AMEsalud
Foreigners

Wellcome

AME
ASISTENCIA MÉDICA

Founded in 1943
Subscribed share capital: 362.000, 00€
Paid-up capital: 362.000, 00€

Valencia, 106-108, ground floor
08015 Barcelona.
Telephone number 932265966- Fax
932267589

State member of the European Economic Area originally and Services Provision: Spain
Control Authority: Directorate General of Insurance, Ministry of Economy and Finance of Spain. Registered with no. C-0290.

Control Authority regarding healthcare: Directorate General of Health Resources, Health Department and Social Security of Generalitat de Catalunya. Registered with no. CAT-30.

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Wellcome letter

AME

Dear policyholder/Insured,

The team of AME ASISTENCIA MÉDICA COMPAÑÍA DE SEGUROS, S.A. would like to extend a warm welcome as a new member of AME family. We are grateful for your reliance and we are available to offer our personalized service, which has always characterized us.

Our broad experience in the area has allowed us to have a long-term relationship with our Insured. Evidence of this are the Insured families of four different generations who keep relying on AME since its foundation in 1943, when a group of doctors from the Hospital Clínico y Provincial de Barcelona undertook with great enthusiasm the challenge of working in high quality private medicine.

Today, more than 75 years later, we endeavor every day to keep counting on the best professionals, clinics, therapeutic and diagnosis centers with the most advanced technology available. We offer an affordable private medicine with fees adapted to the pocket of nowadays families, without ever forgetting the family atmosphere and careful treatment for all those people who place their most precious value on AME, their health.

We know that every case is different in healthcare. That is why we will always be available to answer any question at the following helpline available for Insured clients: telephone number +34 932265966, or our website: www.ameasistencia.com

Thank you for you confidence
Yours faithfully,

Pere Camprubí Ponsa
Manager AME Asistencia Médica Compañía de Seguros, S.A.

Frequently Asked Questions (FAQs)

ABOUT THE CONTRACT

Which documents are part of the insurance contract?

The insurance contract is a written document that includes the General and Especial Conditions and the Supplements or Annexes that may be attached to complete or modify it. The Insurance Application and the Health Questionnaire or Declaration are also part of the contract.

Which documents do you receive when you purchase the insurance?

Along with the insurance contract, you will receive the AME Health Card, for personal and non-transferable use. This way, every insured can identify their selves as one.
Make sure your personal data is correct.

Which documents must you send signed to the company?

You must sign a copy of the documents that are part of the Insurance Contract and send it properly signed to the Sales Consultant you have been assigned and who has contacted you. The insurance shall take effect once the company owns the signed documents and the premium has been paid.

How do I know if my contract with AME has finished?

For any administrative management related to the maturity or renewal of the Insurance Contract, you should contact the policyholder Service Department via telephone 932265966 or physically present in our offices in calle Valencia, 106-108, Barcelona.

INSURANCE FUNCTIONING

How do I look for specialist or centers where I can go?

All the information about the centers and specialist that are available for you is in the Services Guide, which is delivered along with your policy. You can also consult us via our website www.ameasistencia.com

Can I go to the doctor the day after the insurance is purchased? Yes, since the moment the contract enters into force.

Do I have to request an authorization for the doctor visits?

The services covered by the policy are open access or may require a previous authorization from the company. If they are open access, they do not require authorization, such as primary care consultations, specialist, emergency and basic diagnostic services. Will require previous authorization: hospital admissions, surgical procedures, ambulance transfer, therapeutic procedures, special diagnostic services and transplants detailed in the General and Particular Conditions of the policy.

How can I ask for an authorization?

To use the services that require the company authorization such as hospital admissions, surgical procedures, ambulance transportation, therapeutic procedures, special diagnostic services and transplants, the Insured shall make the following information and documents arrive to AME:
Request of specialist and service, indicating:

- Name and last name of the Insured
- Contact telephone number
- Center where the insured wishes to be treated (it must be on the Services Guide)
- Fax or email where they would like to receive the authorization.

In order to ask for the service authorization you can choose between the following options:

- Personally at AME offices: you shall bring the doctors request from Monday to Thursday from 8h until 18h. Friday from 8h until 15:00h. July and August from Monday to Friday from 8h until 15h. Address:Calle Valencia 106-108 ground floor 08015 Barcelona.

- Via email: you can scan the request and send it to ame@ameasistencia.com (transcription is not valid).
- Send the request to the fax number: 932 267 589.

The company takes up to 48 hours to give an answer

What should I do if I need in-home assistance?

If your health condition does not allow the displacement to a hospital or medical center, you shall call the 24 hours emergency number 934 484 679 and your request will be responded. AME will provide the service only at the insured's home indicated in the policy, provided the company has agreed such service in that zone or area.

What is the 24-hour emergency telephone number for?

If you call to the 24 hour emergency number 934 484 679 you will be served by skilled health workers who will provide assistance information about diseases, treatments and health prevention, such as use of medication, understanding of laboratory reports, medical terminology, evaluation reports and diagnosis.

What does the dentistry policy cover?

The coverage includes visits to the dentist, teeth extractions and the following cure. Furthermore, it includes an annual dental cleaning and radiographies.

INSURANCE PAYMENT

What are the payment terms of my insurance?

A single amount to be paid at the signing of the contract.

OTHER QUESTIONS

How can I submit a claim?

In the Insured Assistance Department, where de policyholder or a legitimate person will be able to submit their formal complaints and claims related to their interests and legally entitled rights. It is located in Barcelona, Calle Valencia 106-108.

Means to claim are:

- The Insured Assistance Department of AME Asistencia Médica.
- Commission for the Defense of the Customer in the Directorate General of Insurances and Pension Funds.
- Barcelona Arbitration Court.
- Ordinary Jurisdiction.

How can I modify my policy data?

Modifications related to policy data must be done by the card holder addressed to the company, via regular mail to Calle Valencia, 106-108. 08015 Barcelona, via email to ame@ameasistencia.com or via fax to 932 267 589.

General conditions

AMEhealth Foreign general terms and conditions

PRELIMINARY CLAUSE

The present Insurance Contract is ruled by the law 50/1980, of 8 October, of Insurance Contract (Official State Bulletin from October 17 1980), Royal Legislative Decree 6/2004, of 29 October, enacted the consolidated restated text of the Private Insurance Supervisory Act (Official State Bulletin Of 5 November) and its Development Regulation (Royal Decree 2486/98, of 20 November), accordance with the provisions of the applicable regulations and by the agreed on the General , Special, Particular Conditions and Supplements or Annexes included in this contract, with the insured rights restrictive clauses having no legitimacy or validity if they are not specially accepted by the same ones, as an additional pact of the Particular Conditions.
Mere transcriptions or references to legal imperative precepts and risk delimitation statements will not require such acceptation. The contract consists on the following parts: the Insurance request, the Declaration or Health Questionnaire, the General, Particular and Special Conditions, as well as the Supplements or Annexes that may be issued.

FIRST CLAUSE.- DEFINITIONS

For the purpose of this Contract, the following terms are defined as:

Accident: All forms of body injury suffered while the policy is in force, caused by a violent, sudden, external event beyond the control of the Insured, which has to be documented.

Traffic accident: Suffered by the Insured as a pedestrian, public transport passenger, regular and charter airlines user, car, bicycle and motorbike driver or passenger or suffered when driving by any type of pathway.

High medical technology: it refers to new applications of electronics, informatics, robotics and bioengineering to the medicine field, especially on diagnostic technologies and medical treatment. These techniques are characterized for a high investment cost, the need of specialized staff and they are subject to the reports from the Healthcare Technologies Evaluation Agency (AETS to determine if their security and efficiency in the different indications is sufficient in magnitude to replace the existent technology.

Antiangiogenic: Biologic drug that acts on the vascular endothelium growth factor (VEGF), which is essential for the new blood vessels formation (angiogenesis), inhibiting its development. **Not covered by the policy.**

Policy Insured: Every person/ people designated in the Particular Conditions established in the Insurance.

Insurer or Insurance Company: AME Asistencia Médica Compañía de Seguros, S.A., who assumes the coverage of the contract risks according to the agreed guarantees.

Out-patient / ambulatory medical assistance: Refers to the medical, diagnostic and/or therapeutic assistance in outpatient basis, which is provided in medical offices, the patient’s home and/or the hospital or clinic with no overnight stay and during a under a 24 hours period. **Major ambulatory surgery is not included in this concept.**

In-patient/ hospital medical assistance: Medical assistance provided in a hospital center in internment basis, during a minimum period of 24 hours, for the Insured’s medical or surgical treatment.

Biomaterial: Those materials, natural (biological of animal or human origin or artificial (manufactured, used in the fabrication of health devices and products that interact with biological systems and are applied in different medicine specializations. **Not covered by the policy.**

Major outpatient surgery: All surgical procedure made in the operating room with general, local, regional anesthesia or sedation, which requires less intensive and short period postoperative care and hospitalization is not required. The patient is discharged form hospital few hours after the intervention.

Minor outpatient surgery: Medical assistance that requires surgical procedures or simple interventions performed on an outpatient basis, in superficial tissues and generally needs local anesthesia. The main technics are surgical excision and cryotherapy.

Robotic or computer-aided surgery: Surgical procedure performed by a robot following the surgeon instructions and guided by a tele robotized laparoscopic system and/or aided by a virtual reality computerized system or a 3D image browse (obtained by computer). **Not covered by the policy.**

Cytostatic medicines: Drugs used in cancer treatment that are meant to destroy the cells that form the tumor, aiming to reduce or eliminate de disease. **Not covered by the policy.**

Restrictive clause or Attachment: Agreement established in the insurance contract, through which the guarantee coverage is limited or non-effective when some risk circumstance occurs.

Co-payment: Pre-established amount for each medical act the Insured/Holder assumes for the use of services that are covered by the present policy and detailed in the Conditions.

Health Questionnaire or Declaration: Question form that is part of the Insurance Contract, provided by AME Asistencia Médica Compañía de Seguros, S.A. to the Insured/Holder, who shall determine their health state and the circumstances that may influence the risk assessment and the insurance contract.

Actuarial age: Age every Insured has reached taking as a reference the effective or extension date of the policy.

Disease or injury: All alteration of health state occurred during the policy validity, non-consequence of an accident. A legally recognized doctor in the country or area where the services are provided will make the diagnosis and confirmation.

Congenital disease, injury, anomaly or deformity: All alteration of health state existing at birth because of inheritance factors or conditions acquired during pregnancy until the moment of birth. An acquired condition can appear and be immediately recognized after birth or later, at any period of life.

Services Guide: Group of professionals and medical establishments provided by AME, adapted to every insurance modality contract.

Medical-surgical fees: Professional fees derived from surgical procedure or hospitalization. They include surgeon, assistants, anesthetist, midwife and strict medical staff required during the procedure.

Hospital or clinic: All public or private establishments, legally authorized to treat diseases, injuries or accidents, provided with permanent medical presence and necessary means to make diagnostics and surgical procedures through hospital or outpatient assistance.

Medical or surgical hospitalization: Hospital admission necessary to receive medical or surgical treatment. Social-familiar hospitalization: Ambulatory assistance or hospitalization necessary for rehabilitation or palliative care of chronic diseases or incurable diseases in terminal stage. **Not covered by the policy.**

Implant: Health product designed to be total or partially inserted in the human body through surgical or special technic intervention, with diagnostic, therapeutic and/or esthetic purpose. It is intended to remain there after such procedure. **Not covered by the policy.**

Enzyme or molecular inhibitor: Biological drugs that act on a therapeutic target, intra or extracellular, inhibiting the generation and signal transmission in the cell growth pathway. This therapeutic subgroup includes enzyme inhibitors at different levels (ex. Kinase protein inhibitors, kinase tyrosine inhibitors, proteasome inhibitors, etc.). **Not covered by the policy.**

Biological therapy or immunotherapy: Also called biotherapy or biological response modifying therapy). It is based in modifying, stimulating or restoring the immune system ability to fight cancer, infections and other diseases. Additionally, it is used to reduce some side effects consequence of oncological treatments. The substances or drugs used in antitumor therapy are nonspecific immunomodulatory agents, interferons, interleukins, growth factors or colony stimulators, monoclonal antibodies or antigen-antibody antitumor agents, cytokine therapies and vaccines. **Not covered by the policy.**

Surgical procedure: Action with diagnostic or therapeutic purpose, made through incision or other surgical approach, performed by a surgeon or medical/surgical team that normally requires the use of a specialized operation room in an authorized health center.

Biological or synthetic material: Also called biological prosthesis that implanted through special technics it substitutes, regenerates or supports an organ or its function. This concepts includes cell transplant with regenerative purpose. **Not covered by the policy.**

Orthosis or orthopedic material: Health products of external use, permanent or temporary, that individually adapted to the patient are intended to modify structural or functional conditions of the neuromuscular or skeletal system. Such implantation never requires surgical procedure. **Not covered by the policy.**

Osteosynthesis material: Any type piece or element used for joining two fractured bone ends or for healing articular ends. **Not covered by the policy.**

Regenerative medicine: Includes tissue, cellular and molecular regeneration technics, implants or stem cell transplants and tissue engineering. **Not covered by the policy**.

Doctor: Owner of a Degree in Medicine, legally qualified and authorized to practice medicine and to treat medical or surgically a disease, injury or pain the Insured suffers.

Own resources: Facultative staff and included centers in the Service Guide available for the Holder/Insured according to the insurance modality hired.

Unrelated resources: Facultative staff and not included centers in the Service Guide available for the Holder/ Insured according to the insurance modality hired.

Policy: Insurance contract. Written document that contains the General, Particular, Special conditions and Supplements or Annexes that may be applied to complete or modify it. The Insurance request or application and the Declaration or Health Questionnaire are also part of the policy.

Pre-existing pathologies: Medical condition, health alteration or organic disorder that exists before the contract date or the Insured inclusion to the policy. It is normally perceived as signs and symptoms regardless of a diagnostic existence or pathological nature (pregnancy for example). Any declared preexistence will not be covered, neither said preexistence nor its deficiencies except annex that notifies.

Premium: Is the price of the insurance. In addition, it shall include taxes and charges that are legal at each moment.

Prosthesis: Permanent or temporary products used in case of absence, anomaly or disorder of a body structure that substitute or regenerate total or partially its physiological function. **Not covered by the policy.**

Clinical psychology: Psychology specialty that deals with rehabilitation and treatment of human behavior anomalies and disorders. **Not covered by the policy.**

Psychotherapy: Method of treatment realized with a patient who suffers from a psychic conflict. It is prescribed or indicated by a psychiatrist. **Not covered by the policy.**

Intensity Modulated Radiation Therapy (IMRT): Type of radiotherapy formed three-dimensional that uses images created by a computer through reverse programming computing programs to show the size and shape of a tumor. Radiation beams from a lineal multi-lamination accelerator are focalized in the tumor with different angles and intensity and surrounding tissues receive a minor dose. **Not covered by the policy.**

Helical radiotherapy or tomotherapy: Helical radiotherapy image guided in real time, also called tomotherapy, which integrates TAC and lineal binary multi-laminal accelerator (64 sheets) in the same equipment. In an advanced radiotherapy modality that allows to obtain a 3D tumor image before the radiation administration and to focus the radiation on the tumor from different directions by spinning the radiation focus around the patient in spiral form. **Not covered by the policy.**

Rehabilitation: All acts prescribed by an orthopedist, neurologist, rheumatologist, rehabilitation doctor and made by a rehabilitation doctor or a physiotherapist in a special rehabilitation center meant to substitute the function of affected locomotor system parts by an illness or accident consequences occurred during the policy validity. **Neurological rehabilitation, not covered by the policy.**

Cardiac rehabilitation: Necessary activities to recover an optimum functional level after an acute myocardial infarction or heart transplant.

Individual insurance: According to the contract, individual modality insurance is considered one or various people, connected by different bound to the Insurer interest usually first grade familiars (the Holder, their partner and their non-emancipated children under 30 years old living in the same familiar residence). Its coverage in any case is realized under mandatory adhesion (closed collective) or willingly (open collectives or co-financed) to contract conditions and/or unique contract previously agreed by AME and a contracting collective.

Collective insurance: According to the contract, a collective modality insurance is considered a group of people connected by a bound different to the Insurer interest that fulfill the legal insurance conditions. Its coverage is accomplished through mandatory adhesion (closed collective) or willingly (co-financed or opened collectives) to contract conditions and/or unique contract previously agreed by AME and a contracting collective.

Extra premium: Additional amount or complementary premium credited because of the coverage of a risk excluded of the General Conditions.

Damage: All act whose consequences are covered total or partially by one of the policy guarantees. It is considered as a one same damage the set of services derived from a one same cause and provided by a one same provider.

Insurance Application: Questionnaire provided by the Insurer in which the Holder describes the risk they wish to ensure, with all the circumstances they know and can influence the risk assessment. It includes the Health Questionnaire.

Health card: Magnetic card delivered to each Insured included in the policy and for personal and non-transferable use. It is necessary to access any Service Guide service.

Genetic or gene therapy: Procedure that allows hereditary disease, cancer, infections and other diseases treatment through cell genome modification. Gene therapy consists of insertion through different vectors genetic material in a target cell to obtain a therapeutic effect (protein of interest synthesis, genetic deficit compensation, immune response stimulation or resistance against a viral infection). **Not covered by the policy.**

Policyholder: Natural or legal person that agrees to this contract with AME Asistencia Médica Compañía de Seguros, S.A. and by consequence they accept the terms and obligations, except for the ones that must be fulfilled by the Insured.

Pain unit: Medical service specialized in chronic pain treatment.

Life threatening emergency: Situation that requires immediate and non-delayable (few hours) medical assistance. A delay in these same conditions can end in a life compromise or an irreparable damage in the patient’s physical integrity.

SECOND CLAUSE.- SUBJECT TO THE INSURANCE

According to the limits and conditions stipulated in the General Conditions and established in the Particular and Especial Conditions and/or the Questionnaire or Health Declaration, the Insurer AME covers all the medical-surgical and hospital assistance in all type of diseases or injures included in the specialties and modalities set in the FOURTH CLAUSE.- INSURANCE COVERAGE, previous payment of the corresponding prime.
The Insurer covers the health assistance cost, as long as the policy clauses are fulfilled, that health professionals, centers and services duly authorized provided to the Insured.

In any case, as provided in article 103 of the Insurance Contract Act, the Insurer assumes the cost of an emergency assistance in accordance with the THIRD CLAUSE .- ACCESS TO INSURANCE COVERAGE of the present General Conditions of this policy and to the services covered by the same one. Under no circumstances optative cash compensations will be granted in substitution of health assistance services provision.

Diagnostic and therapeutic advances occurred in the medical area during the insurance policy validity will only become part of the policy coverage when:

1. They are scientifically duly contrasted or have been manifestly overcome by other available. It requires a positive report issued by the health technologies evaluation Agencies. (Ministry of Health or Health Services of the CCAA, Autonomous Communities).

2. They are specifically included in FOURTH CLAUSE.- INSURANCE COVERAGE of these General Conditions.

In every contract renewal, AME will announce to the Insured the new updates or incorporations of technics and treatments that will become part of the Policy Coverage the following policy period. The Insurance is based on the free choice of doctors and hospital centers, between the ones established detailed in AME's Service Guide, according to the insurance modality chosen. When there is no existence of a contract-included service in some area, it will be provided in the closest place where it can be performed, up to the Insured's choice. The right of free choice of doctor and center implies the absence of AME's direct, joint or subsidiary liability for the acts of those, upon which AME has no control capacity because of professional secrecy, health data confidentiality and prohibition of third parties gaining to health data. . The provision modality is the one stipulated in article 105 paragraph 1st Insurance Contract Act,- health costs credit-, without directly assuming the service provision practiced by professionals and qualified centers. In case of medical or hospital malpractice, the Insured undertakes to raise action exclusively against professionals or centers directly involved in the provision and the respective Insurers of civil responsibility, with resignation of actions against AME. The Insurance modality and specific coverages change depending on the type of subscription made by the Insured.

THIRD CLAUSE.- ACCESS TO INSURANCE COVERAGE

AME will deliver the AME Health Card to the Holder of personal and nontransferable use so each beneficiary can identify their selves, as well as the AMEhealth Service Guide with the detail of health professionals, hospital centers, emergency services, diagnostic centers and complementary services.

3.1.- Routine coverage.

The Insured will be able to make free use of the services covered by the policy which are part of the Guide Services. They shall present the Insured Health Card to identify their selves, together with another official identity document (ID card, NIE, Passport…)
When there is no existence of a contract-included service in some area, it will be provided in the closest place where it can be performed, up to the Insured's choice.

The Insurer will not be responsible for facultative professionals' fees not included in the Service Guide, for hospital stays costs or for services originated from private or public centers not agreed with the Insurer, whoever it is the professional that prescribes or performs the service.

Facultative staff data and health establishments that appear in the Service Guide can change, therefore it is recommended to contact the Insured Support Department when an eventuality occurs or to check the updated Service Guide in the Insurer's website.

3.2.- Emergencies

In case of urgent service, the Insured shall request it by phone or go to any Permanent Emergency Center the Insurer has established and whose address and telephone number appear in the provided Services Guide. The emergency in-home service is guaranteed in those areas where the Entity has agreed such service.

3.3.- Authorizations

Services covered by the policy can be open access or require a previous Authorization of the Insurer. Open access services are primary assistance consultations, specialists and urgent consultations, as well as basic diagnostic procedures. Services requiring a previous authorization are hospital admissions, surgery procedures resulting from an emergency, prosthesis and surgical implants, ambulance transfers, therapeutic acts, complex diagnostic tests and transplants included in CLAUSE FOURTH .-INSURANCE COVERAGE.

AME will report a previous specific authorization as long as the provision is prescribed by a doctor included in the entity's Service Guide, being also necessary a report of the prescribing doctor if the entity requires. In any case, the authorization of the prescribed act shall obligatory be valid on a medical center included in the Service Guide. Once the authorization is formed, it will link the Entity economically, unless it is indicated in the same statement that it is a non-covered by the policy provision.
However, in case of emergency assistance it will be enough a written prescription by the doctor agreed with the Entity. The Insured shall obtain AME's authorization within 72 hours after the hospitalization or medical provision included in FOURTH CLAUSE.-INSURANCE COVERAGE.
According to Life-threating Emergency rules, AME shall remain economically linked until the moment of expressing their qualms about the doctor's order in case the Policy does not cover the medical act or hospitalization, within a maximum period of 72 hours.

For authorization issuing and damage processing AME is allowed -according to SIXTEENTH CLAUSE.-PERSONAL DATA TREATMENT AND CESION-, to refinish medical information related to prescriptions, directly from the facultative professional and/or health center, or will be able to ask the Insured an additional medical report containing the background, risk factors, diagnostic and treatment needs. The authorization can be requested at the Insured Support Department, by phone 932 265 966, by fax 932 267 589, by email to ame@asistenciamedica.com, through the website www.ameasistencia.com or in AME's office (Calle Valencia 106-108, 08015 Barcelona).

3.4.- Surgical Hospitalization

Authorizations for surgical hospitalizations in medical centers prosecuted by the Entity will be limited to the established days in the hospital admission prescription indicated by the doctor.

To obtain one or more extensions of the surgical hospitalization days, the Insured shall request them to the Entity and bring a new medical report indicating the purposes of such extension and the prediction of the stay. Under no circumstances, social, familiar or occupational problems will be accepted as a reason for residence (home assistance difficulties, etc.)

The hospital stay will be determined by the assisting doctor's exclusive judgment, who will be able to indicate the continuation of the assistance at the Insured's home in case hospital residence is no longer available. The Entity will not take over the hospitalizations expenses in centers not included in the Service Guide unless they are originated by a Life threatening Emergency. In Life threatening Emergency rules, the Insured or their relatives will communicate and credit such circumstance to the Entity within 72 hours from the admission. It will be a prerequisite for the Entity to take charge for the hospital expenses and that the hospitalization is made in the closest center to the Vital Emergency and not a public center. Once it is possible, the Insured shall be transferred to a center included in the Services Guide.

AME

3.5.-In-Home Assistance

With regard to home visits, the Insurer is obliged to provide services uniquely in the Insured's home indicated in the policy, as long as such service is agreed by the Entity in the area. Any change in the same one shall be notified to the Insurer through any credible mean with a minimum advance of eight days before any service requirement. The Entity is obliged to issue the corresponding supplement.

Any in-home service can be required when the trip to the hospital is medically discouraged because of the patient's health state.

3.6.- Free choice of doctor.

Freedom to choose the facultative doctor between the ones included in the Service Guide guides the assistance provision. The Insured will directly address to the chosen facultative.

3.7.- Co-payments

The Insured will credit for each service received, in payment or participation in the same cost, the amount established in section 4.9 Copayments in FOURHT CLAUSE.- INSURANCE COVERAGE.

The Insurer will remit periodically to the Holder an extract with the services the Insureds may have used included in the Policy and susceptible to copayment, together with the amount of the corresponding copayments. The amount of copayments will be updated by the Insurer according to the established in the present General Conditions in the policy.

3.8.- Subrogation or transfer of rights clause.

Once the service is provided, AME will be able to exercise the rights and actions that because of the damage caused, they correspond to the Insured in front of the people responsible of the same damage, until the limit of the compensation payment. The Insured is obliged to provide to AME the necessary documents to facilitate the subrogation. This subrogation right will not be able to be exercised against the Insured's partner or against relatives until third grade of consanguinity or against the adopter parent or adopted child who live together with the Insured.

FOURHT CLAUSE.-INSURANCE COVERAGE

It is the following Health Assistance provided by this contract:

4.1.- Primary Care

Services will be provided exclusively by health professionals included in the Policy Services Guide.

- General Medicine. Medical assistance with indication and prescription of tests ad basic diagnostic means.
- Pediatrics and Childcare. Assistance for children until 14 years old with indication and prescription of tests ad basic diagnostic means. It includes preventive and childhood development controls (genetic and molecular biological tests are excluded), urine tests and conventional simple radiography.
- Nursing service (injectable and cures): Health Technician Assistance Service or Degree in Nursing or Infirmary owner (ATS/DUE) will be provided in clinic or in-home with a previous petition written by the doctor who takes care of the Insured.

4.2.- Emergency Services

- Urgent Permanent Assistance. It will be provided in centers included in the Services Guide and agreed by the Insurer. General Medicine medical assistance and nursing will be provided in the Insured's home as long as it is justified and indicated by the 24 hours Telephone Medical Assistance Service.

  The Entity will not take over the hospitalization expenses in centers non included in the Service Guide, unless they are originated by Vital Urgency reasons. According to Life threatening or Vital Emergency rules, the Insured or their relatives will communicate and credit such circumstance to the Entity within 72 hours from the admission. As long as there is no medical opposition, AME will be able to transfer the coverage to an agreed center providing the adequate means of transport.

- Emergency Permanent Assistance to displaced people in Spain with the same coverage and exclusions indicated in these General Conditions. Visits and tests after the emergency will be covered for medical control indicated inte the same emergency.

- Ambulance. In case of urgent need as long as special circumstances of physical inability occur that unable the use of other transport services (private car, taxi, bus, etc.), the Insured will be transferred from the place they are to the corresponding emergency services center agreed by AME. In all instances, it will be necessary the written prescription of an AME's doctor together with a report indicating the need of aided transfer. The maximum distance at the Entity's expense will be 300 kilometers, being at the Insured's expense the mileage exceeded. In addition, transfers in incubation are included.

- It is not covered the transfer back from the hospital center, clinic to their domicile or other destination.

4.3.- Surgical and medical specialties.

The coverage includes visits, diagnostic tests, therapeutic acts and procedures resulting from an emergency between the following specialties description, as long as they are provided by facultative professionals and centers included in the Services Guide according to the policy.

- Allergy and Immunology. **Vaccines will be in charge of the Insured**.
- Anesthesiology and Resuscitation. All kind of anesthesia prescribed by an Entity's doctor for surgical procedures covered by the policy. Epidural anesthesia is covered.
- Pathological Anatomy. Including Immunohistochemistry, Hormonal Receptors and Tumor Markers.
- Angiology and Vascular Surgery. **Laser coverage is excluded.**
- Digestive System
- Cardiology. Includes heart rehabilitation after acute myocardial infraction.
- Cardiovascular Surgery.
- General Surgery and Digestive System Surgery.
- Facial and Maxillary Surgery.
- Pediatric Surgery.
- Plastic and Repairing Surgery Including breast reconstruction after radical mastectomy derived of an oncologic process. It comprises surgical procedures to reestablish injuries essentially through grafts or plasties. Cosmetic Surgery is not included.
- Thoracic Surgery. Including sympathectomy by hyperhidrosis (excessive perspiration treatment).
- Medical-surgical Dermatology and Venereology. **Treatments with just esthetic purpose and digital dermoscopy (epiluminiscence) are not included.**
- Endocrinology
- Stomatology-Odontology. Includes extractions, derived stemmatological cures and associated dental radiology (TAC for Implantology are excluded from the coverage). Annual dental cleaning. The rest of dental treatments that are not covered by the insurance will be provided at the Insured's expense. Ask AME's Insured Support Department about other policies coverage.

- Gynecology. Includes women diseases diagnostic and treatment. Annual gynecological revision.
- Hematology and Haemotherapy.
- Internal Medicine.
- Nephrology.
- Pneumology
- Neurosurgery. **Rizolisi material, tools and kits needed for intervention are not included.**
- Neurology.
- Ophthalmology. Includes laser photocoagulation and corneal transplant, being the corneal transplant at the Insured's expense. **Visual refraction defects correction (myopia, hyperopia and astigmatism) and presbyopia are not covered and will be at the Insured's expense.**
- Medical Oncology. Includes study on sentinel lymphatic node in breast cancer.
- Otorhinolaryngology. **Excludes laser technics.**
- Psychiatrics. **Excludes any kind of test, drug addiction and alcoholism treatment, group and individual therapies.**
- Radiology. Includes Interventional Radiology.
- Rheumatology. Infiltration drugs are excluded.
- Traumatology and Orthopedic Surgery. **Excludes infiltrations medication**.
- Urology. **Excludes surgical laser use.**

4.4.- Diagnosis Means

Diagnosis means will be performed in any case with a previous prescription of an Entity's doctor and in medical centers assigned by the same one. Contrast means and radiopharmaceuticals used are included in the Means of Diagnosis coverage exclusively during the Insured's admission in a hospital center and outpatient up to 100, 00€ per test.

- Basis Means of Diagnosis. Includes the following services:
  - –Clinical Analysis, Biochemistry, Hematology, Microbiology and Parasitology. **It excludes Dietary Sensitivity Test.**
  - –Pathological Anatomy and Cytology.
  - –Simple Radiology.

Other Means of Diagnosis. It will be performed in health centers assigned by the Entity. It includes the following services:

- Radio diagnosis. Includes usual technics as Osseous Densitometry, Echography (except 3D or 4D Obstetric Echography), Mammography, Angiography, digital Arteriography and non-Interventionist Radiology.
- Complex Analysis. **It does not include genetic analysis**.
- Nuclear Medicine. Radioactive Isotopes and Gamma Ray Scan.
- Nuclear Magnetic Resonance (NMR).

- Tomography:
  - –Computerized Axial Tomography (CAT/SCANNER)
  - –Multiple Detectors Tomography (MDT). For Coronary System pathologies exclusively.
- Endoscopy, **excluded the endoscopic capsule technic and digital endoscopy**.
- Fibro bronchoscopy: diagnostic and/or therapeutic.
- Cardiologic Diagnosis. Electrocardiogram, Stress Test, Echocardiogram, Holter, Map, Doppler and Hemodynamics. It also includes Coronary Tomography and cardiac SPECT.
- Clinical Neurophysiology. Electroencephalography and Electromyography.
- Otoacoustic emissions or neonatal audible screening for early hearing loss detection.
- Polysomnography. **Exclusively for the in-home study of sleep obstructive apnea syndrome.**
- Optic coherence Tomography (OCT): in ophthalmological diagnosis, according to clinical practice protocols commonly accepted.
- High diagnostic technology. Includes:
  - Computerized multi cut Angiotomography (AngioTC), Angioresonance (AngioRM) and Bile Duct Resonance.
  - Positron Emission Tomography (PET) single or combined with computerized tomography (PET-TC).
  - Fibroscan or Elastograhy. For the sole purpose of evaluating the evolution of hepatic fibrosis in chronic liver diseases, excluding those relating to alcohol abuse. Limited to one policyholder per year.

4.5.- Preventive Medicine

The following preventive medicine programs shall be performed by doctors belonging to the Entity and in centers assigned by the same one.

- Gynecological check:
  - Annual examination including visit, colposcopy, cytology, echography, and mammography according to commonly accepted protocols.
  - HPV Test for early detection of cervix cancer according to protocols commonly accepted.
- Cardiology check :
  - Annual examination including visit, cardiovascular exploration, electrocardiogram, analysis and if needed stress testand echocardiogram.
- Dermatological preventive plan:
  - Consultation and revision of size, colors and shape changes of dysplastic or atypical nevus. **Does not include epiluminiscence.**
- Urological check:
  - Annual revision including visit, renal and vesical-prostate echography, P.S.A. (specific prostate antigen) and transrectal echography and/or prostate biopsy if needed.
- Odontology:
  - Odontology consult and buccal exploration.
  - Periodontal scaling or annual buccal cleaning.
- Colonorectal cancer prevention plan:
  - Medical consultation and physical exploration.
  - Specific test to detect blood in feces.
  - Colonoscopy, if necessary and in a population of risk with a history.

4.6.-Therapeutic Treatments

They shall be requested doctors belonging to the Entity and will be performed in centers assigned by the same one.

- Blood and/or plasma transfusions in hospitalization covered by the policy exclusively.
- Renal and Biliary Lithotripsy.
- Oxygen therapy outpatient and in-home.
- Cardiac Rehabilitation. For prevention of ischemic heart disease after hospital discharge because of a cardiovascular condition.
- Prostate Hyperthermia.
- Treatment of pain. It will be provided outpatient for oncological cases with pain that cannot be controlled by the oncological unity and/or with chronic pain derived of surgical procedures. Likewise, it is covered the internment produced by an acute complication derived of the treatment and medical devices implantation during a maximum period of 7 days. **It excludes expenses from any type of medication, materials, devices, specific doctors and prosthesis.**
- Rehabilitation and Physiotherapy. For the treatment of acute trauma process because of intervention and/or trauma (non chronic pain)as long as the same ones have been developed after the inception date of the policy. It will be provided on outpatient basis and in the hospital center and the Insured shall be hospitalized because of a coverage included in the policy. It shall be performed by a doctor, aided by physiotherapists and made in an adequate center for such purpose included in the Service Guide. **Excluded neurological rehabilitation treatments.**
- Laser therapy. It will be provided exclusively in ophthalmological treatments.
- Orthotoptics. It will be provided as a consequence of strabismus appearing.

4.7.- Hospitalization.

Hospital admissions shall be requested by Entity's doctors and authorized by the protocol established in Clauses 3.3 and 3.4 of this contract. Hospital admissions shall be made in centers agreed by the Entity.

The Insured will have right to a single room and bed for companion except in ICU (Intensive Care Unit), psychiatric hospitalization .

They will be at the Insured's expense the treatment, stays, cures and its materials, patient's maintenance while the patient is hospitalized, as well as surgical expenses, anesthetic products and medication used in the surgical procedure. The medication and material in hospital floor and ICU will be at the Entity's expense up to a maximum of three thousand euro per year per Insured, expect for Oncological Hospitalization. **Biological medication or medical biomaterials are excluded.** The doctor belonging to the Entity responsible for the assistance will determine hospital discharge date.

- Surgical Hospitalization. It covers operating room, anesthetic products and medication expenses used in the surgical procedure in the operating room. Companion's maintenance will be at the Entity's expense in case of surgical operation. **The medication and material in hospital floor will be at the Entity's expense up to a maximum of three thousand euro per year.**
- Medical Hospitalization. For medical diseases treatment, the Entity limits the coverage until the hospital discharge date determined by the doctor belonging to the Entity responsible for the assistance. **The entity limits coverage to € 150.000 per process**.
- Oncological Hospitalization. For medical diseases treatment, the Entity limits the coverage until the hospital discharge date determined by the doctor belonging to the Entity responsible for the assistance up **to a maximum of 15 days.**
- Radiotherapy:
  – Cobalt therapy
  – Particles Lineal Acceleration, **excluding radiosurgery**.
- Chemotherapy. Chemotherapeutic treatments will the at the Entity's expense, in outpatient basis and in clinic basis when hospitalization is needed, being in any case the specialist doctor belonging to the Entity the responsible of the type and treatment realization.
- Oncological medications will be at the Insured's expense. **Only will be guaranteed treatments (not medication)** in which cytostatic products from national market and authorized by the Ministry of Health are used.
- Psychiatric Hospitalization. For schizophrenic crisis and mental disorders in acute phase that cannot be treated at the Insured's home and need hospitalization. Not acute on chronic diseases already diagnosed. Addictions and eating disorders are not included. **The coverage period is limited to 15 days per year.**
- Intensive Care Unit Hospitalization. **The entity limits coverage to € 150.000 per process**
- Day Hospital.

4.8.- Other services:

- Chiropody in clinic.
- Prosthesis. Prosthesis guaranteed by the Entity will be the following ones:
- Mammary prosthesis, exclusively after radical oncological mammary mastectomy. **The prosthesis cost is at the Entity's expense up to 600 euro per process. The cost of any other prosthesis, anatomic pieces, osteosyntesis material, orthopedics and tights will be at the Insured's expense.**
- 24-hour Medical Orientation Telephone Service (934 484 679). Support telephone information, every day of the year, related to diseases, treatments and health prevention, as well as medication use, laboratory reports comprehension, medical terminology, report evaluation and diagnosis.
- Homeopathy. It will be provided by a facultative professional agreed by the Entity included in the Services Guide. **The coverage is limited to 12 visits per insured / year.**

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4.9.- Co-payment

The Insurance Holder will pay in franchise concept or participation in the service cost a determined amount for each service used from the guarantees covered by the present policy. The amount of each one of the copayments will be indicated below according to each one of the sections in FOURTH CLAUSE:

- Visits: 0,00€
- Tests or diagnosis means: 0,00€
- Emergency services: 0,00€
- Treatments: 0,00€
- Hospitalizations: 0,00€

FIFTH CLAUSE.-EXCLUDED COVERAGE

This insurance coverage excludes:

1. Medical Assistance of any type of diseases, damages, injuries, defects or birth deformities preexisting (pregnancy or gestation period) to the effect date of each Insured in the policy, even if there is not a particular diagnostic established, unless such diseases, damages, defects or birth deformities have been declared by the Holder or Insured in the health questionnaire and expressly accepted in the coverage by the Insurer in the Particular Conditions. This exclusion will not affect the Insured added to the policy since their birth. The insurance Holder, in their behalf and in the Beneficiaries', is obliged to manifest in the moment of submitting the insurance application, any kind of injury, congenital pathology, diseases, diagnostic tests, treatments and even the symptoms that could be considered as the beginning of any pathology. In case of omission, the affectation will be excluded of the insurance coverage. If preexisting or congenital diseases were declared, AME Asistencia Médica reserves the right to accept or reject the insurance application. In case of acceptance, AME Asistencia Médica will be able to include the corresponding exclusion clause of such coverage or to implement an additional premium for the coverage of the same ones.
In case of rare, unknown non suspected diseases by the Insured or Holder because of no evidence of symptoms previous to the contract formalization, it is established the imputation of its coverage after 1 year since such formalization or inclusion of the Insured, except for fault of the Holder.

2. Medical Assistance for diseases or injuries consequence of wars, riots, revolutions, repressions and military exercises, even in times of peace and terrorism in any form, the ones caused by officially declared epidemic, the ones related direct or indirectly to chemical, biological, nuclear radiation or radioactive pollution, as well as the ones coming from cataclysms (earthquakes, flood and meteorological or seismic phenomena).

3. Medical Assistance needed as a consequence of diseases or injuries occurred during the practice as an amateur or professional of high risk activities such as: air activities, boxing, martial arts, climbing, rugby, speleology, diving, motor vehicle racing, quad riding, horse riding, paragliding, bungee jumping, descending, skiing (in and out slopes), participation in bets and competitions, bullfighting and enclosing of wild stock, adventure sports or other practice manifestly dangerous.

4. Medical Assistance derived of the professional practice of any sport or participation as an amateur in sportive competitions in general, including preparation trainings to participate in such competitions.

5. Medical Assistance derived of chronic alcoholism, drug addiction or intoxications caused by the abuse of alcohol, psychiatric drugs, narcotics or hallucinogenic drugs, suicide attempt, self-injuries, alimentary disorders, as well as medical assistance of diseases or accidents suffered because of negligence or imprudence of the Insured or injuries resulting of quarrels or aggressions.

6. Analysis and other explorations needed for the certificate and reports dispatch and the submission of any other type of document with no clear assistance function.

7. Medicine and preventive checks (except for the ones detailed in the General Conditions of the policy). The pharmaceutical products and all type of vaccines and auto-vaccines except for the ones expressly detailed in the General Conditions, as well as the Extract provision in allergic procedures.

8. Voluntary pregnancy termination in any case, as well as diagnostic tests related to such voluntary termination and the selective instrumental embryonic reduction. It is also excluded the sterility and fertility treatment and aided fecundation technics. It is excluded the study, diagnosis and treatment of sexual impotence and erectile dysfunction and the diagnosis of infertility and sterility.

9. Cosmetic surgery and any other treatment, infiltration or procedure with esthetic and/or cosmetic purpose, unless there were no other functional defect of the affected part (being not valid pure psychological reasons). There are excluded varices treatments with cosmetic purposes, slimming cures and dermic esthetic treatments in general, including capillary treatments. It is also excluded the surgical correction of myopia, astigmatism, hyper myopia and presbyopia, as well as orthokeratology and the consequences and complications derived from all the exclusions covered by this paragraph.

10. Psychoanalysis, hypnosis, sophrology, ambulatory narcolepsy, psychological tests, individual or group psychotherapy and any other psychological assistance procedure. Alternative and complementary therapies, acupuncture, naturopathy, chiromassage, lymphatic drainage, mesotherapy, gymnastic, osteopathy, hydrotherapy, three-phase oxygen therapy, press therapy, ozone therapy and other similar provisions or specialties not officially recognized.

11. Hospital admissions derived from terminal procedures.

12. Organs, tissues, cells or cell components transplants or self-transplants, grafts or autografts, except for the ones indicated in this General Conditions. The Insurer is not responsible for the conservation, and organ to transplant.

13. Prosthesis, osteosynthesis material as well as any other type of orthopedic material, biological or synthetic material, grafts, meshes, spinal implants and artificial heart, unless they are expressly included in annex in the Particular Conditions in the policy.

14. Any diagnosis means and/or treatments through gene therapy, studies for the gene map determination and any other gene technic, with the exclusive exception of those figures expressly included in the Services Annex in the policy appearing in the Particular Conditions.

15. Medical Assistance that demands the treatment of diseases or occupational accidents, as well as the one derived from the use of motor vehicles covered by the Car Insurance of Mandatory Subscription.

16. Expenses derived from medical assistance provided in Social Security centers or centers integrated in the National Health System.

17. Physiotherapy and rehabilitation when the functional recuperation has been achieved or the maximum possible, when it becomes a therapy of occupational maintenance, rehabilitation in chronic diseases of the locomotor system when sequelae are stabilized, as well as irreversible neurologic injuries maintenance rehabilitation of different origin. It is excluded the early stimulation, in-home rehabilitation or as hospital admission motive and the one performed in centers not included and/or authorized in the Health Centers and Services register of the respective Autonomous Community.

18. Dialysis, hemodialysis and artificial kidney treatment. Hyperbaric chamber.

19. Health assistance derived from H.I.V. (Human Immunodeficiency Virus) infection and diseases related to it.

20. Gender reassignment operation.

21. Travel and transfer expenses except for the ambulance in the terms contemplated in the services description.

22. Equally, there are excluded those procedures of experimental nature or with no efficiency proven in prevention, treatment or healing of diseases, conservation or life expectancy improvement, pain elimination or decrease and the ones consisting of mere leisure, resting, comfort or sportive activities. All those diagnosis and therapy procedures whose clinic security and effectiveness are not scientifically proven and/or have not been ratified by the Evaluation Agencies of Health Technologies, or have been manifestly overtaken by others available.

23. Stays, assistance, and treatments and non-hospital centers such as hotels, spas, asylums, residences, resting or relaxing centers, diagnostic centers and similar, even if they are prescribed by facultative professionals, as well as admissions in centers dedicated to activities related to leisure, resting and dietary treatments. Psychiatric hospitalization, except for acute outbreaks, hospitalization because of family or social reasons and hospitalization replaceable for ambulatory or in-home assistance. It is also excluded medical assistance in private centers not agreed, and the one provided in hospitals, centers and other establishments of public entitlement integrated in the Health National System of Spain and/or dependent of Autonomous Communities. In any case, AME Asistencia Médica reserves the faculty to reclaim the Insured the regaining of the assistance expenses credited by the health public system, for the medical- surgical and hospital assistance provided.

24. Analysis and other explorations required for the certificates and reports issuing and any document provision with no clear assistance function.

25. In clinic psychiatrics and psychology, the consultations, diagnostic and therapy technics that do not follow the pharmacologic and neurobiological treatment standards, such as psychoanalysis, hypnosis or ambulatory narcolepsy, sophrology and sleep or resting cures. It is also excluded group or couple psychotherapy, psychological tests and psychometrics, psychosocial or neuropsychiatric rehabilitation, educational or cognitive behavioral therapy in oral and written communication disorders and the development form different origins.

26. Navigation system or Carto (3D) mapping or electro anatomic auricular cartography non-fluoroscopic of ablation by radiofrequency.

27. Crossing over therapy or corneal Cross-linking

28. Intracranial and tumor spinal surgery aided by 3D neuro navigators.

29. Surgical interventions derived from epilepsy or Parkinson.

30. Robotic surgery.

31. Laser treatments, except for the ones indicated in the coverages.

32. Obesity surgery and implantation/collocation of gastric balloon.

33. Medical surgical treatments of roncopathy or sleep obstructive apnea, radiotherapy treatments and/or modalities and its medical indications. In addition, it is also excluded proton therapy, neutron therapy, radiosurgery with Cyber knife, extracranial and/or adapted to respiration (4D) stereotaxic radiosurgery.

34. Speech therapy for speech, phonation and language disorders recovery, caused by anatomic, psychomotor or congenital neurological alterations of different origins.

35. Regenerative and Biological medicine, Immunotherapy, Biological therapies, Gene Therapy, as well as the applications of them all. In addition, there are excluded any kind of experimental treatments, the ones of compassionate use and the ones in clinical trial in all its phases or grades.

36. Endodontic, Periodontics and Orthodontic Dentistry, fissure sealants, dental fillings in people above 14 years old, reconstructions, dental prosthesis, apicectomies, implanthology and necessary diagnostic means to perform those treatments.

37. Prostate benignant hypertrophy surgery with laser (for example, green laser).

38. Genetic and molecular biological tests.

39. Expenses for using the phone, television, companion alimony in the clinic, travel and transfer expenses, except for ambulance service in terms contemplated in section Emergency Services of this General Conditions, as well as other services non-indispensable for the necessary hospital assistance.

40. Genetic counselling, paternity or family relationship tests, gene map procurement with preventive or predictive purpose, massive gene sequencing or molecular karyotype, Comparative Genomic Hybridization technics, microarray based platforms with automated result interpretation. As well as any other genetic and/or molecular biological technic requested with prognostic or diagnostic purpose if it can be obtained through other means or has no therapeutic impact.

41. Brachytherapy.

42. El DATSCAN - SPECT cerebral (Single Proton Emission Computed Tomography).

43. MR or NMR Spectroscopy of high resolution or field (3 Teslas).

44. All obstetrical process: it includes medical tests, childbirth and/or caesarean.

45. The rhizolysis kit and the lumbar facets (infiltration).

SIXTH CLAUSE.- CONTRACT PERFECTION AND INSURANCE DURATION

This contract has been agreed according to the statements made by the policyholder and the Insured in the previous Health Questionnaire, which have been taken into account by the Insurer to accept the risk and have been used to set the premium.
The insurance shall be stipulated during the period expected in the Particular Conditions. Expressly settles that there will be no extension to this agreement, and contract would be extinguished on the expiration date without the need to urge resolution for any of the parties.
During the care or treatment in hospital system of urgent nature of the insured and until the date that obtains the medical discharge at the hospital, the insurer may not cancel the policy, unless waiver of the insured to continue treatment.
The contract of the insurance and ther imodifications will have no effect while the policy is not signed and fully paid, unless provided otherwise convenant in the particular conditions.
Do not fit into this insurance, high or low of insured, except upon death of the insured.

SEVENTH CLAUSE.- PAYMENT OF PREMIUMS

The insurance Holder according to Article 14 of the Insurance Contract Act is obliged to the payment of the first premium or single premium in the moment of the contract acceptance, which will be made by cash payment unless another procedure is established in the Particular Conditions.
The premium only shall be payable, in accordance to the article 15 of the above-mentioned law, once the contract is signed; if it had not been paid by the policyholder, the insured has the right to terminated the contract or to demand the payment based on the policy. In any case, if the premium has not been paid until there is the damage, the insurer will be released from its obligation, except in opposite pact.
If the contract had not been resolved or terminated in accordance with the above conditions, coverage returns to have effect within 24 hours of the day in wich the policyholder paid the premium. The insurer is only obligated for the receipts issued by the direction for the legally authorized representative.
The payment of the amount of the premium made by the policyholder of the insurance to the broker not be made understood to the insurer, unless, in return, the broker deliver to the policyholder the receipt of the premium issued by the insurer.

EIGHTH CLAUSE.- OTHER OBLIGATIONS AND DUTIES OF THE HOLDER AND/OR INSURED

- The policyholder, or in its case the Insured, has the following obligations:

  - To declare the Insurer, according to the Health Questionnaire, that they must provide with veracity, diligence and with no reserve all the circumstances known by them that can influence the risk valuation. In that case, the Insured loses the right to the guaranteed provision and the Insurer reserves the right to terminate the contract within a month period since the knowledge of the non-compliance of the Insured/Holder’s obligations.

  - To communicate the Insurer, during the contract course as soon as possible, all the circumstance that according to the health questionnaire completed before the perfection of the contract may aggravate the risk and that in case of being known by the Insured, this one would not have agreed or would have concluded in more burdensome conditions for the Insured. In such circumstances, the Insured will be able to propose a modification of the contract conditions or terminate it if the Holder’s proposition is rejected.

  - To communicate the Insurer the Insured’s change of the usual profession or residence.

- If the change of domicile/residence or usual profession represents an aggravation of the risk, it will be applied the indicated in the second section above. If on the other hand it represents a decrease of the risk, it will be applied the indicated in the following second section.

- To communicate the Insurer, as soon as possible, all the Insured authorizations and cancellations produced during the validity of the present contract. Taking effect the authorizations the first day of the month following to the notification date effected by the insurance Holder, and the casualties at the end of the contract.

- To reduce the accident consequences, using all means within reach for the soon reestablishment. The non-compliance of this duty, with the manifest intention to damage or deceive the Insurer, will release the Insurer from any provision derived of the accident.

- To provide the subrogation that in the Insurer's favor the articles 43 and 82 of the Insurance Contract Act establish, in the rights and actions that because of the assistance provided and until the limit of the amount of the same one, can correspond to the Insured in front of other responsible people of the disease or accident, or in front of the people or entities that legally shall fulfil such assistance expenses.

- To credit to any facultative or health center in the Services Guide their Insured condition, submitting the Health Card. Equally, it will be necessary to show the Identity National Document or identifying official document (NIE, passport etc.)

- The Insurer shall be exempted from the provision payment in case the accident has been cause by Insured's bad faith.

NINTH CLAUSE.- HOLDER AND/OR INSURED FACULTIES

The policyholder will be able to claim the Insurer, within a month period since the policy delivery, the correction of the differences existing between the policy and the insurance proposition if there were or the agreed clauses, according to Article 8 of the Insurance Contract Act. Expired such period without the claim effected, it shall be applied the conditions of the policy.
The policyholder or Insured will be able, during the contract validity, to raise awareness in the Insurer all the circumstances that decrease the risk and being of such nature that if they were known by this one in the moment of the contract perfection, it would have been concluded in more favorable conditions for the Insured.

In such case, when the current period covered by the policy, the future premium amount shall be reduced in the corresponding proportion. The Holder has the right, unless otherwise agreed, to terminate the contract and to the refund of the difference between the fulfilled premium and the corresponding to pay, since the informing of the risk decreased.

THENTH CLAUSE.-OTHER OBLIGATIONS OF THE INSURER

Besides the insured assistance provision, the Insurer shall provide the Policy to the Holder or the provisional coverage document or the one corresponding, as well as a sample of the Health Questionnaire and other documents subscribed by the insurance Holder.
The Insurer will also provide to each Insured the Health Card, of personal and non-transferable use. In case of loss, subtraction or deterioration, the Holder and/or Insured has the duty of informing the Insurer within a 72 hours period. In such cases, the Insurer will proceed to issue and send a new card to the Insured's residence that appears in the policy, cancelling the one lost, subtracted or deteriorated.
Likewise, the policyholder and/or Insured are obliged to return the Insurer the corresponding card to the Insured cancelled in the Policy.

The Insurer will not be responsible for the improper or fraudulent use of the health card. Equally, the Insurer will deliver or provide the Holder the information in the Services Guide specifying the Permanent Emergency Center, with the addresses and schedules of the professionals' consultations, centers and agreed health services.

ELEVENTH CLAUSE.-INSURER'S FACULTIES

When the Insurer has knowledge of the reserve or inaccuracy of the data provided by the Holder or Insured in the Health Declaration or Questionnaire before the subscription to the Policy, will be able to terminate the contract through a digital declaration addressed to the Holder or in its case to the Insured within a month period since they have been informed.

If the accident occurs before the Insurer makes the declaration the previous section refers to, the provision will be proportionally reduced to the difference between the agreed premium and the one applied in case of knowing the real risk entity, unless the insurance Holder and the Insured had acted with malice or gross fault when declaring the risk, in which case they lose the right to the service provision.

In case of risk aggravation on an already concluded contract:

a. The Insurer is able to, within a two-month period starting from the day the risk aggravation is declared by the policyholder and/or Insured, propose a modification of the contract. In such case the insurance Holder disposes of 15 days starting from the day of this proposition reception to accept or reject it. In case of rejecting or silence on the part of the insurance Holder, the Insurer can, when such period has finished, terminate the contract with a previous warning to the insurance Holder, granting a new 15 days period to the Holder. When this second period has finished, within the following 8 days the definitive termination of the contract will be communicated to the policyholder.

b. The Insurer will also be able to terminate the contract by a written communication to the policyholder or in its case to the Insure within a month period starting from the day of the aggravation risk knowledge. In case the insurance Holder or Insured do not effect the risk aggravation declaration and an accident occurs, the Insurer is released from the provision if the policyholder and/or the Insured had acted with bad faith. In other case, , the Insurer's provision will be proportionally reduced to the difference between the agreed premium and the one that would have been applied in case of knowing the real nature of the risk.

TWELFTH CLAUSE.- NULLITY OF THE CONTRACT

The contract will be void, unless in the cases specified in the Insurance Contract Act, if in the moment of its formalization, an accident had already occurred and whose coverage is requested by the Insured/Holder.

THIRDTEENTH CLAUSE.- COMMUNICATIONS

Communications to the Insurer from the policyholder, Insured or Beneficiary will be made in the registered office indicated in the Policy. If the communications are made to the Agent that mediates the contract, those will have the same effects as if they were made directly to the Insurer.
Communications from the Insurer to the policyholder, Insured of Beneficiary, will be made in the domicile indicated in the Policy, unless a change of address is notified to the Insurer.
Communications made by an insurance Broker to the Insurer on behalf of the policyholder, will have the same effects as if they were made by the policyholder, unless otherwise agreed.

FOURTEENTH CLAUSE.- LEGISLATION, PRESCRIPTION AND COMPLAINT PROCEDURES

The Spanish Law will be applied to this contract.
Actions derived from this Insurance Contract prescribe after 5 years, this period being calculated from the day on which they were taken.
According to Law 44/2002 and the Order 734/2004 in which it is enacted, this company has a Department of Policyholder Service where the policyholder or a legitimate person will be able to make complaints and demands related to their interests and legally entitled rights, with registered office in Barcelona,
Calle Valencia no.106-108, ground floor.

Complaint procedures are:

a. Department of Policyholder Service: such department is located in the Insurance Entity offices, and has the complaints and demands submission form available for the Insureds and adapted to the legal requirements and functioning rules of the a Department of Policyholder Service.
b. Commission for the Defense of the Client in the Directorate-General of Insurance and Pension Funds: according to the procedure established by the consolidated text of the Private Insurance Supervisory Act and ECO/734/2004 Order, the claimant will be able to transfer the complaint or demand before the Commission for the Defense of the Client in the Directorate-General of Insurance, for which they shall certify that a two month period has passed since the claim presentation before the Department of Policyholder Service, being the complaint not solved or denied or dismissed its admission, totally or partially. This channel cannot be used if the administrative, judicial or arbitral channel has been appealed.
c. Barcelona Arbitration Court: for the decision of all disputes derived from the present Contract parties will be able to undertake institutional arbitration of the Barcelona Arbitration Court, delegated to the same one the arbitrator appointment and the arbitration administration. They are obliged to abide by the arbitration decision.
d. Ordinary Jurisdiction: The Insured can also go to the Court of Justice submitting to the same ones the produced claim, being the judge competent for the knowledge of actions derived from the same one in the Insured's domicile, no contrary agreement possible.

FIFTEENTH CLAUSE.-PERSONAL DATA TREATMENT, TRANSFER AND PROTECTION

The Entity will be able to modify or reduce annually the guarantees and provision taking into consideration the Royal Legislative Decree 6/2004, October 29, approving the restated text of the Private Insurance Supervisory Act, according to the technical actuarial calculations and in basis of the assistance, services and guaranteed capital costs modifications and necessary incorporation technological innovations.
According to Spanish governing law 15/1999 on Personal Data Protection, the Insurer is obliged to hold the personal data provided by the policyholder and/or Insured confidentially.

The Holder/Insured expressly consents:

a. The personal data provided, as well as any other data that may be provided during the contract duration, included in both cases health data (included in a data file, computerized or not) whose responsible is AME ASISTENCIA MÉDICA Compañía de Seguros S.S., (from now on, AME), single recipient of the data, unless in the assumption of the planned cessions in the present clause, with the aim to perform the contractual relationship, for the self-management of the Insurance Company activity, fraud prevention and investigation, customers loyalty campaigns development, as well as for evaluating and delimiting the risk. Likewise, they consent their data (included health data) treatment by other Insurance and reinsurance entities, or other medical centers and professionals of medicine that, because of reinsurance, coinsurance or accident management operation reasons, to intervene in the policy and its accidents management.

b. That AME can request health professionals and medical centers (public and private), information related to the Insureds' health and assistance procedures, with the purpose of the policy's right risk valuing, policy coverage verification, accidents justification, authorization study for the services that require it, fraud prevention and investigation, demands attention, services payment from the Insured to such health professionals and medical centers and the compliance of the obligations derived from AME under the insurance contract. The present authorization shall also extend to the professionals and medical centers which require medical information to proceed to the referral to AME, only in accordance with the present clause. Personal data (included health data) received by AME from such professionals and medical centers will be treated according to the statements in the present clause, being included in a file, AME's responsibility, with the purposes indicated in the present paragraph.

c. The international transfer of Insured's data (included health data), even to countries that do not provide a protection level comparable to the Spanish data protection regulations, when it is precise for the fulfillment of the purposes indicated in the present clause.

d. Insureds/Beneficiaries/Holders are not informed on the part of AME of every first data transfer that may be produced, according to the statements indicated in the present clause.

e. The recording of telephone calls made to AME's contact telephone numbers, for the control of the quality of the service and demands management.

Data of the insurance contract and accidents linked to it, may be transferred to joint files for claims settlements, according to Article 25 of the Royal Legislative Decree 6/2004, October 29, and Spanish governing law 15/1999, December 13.
The policyholder, after informing about the full contents in the present clause to the Insureds/Beneficiaries, under the same terms the Holder has been informed, is fully committed to obtain the express consent of the Insureds/Beneficiaries that are going to be included in the policy:

a. To provide their personal data to AME, for the performance of the data treatments planned in the present clause.

b. So on AME's part, an extract where the used services by the Insured are indicated, can be remitted to the Holder together with the franchises amount that may correspond, so it is able to proceed to the franchise payment or participation in the received services costs.

The Holder, in case any change is made in the data provided to AME for their further procession in accordance with the present clause, will notify it to AME so the entity proceeds to such modification.

All refinished data, as well as the previous ones and transfers, are indispensable for the establishment and development of the contractual relationship.

The Holder/Insured authorizes AME to remit information, even through electronic means, about products or services related to financial services or products, about insurances, telecommunications, home, health and assistance or developers.

The data holder will be able to exercise the access rights, rectification, cancelation or opposition. They should contact AME ASISTENCIA MÉDICA Compañía de Seguros S.A., C/Valencia, 106-108, ground floor. 08015, Barcelona.

SIXTEENTH CLAUSE .- AREA OF HEALTH INSURANCE

Guarantees of the present contract extend, according to the statements in the General Conditions, to all the national territory.

SEVENTEENTH CLAUSE.- EXEMPTION OF LIABILITY

Health professionals, centers and services authorized that the Entity provides to the Insured/Holder and whose assistance is requested, enjoy full autonomy, independence and responsibility in the health assistance provision.

Consequentially, AME, in no case, will respond for acts and/or omissions of health professionals, centers and services mentioned above, being the relationship between them and the Insureds totally unrelated to AME.

The policyholder, to the effects stipulated in Article 3.º of the Law of Insurance Contracts, recognizes having received a copy of the present General Conditions and Appendix of the contract, accepting them by means of his signature and expressly states his full acceptance of the limiting and delimiting clauses included within, and especially, the exclusions of coverage that have been specially highlighted and separately and the content of which is known and understood by its reading.

policyholder Insured/s

AME ASISTENCIA MÉDICA COMPAÑÍA DE SEGUROS, S.A.
Management

C/Valencia, 106 - 108 Bajos
08015 Barcelona

ame@ameasistencia.com

www.ameasistencia.com