIC HYPERTHERMIA.**
- **BLOOD AND/OR PLASMA TRANSFUSIONS exclusively as part of an in-patient regime covered by the policy.**
- **RENAL AND BILIARY LITHOTRICS.**
- **PAIN MANAGEMENT.** To be provided on an outpatient basis for cancer cases with pain that cannot be controlled by the oncology unit and/or with chronic pain derived from surgical procedures. Likewise, hospitalisation produced by the acute complication of the treatment and by the implantation of reservoirs is covered, **for a maximum period of 7 days per process. The costs of any type of medication, material, specific medical devices and/or prostheses are excluded.**
- **LASER THERAPY.** To be provided in ophthalmology treatments (YAG and argon laser).

3.7. Hospitalisation

To be carried out in a health centre designated by the Entity and always with the prior written prescription of an ASSSA physician and authorisation issued by the Entity's Offices under the following conditions:

- **HOSPITALISATION FOR SURGERY.**

  In a single room with a bed for a companion, with ASSSA being responsible for the expenses of the stay on the ward, operating theatre and anaesthesia products, dressings and medication used in the surgical procedure inside the operating theatre. The Entity will also be in charge of living expenses for the patient and their companion. **Medication and material in the hospital ward will be payable by the Entity up to a maximum of three thousand euros per year per Insured.**

  The duration of the hospital stay covered by the insurance will be determined by the doctor in charge of treatment and for as long as the surgical cause remains as the cause of the hospitalisation.

- **MEDICAL HOSPITALISATION.**

  Cover for a single room with a bed for a companion for the purpose of treating a medical illness. Room costs and the patient's living expenses will be paid by ASSSA, **with the maximum coverage of €150,000 per claim.**

- **ONCOLOGICAL HOSPITALISATION for:**
  - **RADIOTHERAPY** with a linear electron accelerator (ALE) **as a day patient.**
  - **CHEMOTHERAPY.** Guaranteed chemotherapeutic treatments will be those using cytostatic pharmaceutical products authorised by the Ministry of Health and sold on the national market. The coverage includes: consultations, planning and follow-up by the Entity's specialist oncology doctor both on an outpatient basis and in a clinic when admission is necessary, in a single room with a bed for a companion. ASSSA will cover costs for the patient's stay on the ward and their living expenses **up to a maximum of fifteen days per process and medication will be payable by the Insured.**

- **PSYCHIATRIC HOSPITALISATION.**

  In a room **without a bed for a companion** for the treatment of acute flare-ups of schizophrenia and or mental disorders that cannot be treated at the patient's home and require hospitalisation, **provided they are not chronic illnesses that have already been diagnosed and become more severe.** The patient's stay and living expenses will be paid by ASSSA, **the maximum coverage being 15 days per year and per Insured.**

- **HOSPITALISATION IN ICU (Intensive Care Unit).**

  The patient's stay and living expenses will be paid by ASSSA, **with the maximum coverage being €150,000 per claim.**

- **DAY HOSPITALISATION.**

  Medication and material used on the ward will be payable by ASSSA **up to a maximum of three thousand euros per year per Insured.**

3.8. Other services

- **CHIROPODY in consulting room.**
- **24-HOUR MEDICAL GUIDANCE TELEPHONE SERVICE.** Telephone support providing information every day of the year on diseases, treatments and preventive healthcare plus on the use of medication, understanding laboratory reports, medical terminology, evaluation of reports and diagnoses.
- **HOMEOPATHY.** To be provided by a physician arranged by the Entity. **Limit 12 sessions per year and per Insured.**
- **BREAST PROSTHESES** after radical mastectomy as part of cancer treatment. The cost of the prosthesis will be paid by the Entity **up to a maximum of 600 euros per process.**

4. Exclusions

The following are excluded from the coverage of this insurance:

1. Medical treatment for all kinds of diseases, injuries, defects or congenital deformations that are pre-existing (pregnancy or gestation) to the effective date of the registration of each Insured in the policy, even if a specific diagnosis had not been established, unless the aforementioned illnesses, injuries, defects or deformations have been declared by the Policyholder or Insured in the health questionnaire and their cover expressly accepted by the Insurer in the Particular Conditions. The insurance policyholder, on their own behalf and on behalf of the beneficiaries, is obliged to declare at the time of signing the insurance application, any type of injury, congenital pathology, diseases, diagnostic tests, treatments and even the symptoms that could be considered as the beginning of any pathology. In the event of concealment, the condition will be excluded from the coverage of the insurance contract. If pre-existing and/or congenital diseases are declared, ASSSA reserves the right to accept or reject the insurance application.
2. Medical treatment for diseases or injuries produced as a consequence of wars, riots, revolutions, repressions and military manoeuvres, even in times of peace, and terrorism in any of its forms; those caused by officially declared epidemics; those that are directly or indirectly related to chemical, biological, nuclear radiation or nuclear or radioactive contamination, as well as those that come from cataclysms (earthquakes, floods and seismic or meteorological phenomena).
3. Medical treatment required as a result of illnesses or injuries produced during the practice as an amateur or as a professional of high-risk activities such as: aerial activities, boxing, martial arts, climbing, rugby, caving, diving, motor vehicle racing, quad biking, horse riding, paragliding, bungee jumping, canyoning, skiing (on and off piste), participation in bets and competitions, bullfighting and rounding up wild cattle, adventure sports or any other manifestly dangerous practice.
4. Medical treatment derived from the professional practice of any sport or participation as an amateur in sports competitions in general, including preparatory training to participate in the aforementioned competitions.
5. Healthcare derived from chronic alcoholism, drug addiction or intoxications due to the abuse of alcohol, psychoactive drugs, narcotic drugs or hallucinogens, attempted suicide and self-harm and eating disorders, as well as medical treatment for illnesses or accidents suffered due to fraud, negligence or recklessness by the Insured or injuries due to fights, assaults.

6. Analysis and other examinations necessary for the issuance of certifications, issuance of reports and the release of any type of document that does not have a clear healthcare function.
7. Medicine and preventive check-ups except those detailed in Clause 3 of this contract. Pharmaceutical products and all types of vaccines and self-administered vaccines except for those expressly detailed in the General Terms and Conditions. Plus the supply of extracts in allergic processes.
8. Voluntary interruption of pregnancy in any case, as well as related diagnostic tests, and selective instrumental embryonic reduction. Treatment of sterility and infertility and assisted fertilisation techniques are also excluded. The study, diagnosis and treatment of impotence and erectile dysfunction are excluded.
9. Health care derived from and/or related to the speciality of obstetrics.
10. Any treatment, infiltration or action that has an aesthetic and/or cosmetic purpose, unless there is a functional defect of the affected part (purely psychological reasons are not valid). Varicose vein treatments for cosmetic purposes, slimming cures and dermocosmetic treatments in general, including hair treatments, are also excluded. Surgical correction of myopia, astigmatism, hypermetropia and presbyopia, as well as orthokeratology, is also excluded. As well as the consequences and complications derived from all the exclusions included in this section.
11. Psychoanalysis, hypnosis, sophrology, ambulatory narcolepsy, psychological tests, individual or group psychotherapy and any method of psychological treatment. Alternative and complementary therapies, acupuncture, naturopathy, chiromassage, lymphatic drainage, mesotherapy, gymnastics, osteopathy, hydrotherapy, triphasic oxygen therapy, pressotherapy, ozone therapy and other similar services or specialities not officially recognised.
12. Transplants or self-transplants of organs, tissues, cells or cellular components, grafts or self-grafts, except as expressly detailed as covered in Clause 3. The Insurer is not responsible for the organ to be transplanted or for its conservation and/or transfer.
13. Osteosynthesis material, biological or synthetic materials and medications, anatomical and orthopaedic parts, grafts, meshes, spinal implants and the artificial heart as well as prostheses of any kind that will always be paid by the Insured, except those expressly detailed as covered and with the limits indicated in Clause 3 of this contract. In no case will the prostheses be covered if the surgical intervention necessary for their placement is also not covered.
14. Genetic and molecular biology tests as well as any means of diagnosis and/or treatment through genetic therapy, studies to determine the genetic map and any other genetic technique.

15. Medical care that requires treatment for work-related illnesses or accidents, as well as that derived from the use of motor vehicles covered by compulsory motor insurance.
16. Physiotherapy and rehabilitation treatments when functional recovery or the maximum possible recovery has been achieved, rehabilitation in chronic diseases of the locomotor system when the sequelae have stabilised, and neurological and maintenance rehabilitation in irreversible neurological injuries of various origin. Early stimulation, rehabilitation carried out at home and in unauthorised centres and/or centres not registered in the registry of Health Centres and Services of the respective Autonomous Community is excluded.
17. Medication of any type except for those expressly detailed as being covered in Clause 3 of this contract.
18. Dialysis, haemodialysis and artificial kidney treatment as well as Hyperbaric Chamber.
19. Medical treatment derived from Human Immunodeficiency Virus (HIV) infection, AIDS and related diseases.
20. Procedures of an experimental nature or that have not sufficiently proven their effective contribution to the prevention, treatment or cure of diseases, conservation or improvement of life expectancy, elimination or reduction of pain and suffering and those that consist of mere activities of leisure, rest, comfort or sport. All those diagnostic and therapeutic procedures whose clinical safety and efficacy are not scientifically proven and/or have not been ratified by the Health Technology Assessment Agencies, or have been clearly outperformed by others available.
21. Stays, assistances and treatments in non-hospital centres such as hotels, spas, spa centres, nursing homes, residences, rest centres, diagnostic centres and the like, even if they are prescribed by doctors, as well as admissions to centres dedicated to activities related to leisure, rest and dietary treatments. Psychiatric hospitalisation, except in the case of acute flare-ups, hospitalisation derived from terminal processes and hospitalisation for social, personal or family reasons and that which is replaceable by home or outpatient care. Medical care in non-approved private centres, and care provided in hospitals, centres and other publicly owned establishments integrated in the National Health System of Spain and / or dependent on the Autonomous Communities is also excluded. In any case, ASSSA reserves the right to claim from the Insured the recovery of the medical assistance expenses paid by ASSSA to the public health system, for medical-surgical and hospital care provided.

22. In psychiatry and clinical psychology, consultations, diagnostic techniques and therapies that do not follow neurobiological or pharmacological treatment criteria, such as psychoanalysis, hypnosis or ambulatory narcolepsy, sophrology and rest or sleep cures. Group or couple psychotherapy, psychological and psychometric tests, psychosocial or neuropsychiatric rehabilitation, educational or cognitive behavioural therapy in oral and written communication disorders and developmental disorders of various origins are also excluded.
23. Medical and/or surgical treatments for snoring or obstructive sleep apnoea. Radiation therapy treatments and/or modalities and their medical indications, Brachytherapy, Proton therapy, Neutron therapy, Cyberknife radiosurgery, extracranial and/or breathing adapted (4D) Stereotaxic Radiosurgery.
24. Robotic surgery (Da Vinci plus others) and assisted by neuronavigators, navigation systems or Carto (3D) mapping or electro-anatomic non-fluoroscopic radiofrequency ablation atrial mapping.
25. Regenerative Medicine, Biology, Immunotherapy, Biological Therapies, Gene Therapy or Genetics, as well as the applications of all of them. In addition, all types of experimental treatments, those of compassionate use, as well as those that are in clinical trials in all their phases or degrees, are excluded.
26. Genetic counselling, paternity or kinship tests, obtaining genetic risk maps for preventive or predictive purposes, massive gene sequencing or molecular karyotype, comparative genomic hybridisation techniques, and microarray platforms with automated interpretation of the results, as well as any other genetic and/or molecular biology technique that is requested for prognostic or diagnostic purposes if it can be obtained by other means, or does not have therapeutic repercussions.
27. Brain DATSCAN-SPECT (Single Photon Tomography (Spectrography - SPECT)), spectroscopy by MR or high resolution or field (3 Teslas) and fusion biopsy NMR.
28. Surgical interventions derived from epilepsy or Parkinson's, obesity surgery and gastric balloon implantation or placement, and sex change surgery.
29. Any type of medical assistance (diagnostic, therapeutic and/or surgical) using laser except as expressly detailed as being covered in Clause 3.
30. Speech therapy and Phoniatrics for the recovery of speech, phonation and language disorders, caused by congenital and psychomotor anatomical or neurological alterations of various origins.
31. Medical-surgical treatments with radiofrequency techniques used in specialities such as Angiology and Neurosurgery.
32. The Kit, material and tools for rhizolysis and lumbar facets in back infiltrations, as well as the radiofrequency kit.

33. **The expenses for using the telephone, television, meal expenses for the companion in the clinic, travel expenses and journeys, except for ambulance in the terms contemplated in clause 3 of this contract, as well as other services that are not essential for the necessary medical-hospital assistance.**

5. Form of providing services

5.1. Covered health care will be provided in all cities where ASSSA has an approved medical directory. When any of the services guaranteed in this contract do not exist in any of these towns, it will be provided in any other city where this is possible, **with travel expenses being payable by the Insured.**

5.2. The Insured may freely choose any of the doctors listed in the current medical directory to receive the service he or she needs in accordance with the coverage guaranteed in this policy. The Insured must confirm the information that appears in the medical directory and request an appointment by phone for a consultation, identifying themselves as an ASSSA Insured.

The Insured is obliged at the time of receiving the assistance to present the health card and, if requested, their identity document.

5.3. Home visits will be made **only when the Insured, as a result of illness, cannot go to the consulting room of their family doctor,** and must be requested before 09:00 hours to be carried out in the morning and before 16:00 hours to be carried out in the afternoon of the same day. Notifications received after this time will be taken care of the following day, except in urgent cases for which the Insured must request the service from the emergency centre that the Entity has permanently established and that appears in the medical directory.

The ATS/NURSING service will always require a written prescription from an ASSSA physician. For the provision of this home service, the same rules established for home visits described above will apply.

The Insurer undertakes to provide assistance only at the Insured's address as it appears in the policy. Any change in this must be notified to the Insurer by any reliable means at least eight days in advance of the request for the provision of services at the new address.

5.4. The provision of certain services must be prescribed by an Entity physician and the Insured must obtain authorisation at the ASSSA offices. This authorisation, once delivered, will financially bind the Entity, unless it is expressly indicated that the provision is not covered by the policy.

The Diagnostic Methods (except Basic Diagnostics), Therapeutic Treatments, Medical Check-ups and certain specialities duly listed in the current medical directory will require prior authorisation.

In urgent cases, the Entity's doctor's order will suffice, but the Insured must obtain confirmation of the order within seventy-two hours following admission. In the latter case, the Entity will be financially bound until the moment it expresses its decision in the event that it understands that the policy does not cover the act or hospitalisation.

To receive an emergency service, the Insured must make a request by phone or go directly, as appropriate, to a permanent emergency centre listed in the current ASSSA medical directory.

6. Payment of premiums

6.1. The Policyholder, in accordance with the provisions of article 14 of the Insurance Contract Law, is obliged to pay the single premium that will be verified at the address of the Policyholder unless otherwise specified in the Particular Conditions.

This payment obligation is unique and for the entire duration of the policy.

6.2. The premium will be due once the contract is signed. If it was not paid due to the Policyholder's fault, the Insurer has the right to terminate the contract or to demand enforcement of payment based on the policy. If the premium was not paid before the loss occurred, the Insurer will be released from its obligation, unless otherwise agreed.

6.3. The Insurer will only be bound by the receipts issued by its Management or by its legally authorised representatives.

The payment of the premiums made to an exclusive Agent of the Insurer will have the same effects as if it had been made directly to the Insurer.

7. Obligations of the Policyholder and/or Insured

The Policyholder and, if applicable, the Insured, have the following obligations:

7.1. Before formalising the contract, the Policyholder or Insured, in accordance with the health questionnaire they are required to complete, must inform the Insurer of all known circumstances that may influence the risk assessment. The Policyholder or Insured will be exonerated from this obligation when the Insurer does not submit any questionnaire or when, even when submitting it, there are circumstances that, although they may influence the risk assessment, are not included in it.

The Insurer may terminate the contract by a declaration addressed to the Policyholder within one month of becoming aware of omissions or inaccuracies by the Policyholder. Unless there is intent or gross negligence on their part, the premiums relating to the current period at the time this declaration is made shall correspond to the Insurer.

If the event occurs before the Insurer makes the declaration to which the preceding paragraph refers, its benefits will be reduced proportionately to the difference between the agreed premium and that which would have been applied if the true magnitude of the risk had been known. If intent or gross negligence of the Policyholder was involved, the Insurer will be released from the payment of the benefit (article 10 of the Insurance Contract Law).

7.2. The Insurer must be notified of any change of address as soon as possible.

7.3. To minimise the consequences of the event, using the means available for prompt recovery. **Failure to comply with this duty will release the Insurer from all benefits derived from the claim.**

7.4. When the Insurer knows that health actions have been carried out that are excluded from coverage, it will have the power to claim their amount from the Insured or the insurance entity that must cover the aforementioned actions on the basis of civil liability or medical care insurance. The Insured is obliged to collaborate so that the subrogation with the Insurer is fully effective and the recovery of the medical care costs excluded from coverage occurs satisfactorily. **In the event of non-compliance with the duty of collaboration, the cost of medical care will be borne by the Insured.**

8. Rights of the Policyholder and/or Insured

8.1. Those listed in clause 3 as Description of Coverage.

8.2. The Policyholder and/or Insured may claim from the Insurer, within a period of one month from the delivery of the policy, that the existing differences between it and the insurance application or the agreed clauses be remedied.

8.3. Likewise, the Policyholder and/or Insured has the right to have the policy drawn up in any of the official Spanish languages of the place where it is formalised or in a different one if requested in accordance with European Union Directive 92/96 and article 8 of Insurance Contract Law.

9. Obligations of the Insurer

9.1. In addition to providing the contracted assistance, the Insurer must deliver to the Policyholder the policy or, where appropriate, the provisional coverage document, as well as a copy of the health questionnaire and other documents signed by the Policyholder.

9.2. Likewise, the Insurer will deliver to the Policyholder the health card and the medical directory in which the permanent emergency centre or centres, the sanatoriums, clinics and the addresses of the doctors in the different specialities will be specified.

10. Duration of the insurance

10.1. The Insurance is stipulated for the period of time established in the Particular Conditions.

It is expressly established that there will be no extension to this contract, therefore it will be extinguished on the expiration date without it being necessary to urge its resolution by any of the parties.

The Insurer may not terminate the policy during the Insured's urgent hospital care or treatment and up to the date on which he/she was discharged from hospital, unless the Insured declined to continue treatment.

The Insurer may only terminate the contract in the event that there is fraud or bad faith on the part of the Policyholder and/or Insured.

11. Loss of rights, termination and indisputability of the contract

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

a) In the case of withheld or inaccurate information when completing the Health Questionnaire. The Insurer may terminate the contract by means of a declaration addressed to the Policyholder within one month of becoming aware of omissions or inaccuracies by the Policyholder. Unless there is intent or gross negligence on their part, the premiums relating to the current period at the time this declaration is made shall correspond to the Insurer.

If the event occurs before the Insurer makes the declaration to which the preceding paragraph refers, its benefits will be reduced proportionately to the difference between the agreed premium and that which would have been applied if the true magnitude of the risk had been known. If intent or gross negligence of the Policyholder was involved, the Insurer will be released from the payment of the benefit (article 10 of the Insurance Contract Law).

b) When the loss was caused by bad faith of the Insured (article 19 of the Insurance Contract Law).

c) Unless agreed otherwise, if the premium has not been paid before the loss occurs (article 15 of the Insurance Contract Law).

11.2. The Insured may terminate the contract when the medical directory changes, provided that such change affects the family doctor, obstetrician, paediatrician in the area or affects 50% of the specialists, having to notify such decision to the Insurer in a reliable way. **This rule will not apply in the case of temporary substitutions, originated for just cause or when it refers to doctors with special surgical techniques, as well as dentists, analysts and electro-radiologists.**

11.3. If a medical examination has been carried out or full rights have been recognised, the policy will be indisputable as regards the state of health of the Insured(s) and the Entity may not deny their benefits alleging the existence of previous illnesses, unless, expressly and as a consequence of the aforementioned recognition, an exception is made in the Particular Conditions of the policy.

If no medical examination has been carried out or full rights have been recognised, the policy will be indisputable after one year has elapsed from the conclusion of the contract, unless the Policyholder and/or the Insured have acted fraudulently.

11.4. If the Policyholder, when applying for the Insurance, has inaccurately declared the age of any of the Insured, the Insurer may only terminate the contract if their true age on the effective date of the policy exceeds the limits of admission of the Insurer.

In the event that, as a result of an inaccurate declaration of the year of birth, the premium paid would have been less than the one that should have been paid, the Policyholder will be obliged to pay the difference between the amounts actually paid as premium and what they would have had to pay based on their true age. If the amount already paid is higher, the Insurer will be obliged to reimburse the Policyholder for the excess received.

12. Personal data processing

12.1. In accordance with the provisions of current European and Spanish regulations regarding the protection of personal data, the Insurer undertakes to keep confidential the data it receives from the Policyholder and/or Insured. The Insurer will apply all the technical and organisational means required to fulfil the obligations set out in current legislation.

12.2. The Insurer is expressly authorised by the Policyholder and/or the Insured to process the personal data for the legitimate purpose of executing the signed contract or policy, and that are included in the questionnaires or are known as a result of claims, and to produce the necessary files containing personal information for the sole purpose of maintaining, developing and monitoring the legal relationship between the Policyholder and the Insurer. The data will be stored by the Insurer during the period required in order to fulfil the purpose for which they were collected and to determine the possible responsibilities that may derive from this purpose and from the data processing.

12.3. The body responsible for data processing is Agrupación Sanitaria Seguros S.A., with the address at which the rights of access, rectification, erasure, restriction of data processing and portability and any other information described in Regulation (EU) 679/2016 General Data Protection being Avenida Alfonso X El Sabio, 14 – Entresuelo, 03004, Alicante. A complaint may also be made before the controlling authority (Spanish Data Protection Agency - www.aepd.es).

13. Communications and jurisdiction

13.1. Communications to the Insurer by the Policyholder or the Insured will be made always in writing to the company's registered office that appears in the policy, but if they are made to an agent or representative of it, they will have the same effects as if they would have been made directly to the Insurer, in accordance with article 21 of Insurance Contract Law.

13.2. Communications from the Insurer to the Policyholder and/or Insured will be made to the address that appears in the policy, unless they have notified the Insurer of their change of address.

Communications made by an Insurance Broker or Broker to the Insurer on behalf of the Policyholder will have the same effects as if they were made directly by the Policyholder himself, unless otherwise indicated by the latter (Article 21 of Insurance Contract Law).

13.3. This contract is subject to Spanish Jurisdiction, the competent judge being the one corresponding to the Insured's home address (article 24 of the Insurance Contract Law).

14. Prescription

In accordance with article 23 of the Insurance Contract Law, the actions derived from this Insurance Contract will prescribe within a period of five years from the moment they can be exercised.

15. Complaints and claims

ASSSA has a Customer Service and Customer Ombudsman located in the ASSSA offices at the disposal of the Insured and for the purpose of attending and resolving complaints and claims in accordance with the procedure outlined in Order ECO 734/2004, of March 11 and in the ASSSA Customer Ombudsman Regulation.

The policyholders, insured, beneficiaries and rights holders thereof may submit their complaints and claims to:

- Customer Services, by writing to Av. Alfonso X el Sabio, 14, 03004 Alicante or by email to the address sacquejasyreclamaciones@asssa.es.

- Customer Ombudsman, by writing to C / Velázquez 80, 28001 Madrid, or by email to the address reclamaciones@da-defensor.org.

The Insured or legitimate persons who prove that they have made their claim to any of the aforementioned addresses and are not satisfied with their resolution, or that, after a period of one month from the presentation of the same, it has not been resolved, may send their complaint or claim to the Claims Service of the General Directorate of Insurance and Pension Funds, by writing to the address at Paseo de la Castellana, 44, 28046 Madrid, or through the web www.dgsfp.mineco.es.

In addition to the claim channels indicated above, they may also be raised in court before the competent judges and courts.

16. Travel assistance

The Insured, resident in Spain and travelling in Spain or abroad will have the right to the guarantees established in point 16.1 provided that **the required assistance occurs within 90 consecutive days from the start of the trip and, when the insured is more than 30km from their usual address.**

16.1. Description of coverage

Medical and health care

The expenses corresponding to the intervention of professionals and health establishments required for the care of the Insured if they are sick or injured, **with a limit of €15,000 per person when the required Assistance occurs abroad and a limit of €900 per person when this Assistance occurs in Spain.**

This expressly includes but is not limited to the following services:

a) Attention by emergency medical teams and specialists.

b) Complementary medical examinations.

c) Hospitalisations, treatments and surgical interventions.

d) Medication supplied while being in hospital, or refund of its cost in injuries or illnesses not requiring hospitalisation.

In the event of a life-threatening emergency as a consequence of an unforeseeable complication from a chronic or pre-existing disease, **only the expenses of first-response medical care carried out as an emergency will be covered and within the first 24 hours from your admission to the hospital. The expenses covered for this cause may in no case exceed 10% of the sum insured for the guarantee of Medical Assistance.**

The costs of professional treatment for acute dental problems, understood as those that due to infection, pain or trauma require emergency treatment **with a limit of €120 per person per year.**

Repatriation or medical transportation of the injured or sick

In the event of an accident or illness of the Insured, the following will be covered:

a) Cost of ambulance to the nearest clinic or hospital.

b) Control by the medical team in contact with the doctor treating the injured or sick Insured person to determine the most appropriate measures, the best treatment and the most suitable means for possible transfer to another more suitable hospital or to his or her home.

c) The costs of transferring the injured or sick person, by the most appropriate means of transport, to the prescribed hospital centre or to their home address. The means of transport used will be decided based on the urgency and severity of the case. Exclusively in Europe, a specially equipped medical aircraft may be used.

If the Insured is admitted to a hospital not close to their home, the subsequent transfer to it will be covered at the time.

In the event that the Insured does not normally reside in Spain, they will be repatriated to the place where their trip began in Spain.

Repatriation or transportation of other insured persons

When in application of the guarantee of "Repatriation or medical transport of the injured or sick" or "Repatriation or transport of the deceased Insured", one of the Insured has been repatriated or transferred, due to illness, accident or death and this prevents their spouse, forbears or descendants in the first degree, siblings, or a companion continuing the trip by the initially foreseen means, cover will include transporting them to their home or to the place of hospitalisation.

In the event that the persons referred to in the preceding paragraph do not normally reside in Spain, they will be repatriated to the place where their trip began in Spain.

Repatriation or transportation of under age or disabled children

If the Insured repatriated or transferred, in application of the guarantee of "Repatriation or medical transport of the injured or sick", is travelling in the sole company of children with disabilities or children under fifteen years, the round trip travel costs for a hostess or a person designated by the Insured to accompany the children on their return home will be covered.

In the event that the persons referred to in the preceding paragraph do not normally reside in Spain, they will be repatriated to the place where their trip began in Spain.

Travel of a relative in the event of hospitalisation

a) If the condition of the sick or injured insured person requires their hospitalisation for a period of more than five days, the insurance will cover a round ticket by plane (tourist class) or train (1st class) available for a relative of the insured person or a person delegated by them, to accompany them.

b) Upon presentation of the corresponding invoices, an amount equivalent to the companion's expenses will be paid, **up to a limit of €100 per day with a maximum of 10 days in the case of travel abroad and a limit of €50 per day with a maximum of 10 days when the travel takes place in Spain.**

c) If the insured travels in the company of children with disabilities or those under 18 years of age and the hospitalisation is expected to exceed one day, a round trip ticket will be made available to a relative of the Insured, or the person designated by the latter, by plane (tourist class) or train (1st class), so they may accompany the children. However, and pending the arrival of the family member or person designated by the Insured, whenever possible, the arrangements and cost of hiring a caregiver in order to take charge of the custody of the children with disability or under 18 years of age will be covered.

Convalescence in a hotel

If the sick or injured Insured cannot return home due to medical prescription, the hotel expenses caused by the extension of stay will be covered, **up to a limit of €100 per day with a maximum of 10 days in the case of travel abroad and up to a limit of €50 per day with a maximum of 10 days for travel in Spain.**

Repatriation or transportation of a deceased insured person

In the event of the death of an Insured, the organisation of the transfer of the body to the place of burial in Spain and the expenses incurred will be covered. These expenses will be understood to include those for post-mortem handling in accordance with legal requirements.

Burial and ceremony expenses will not be included.

The return to their home of the other Insured will be covered when they cannot do so by the means initially foreseen.

In the event that the Insured does not normally reside in Spain, they will be repatriated to the place where their trip began in Spain.

Travel of a relative in the event of death

- **a)** In the event of the death of an Insured, the organisation and travel of a relative to the place of death will be covered so that they can accompany the body on the repatriation journey.
- **b)** An amount equivalent to the companion's expenses will be paid against the presentation of the corresponding invoices, **up to a limit of €100 per day with a maximum of 10 days in the case of travel abroad and up to a limit of €50 per day with a maximum of 10 days when the travel takes place in Spain.**

Early return due to the death of a relative

If any of the Insured has to interrupt their trip due to the death of a family member as defined in this policy, transportation will be covered, as a round trip, by plane (economy class) or train (1st class), to the place in which the burial in Spain takes place.

Alternatively, at their choice, the Insured may opt for two airline (tourist class) or train (1st class) tickets, to their usual address.

Early return due to a serious loss in the home or professional premises of the Insured

A transport ticket will be made available to the Insured to return to their home in Spain, in the event that they have to cut their trip short due to serious damage to the main residence or professional premises of the Insured **(provided that they are the direct operator or exercise a liberal profession in the aforementioned premises) caused by fire, provided that this has led to the intervention of the fire brigade, consummated theft that has been reported to the police, or serious flooding,** which makes their presence essential, providing these situations cannot be resolved by direct family members or people they trust, **and provided the event occurred after the start date of the trip.**

Likewise, the Insured will have a second ticket for the transport of the person who accompanied the Insured and who brought forward their journey, **provided this second person is also insured by this policy.**

Search, location and shipment of lost luggage

In the event of loss of luggage on a regular flight, all possible measures will be taken to ascertain its location, inform the Insured of any news that may occur in this regard and, where appropriate, have it reach the beneficiary without any charge for the same.

Transmission of urgent messages

Urgent messages ordered by the Insured will be transmitted, as a result of the claims covered by these guarantees.

Sending medicines abroad

In the event that the Insured, while abroad, needs a medicine that cannot be acquired in that place, it will be located and sent through the fastest channel and subject to local laws.

Cases in which a drug is no longer manufactured or unavailable via the usual distribution channels in Spain are excluded.

The Insured will have to reimburse the cost of the medicine, upon presentation of the purchase invoice for the aforementioned medicine.

Interpreter Service

If, due to any of the assistance guarantees covered by this Travel Assistance policy, the Insured requires the presence of an interpreter in a first intervention, a person will be made available to enable a correct translation of circumstances and situations to the Insured.

Legal information abroad

In the event that the Insured has a legal problem with third parties, related to an accident that occurred in their private life, they will be put in contact with a Lawyer, if there is one in the locality, to arrange an interview with the Insured **at their expense.**

This service will be provided only in countries that maintain diplomatic relations with Spain, except in cases of force majeure or in the case of an event beyond the control of the Insurer. **The Insurer is not responsible for the outcome of the legal consultation.**

16.2. Exclusions

The guarantees contracted do not include:

a) Acts voluntarily caused by the insured party or those involving dishonesty or gross negligence by them.

b) Chronic, congenital and/or pre-existing ailments and diseases, as well as their consequences, suffered by the Insured prior to the start of the trip or at the time of signing the insurance, except those expressly covered.

c) Death by suicide or injuries or diseases arising from an attempt or intentionally caused by the Insured person themselves, and those arising from the criminal enterprise of the Insured person.

d) Diseases or pathological conditions caused by the ingestion of alcohol, psychotropic drugs, hallucinogens or any drug or substance with similar characteristics.

e) Cosmetic treatments and the provision or replacement of hearing aids, contact lenses, glasses, orthoses and prostheses in general, as well as any cost resulting from childbirth or pregnancy and any type of mental illness.

f) Injuries or illnesses derived from the Insured's participation in sporting bets, competitions or events, and the practice of sports and/or adventure activities not expressly covered.

g) Circumstances that arise, directly or indirectly, from events caused by nuclear energy, radioactive radiation, natural catastrophes, war, disturbances or terrorist acts.

h) Claims that occur in those countries which, at the time of the Insured's travel or transfer, are in a state of war or siege, insurrection or warfare of any kind or nature, even when they have not been officially declared. These areas can be identified when the Ministry of Foreign Affairs has issued a recommendation not to travel for security reasons.

i) Injuries caused by the professional practice of any type of sport.

j) The rescue of people in the desert and/or at sea.

k) Any type of medical or pharmaceutical expense of less than €9.

l) The use of a medical aircraft except in Europe and always at the discretion of the Medical Team.

16.3. Notice of a claim

When making a claim that may give rise to the covered benefits, the Insured must, without fail, contact the emergency telephone service established by the Insurer, indicating the name of the Insured person, policy number, their location, contact telephone number and type of assistance required. This communication may be made on reversed charges, in the event that this is impossible the Insured may request reimbursement of the cost of the calls made to the Company, provided they are duly documented and justified.

16.4. Additional provisions

No obligation will be assumed in connection with services that have not been requested or that have not been carried out with a prior agreement, except in duly justified cases of force majeure.

When a direct intervention is not possible in the provision of services, the Insured will be reimbursed for duly accredited expenses derived from such services, within a maximum period of 40 days from the presentation thereof.

CUSTOMER SERVICE HELPLINE

932 265 966