PLA COMPENSA

General Conditions

ASISTENCIA SANITARIA COLEGIAL, SOCIEDAD ANÓNIMA DE SEGUROS

Registered offices: Av. Josep Tarradellas, 123-127, ground floor
08029 Barcelona
Telephone 93 495 44 44

SUBSCRIBED CAPITAL: 2,107,000 EUROS PAID-IN
CAPITAL: 2,107,000 EUROS

ALL ASSETS AND RIGHTS LOCATED IN MEMBER STATES OF THE EUROPEAN ECONOMIC AREA

Member State of the European Economic Area Originating and Providing Services: SPAIN

CONTROLLING AUTHORITY: GENERAL DIRECTORATE OF INSURANCE AND PENSION FUNDS OF THE MINISTRY OF ECONOMY AND TREASURY
REGISTRATION NUMBER C-416

ASSISTÈNCIA SANITÀRIA INSURANCE WITH SHARED COST OF SERVICES USED BY THE INSURED PERSON AND FREE CHOICE OF DOCTOR

COPAYMENT HEALTHCARE INSURANCE

COMPLETE SERVICE POLICY WITH LOCAL CHILDCARE AND PAEDIATRICS

Barcelona Mercantile Register volume 1063, folio 142, book 546, corporate section, C.I.F. A 08169526

GENERAL CONDITIONS

CLAUSE ONE: APPLICABLE LAW

This insurance contract is subject to the following rules:

1. Governing regulations

A. In matters ruling the insurance:

Law 20/2015, of 14 July, on Regulation, Supervision and Solvency of Insurance and Reinsurance Companies.

Royal Decree 1060/2015, of 20 November, on Regulation, Supervision and Solvency of Insurance and Reinsurance Companies.

And all other current and complementary provisions in terms of organisation and supervision.

B. In matters of subscribing to private insurance:

Law 50/1980 of 8 October, on Insurance Contracts, hereinafter **the Law**, and related legal amendments.

C. In matters of mediation:

Directive (EU) 2016/97 of the European Parliament and of the Council of 20 January 2016 on insurance distribution and its national transposition regulations.

D. In matters of personal data:

Regulation (EU) 2016/679 of the European Parliament and of the Council, of 27 April 2016, on the protection of natural persons with regard to the processing of personal data and on the free movement of such data.

Organic Act 3/2018, of 5 December on Personal Data Protection and Guarantee of Digital Rights.

2. **Contractual rules**

According to what has been agreed in the **General and Particular Conditions** of this Contract and **Article 3 of the Law**, clauses limiting the rights of insured persons and not specifically accepted in writing by them as an additional agreement to the **Particular Conditions** are not valid. Mere transcriptions or references to legal precepts or governing regulations do not require acceptance.

Article 2 of the Law declares valid those contractual clauses that differ from the legal ones and that are more beneficial to the INSURED PERSON.

CLAUSE TWO: DEFINITIONS

For the purposes of this Contract, the following definitions hold:

1. **INSURER**: **ASISTENCIA SANITARIA COLEGIAL, SA DE SEGUROS**, which, by charging the **PREMIUM**, assumes the risk contractually agreed.

2. **POLICYHOLDER**: The natural or legal person who, together with the INSURER, subscribes the Insurance Contract and who is responsible for the obligations arising from it unless by their nature they are to be fulfilled by the INSURED PERSON.

3. **INSURED PERSON**: Each of the natural persons designated in the **Particular Conditions** who are covered by the Insurance and who, in the absence of the POLICYHOLDER, assume the obligations arising from the

Contract.

4. **POLICY**: The document containing the conditions regulating the insurance. The Policy consists of: the **General Conditions**; the **Particular Conditions**, which cover individual risks; **the Special Conditions**, if applicable, and the **Supplements** or **Annexes** issued to complement or modify it.

5. **WAITING PERIOD**: The time that must pass between the date the insurance comes into force and the date the guarantees contained in it begin to take effect, during which the INSURED PERSON is not entitled to benefits arising from the insurance.

6. **PREMIUM**: The cost of the insurance. It also includes the surcharges and taxes applicable at any moment.

7. **RISK**: The health of the INSURED PERSON and his/her healthcare in the event of illness, within the agreed limits.

8. **INTEREST**: That of the INSURED PERSON, in avoiding the economic damage resulting from paying for the services arising from the health risk within the agreed limits.

9. **LOSS**: An occurrence foreseen in the Contract, whose risk is the object of cover and which, having occurred, gives rise to healthcare benefits by the INSURER, while the POLICYHOLDER is responsible for the amount due in COPAYMENT.

10. **SERVICE**: Each of the benefits in which medical or surgical care materialises, whose risk is assumed by the INSURER and that are described in the **General** or **Particular Conditions.**

11. **ILLNESS**: Physiological alteration manifested in characteristic symptoms, diagnosed and confirmed by a doctor.

    All injuries and sequels arising from the same loss and all disorders due to the same or related causes will be considered a single illness.
    If a disorder is due to the same cause that led to a previous illness, or to related causes, including sequels and after-effects and complications arising from the previous illness, the illness will be considered a continuation of the earlier one and not a separate illness.

12. **PRE-EXISTING ILLNESS**: An illness already diagnosed or treated; which had been cause for medical consultation or which produced the first symptoms before the date the Contract came into force.

13. **ACCIDENT**: Bodily injury arising from a sudden, external, violent cause against the wishes of the INSURED PERSON.

14. **HOSPITAL**: Public or private establishment legally authorised to treat illnesses or bodily injuries, equipped with material and human resources for making diagnoses or carrying out surgical operations and attended by doctors and healthcare staff 24 hours a day.

    Old people's homes, nursing homes, rest homes, spas and facilities for the treatment of old people, long-term patients, handicapped people, drug addicts and alcoholics are not considered hospitals.

15. **HOSPITALISATION**: Situation in which someone is registered as a patient at a hospital and is admitted there for more than 24 hours or as an outpatient.

16. **EMERGENCY**: A condition that cannot wait for attention from the INSURER'S normal services since it could result in a commitment for life or irreparable damage to the physical integrity of the patient.

17. **COPAYMENT**: A fixed amount the POLICYHOLDER and/or INSURED PERSON must pay the INSURER for use by the INSURED PERSONS of certain services laid out in Annexe I, Description of Services.

18. **EXEMPTION**: Limitation of cover of the risk assumed by the INSURER.

19. **MAXIMUM COPAYMENT LIMIT**: The maximum annual amount the COPAYMENT of each INSURED PERSON can reach, for each exemption.
The annual payment is calculated by calendar year and the service is reckoned on the date it was effectively made.

20. **DURABLE MEDIUM**: One allowing the Insurance Contract and any other information relating to the insurance itself to be stored, easily recovered and reproduced without changes, either on paper or on any other inalterable means.

CLAUSE THREE: OBJECT OF THE INSURANCE

Within the limits and conditions stipulated in the Insurance Contract formalised in this Policy and by payment of the PREMIUM and, if applicable, the corresponding COPAYMENT, the INSURER undertakes to provide the INSURED PERSON the medical and/or surgical and hospital attention for illness or injury of any type included in the specialities and forms appearing in Annexe I, Description of the Services and in the remaining Annexes or Supplements.

In all events, as foreseen under **Article 103 of the Law**, the INSURER assumes responsibility for any urgent care that is needed, in accordance with the provisions of the Contract and, in the case of non-partner facilities, provided that the authorization of the INSURER is requested within seventy two hours following the admission to the hospital institution or at the beginning of the provision of the healthcare service.

In no case can optional compensations in cash be granted in place of the healthcare services provided.

CLAUSE FOUR: DESCRIPTION OF THE COVER

The cover under this Contract is described in the **Annexes** and **Supplements** attached to this Policy.
Annexe I lists those healthcare services subject to **COPAYMENT** and the amount payable by the POLICYHOLDER and/or INSURED PERSON.

The INSURER will issue the INSURED PERSON with the 'List of physicians' which, as well as the list of doctors and specialists, includes emergency services, nursing services, organisations authorised to provide care services, hospitals to be used in the Barcelona province and an extract of the regulations for use of the services subscribed. Similarly, the INSURER will issue the national network of partners providing healthcare all over Spain.

CLAUSE FIVE: EXCLUSIONS

The following are excluded from cover under this Insurance:

I. The risks described below:

1. ***Illnesses, injuries or physical defects already existing at the time of subscribing the insurance (including consequences and side effects), unless declared in the 'Health Questionnaire' and expressly agreed by the INSURER.***

2. ***Officially declared epidemics.***

3. ***Accidents caused by the following natural phenomena: earthquakes, underwater earthquakes, abnormal flooding, volcanic eruption, atypical cyclonic storms and falling space objects and meteorites.***

4. ***Those produced by abnormal violent events such as terrorism, rebellion, sedition, mutiny and social disturbance or armed conflict, whether or not there is an official declaration of war.***

5. ***Those arising from the deeds or actions of the Armed Forces and Security Bodies in peacetime.***

6. ***In general, risks of an unusual nature whose coverage corresponds the Insurance Compensation Consortium (Consorcio de Compensación de Seguros), in accordance with its legal statute.***

7. ***Those bearing a direct or indirect relationship with nuclear or radioactive facilities covered by the Nuclear Risk Insurance.***

8. ***In all cases of hospitalisation, expenses incurred in the use of telephones, televisions or other non-essential services for the necessary hospital care are excluded.***

9. ***Healthcare for pathologies caused by the INSURED PERSON's involvement in high-risk professional or sporting activities, either as a professional or as an amateur, such as: underground, underwater or aerial activities, motor vehicles, boats, boxing, bullfighting, equestrianism, horse riding, etc., and anything else of the same sort.***

II. The following health services:

1. ***Aesthetic surgery and treatments, their after-effects and surgery and treatment as a consequence of either.***

2. ***Analyses and other tests necessary for issuing certificates, reports or any type of medical document without a clear caring function.***

3. ***Diagnostic means and treatment techniques that are not common practice in the public health system.***

4. ***Dental fillings and prostheses, orthodontic treatment, root canal treatment and dental implants, as well as tests prior to undergoing these treatments.***

5. ***Psychoanalysis, hypnosis, individual or group psychotherapy, psychological tests, sophrology, outpatient narcolepsy and treatment for drug addiction or alcoholism.***

6. ***Maintenance and occupational physiotherapy and rehabilitation for chronic illnesses when injuries have stabilised.***

7. ***Orthotics and orthopaedic and anatomical products.***

8. ***Stays in old people's homes, rest cures, treatments in spas, even when prescribed by a physician, and admission to hospital as a result of dietary treatments for losing or gaining weight.***

9. ***Hospitalisation for problems of a social or family nature, or when it can be replaced by home or out-patient care.***

10. ***Medical check-ups or health tests.***

11. ***Alternative therapies such as homoeopathy and acupuncture.***

12. ***Experimental surgery and treatments not recognised by medical science.***

13. ***Excluding cosmetic dermatology.***

14. ***Excluding refractive surgery.***

15. ***Medical attention provided as part of disciplines that are not included in the list of official specialities in force and published by the Ministries of Education and Health.***
16. ***Regenerative medicine, biological medicine. Treatments with immunotherapy or gene therapy.***

III. Services excluded unless expressly included in the **Particular Conditions**:

1. ***Healthcare required by treatment for occupational accidents or professional illness according to the applicable legislation.***

2. ***Healthcare for personal injury, in the case of compulsory insurance under the consolidated text of the Law on Civil Liability and Motor Vehicle Insurance.***

3. ***Preventive medicine.***

4. ***Diagnosis and treatment for sterility, family planning and assisted reproduction techniques.***

5. ***Internal, skeleton and cardiovascular prostheses; osteosynthesis material and intraocular lenses.***

6. ***Transplantation of organs, tissues and haematopoietic precursors.***

7. ***Tests for early detection of congenital illnesses, except for those described in Annexe I, under Description of Services and in other Annexes and Supplements.***

8. ***Genetic counselling.***

9. ***Medication for patients not in hospital.***

10. ***Medication for out-patient or day hospital cancer treatments.***

11. ***In cancer treatments:***

    - ***Radiotherapy, linear accelerator and radiosurgery.***
    - ***Antineoplastic chemotherapy in hospitalised patients.***
    - ***Palliative cure home service.***

12. ***CPAP therapy at home.***

13. ***The following are excluded in all cases of hospital admission:***

    - ***Expenses arising from check-ups or preventive treatments.***
    - ***Full board for the accompanying person.***

14. ***Physiotherapy service with a trained physiotherapist.***

15. ***In rehabilitation and functional recovery, conditions requiring educational therapy, such as language education in congenital conditions or special education in patients with psychiatric effects, are not included.***

16. ***Chiropodist.***

17. ***Ambulance.***

18. ***Haemodialysis, artificial kidney and peritoneal dialysis.***

19. ***The Policy cover does not include new complementary diagnostic or therapeutic techniques appearing in the medical care offer unless expressly mentioned.***

CLAUSE SIX: WAITING PERIOD

All the services covered by this Policy will be attended from the moment the Contract comes into force, **except for those services whose waiting periods appear below:**

SIX MONTHS for:

- ***Surgical interventions and hospitalisation for any reason or of any nature.***
- ***Special diagnostic techniques.***
- ***Special therapeutic techniques.***
- ***Blood and plasma bank.***
- ***Oxygen therapy.***
- ***Renal lithotripsy.***
- ***Early detection of breast cancer by mammography.***
- ***Invasive prenatal diagnosis techniques (amniocentesis, etc.).***
- ***Maternal education and preparation for childbirth.***
- ***Children's speech therapy.***
- ***Phoniatric treatment.***

EIGHT MONTHS for:

- ***Assistance at childbirth.***

Cases of **EMERGENCY** medical and/or surgical admission to hospital, premature birth, **EMERGENCY** labour dystocia will in all cases be covered without considering possible waiting periods according to what has been agreed in the **General** and **Particular Conditions** of this Contract.

CLAUSE SEVEN: PROVISION AND USE OF THE SERVICES

Care will be provided in accordance with the principles and rules described below:
Exercise of the rights guaranteed by the Contract is personal and non-transferable.

1. It is agreed that the INSURED PERSONS covered by this Contract shall have free choice of any doctor included in the INSURER's 'List of physicians'.

2. Once the Contract has been subscribed, the INSURER will issue the INSURED PERSON with a card accrediting his/her condition. This card must be signed by the owner and shown when using the services, along with the national identity card for those required to have one, if requested.

3. The INSURED PERSON card is the means of providing evidence of the status as such and of recording the acts carried out.
   The INSURED PERSON must sign the receipt for the service received and will be given a copy for his/her records.

4. For each service included in Annexe I subject to COPAYMENT, the POLICYHOLDER and/or the INSURED PERSON will pay the amount established in the Particular Conditions up to the established annual limit. The INSURER will issue a monthly balance which he/she will send to the POLICYHOLDER and/or the INSURED PERSON, listing the services used by the INSURED PERSON and showing the corresponding amounts. Payment will be made by banker's order from the account designated by the POLICYHOLDER for paying the PREMIUM.

5. The amount of the COPAYMENT is established in the Particular Conditions for this Contract. It can be reviewed simply by notification on the part of the INSURER's management bodies. This notification will be included in the Particular Conditions to modify the initial conditions.

6. The care services covered by this Contract will be provided solely in the province of Barcelona by the professionals, authorised organisations and hospitals appearing in the INSURER's 'List of physicians', in the surgeries indicated.

7. The INSURER undertakes to provide home services only at the domicile appearing in the Policy. Any change of address on the part of the INSURED PERSON must be notified in writing as soon as possible.

8. The INSURER undertakes to provide healthcare for the INSURED PERSON travelling in any province in the national territory, both in the provincial capital and in those towns where there are partner facilities, according to the list appearing in the national network of partner organisations

9. Family doctors and paediatricians may be freely chosen by the INSURED PERSON out of those making up the 'List of physicians'. Home visits will only be made when, for reasons depending only on the INSURED PERSON's illness, the INSURED PERSON can not travel to the doctor's surgery.

10. The INSURED PERSON may, by appointment, visit the chosen specialist's surgery, ***except for those specialities which by their very nature require a written request from one of the INSURER's doctors and/or prior written authorisation from the INSURER, in keeping with the regulations in the 'List of physicians'***.

11. ***All the healthcare services covered by this Contract are subject to their suitability based on medical criteria (protocols and guides to clinical practice) founded on scientific evidence and in relation to their benefit for diagnosis, monitoring and/or treatment of the pathologies***.

    As well as the written request from the doctor on the 'List of physicians', some special services also require authorisation from the INSURER's administrative services.

12. In any event, the INSURER reserves the right to modify the administrative procedures and the criteria for authorisation of services for the sake of greater efficiency and equity in the cover provided, taking scientific progress into account.

13. Hospitalisation must be ordered by a doctor on the INSURER's 'List of physicians' in a written instruction giving the reason for the admission, intervention or treatment and the number of stays foreseen. This instruction must be presented at the offices of the INSURER for the corresponding authorisation.

    The INSURER will issue confirmation unless he/she considers that the service is not covered by the Contract. Confirmation is economically binding on the INSURER.
    Despite the provisions of the preceding paragraph, in emergency cases the instruction by the doctor on the INSURER's 'List of physicians' is sufficient, ***although the INSURED PERSON must request the authorisation of the INSURER within seventy two hours following the admission to the hospital institution or at the beginning of the provision of the healthcare service to be able to benefit from the cover.***

    In these emergency cases, the INSURER is economically bound until he/she expresses his/her objections to the doctor's instruction on the grounds that the Contract does not cover hospitalisation.

    The INSURER will not be responsible for hospitalisation expenses at non-partner facilities.

    In no case will problems of a social nature (difficulties for family attention at home, etc.) be accepted as a cause for hospitalisation. The length of time a patient stays in hospital depends entirely on the criterion of the doctor on the INSURER's 'List of physicians', who may indicate and/or continue treatment at the INSURED PERSON's home, according to his professional criterion**.**

    When a patient, on admission to hospital, decides to use a room with a higher cost than that provided by the INSURER, he/she will be responsible for paying the difference resulting from this decision.

    Once the INSURER's physician has ordered the patient's discharge from hospital, ***if the INSURED PERSON decides to extend the number of days in hospital, the expenses arising after the discharge will be excluded from the cover in the Contract.***

14. In case of emergency, the INSURED PERSON must request services from or visit the Permanent Emergency Centre or Centres established by the INSURER, whose telephone number and address appears in the 'List of physicians' issued to the INSURED PERSON.

15. ***The INSURER will not be responsible for the cost of any healthcare service if he/she has not previously authorised it*** and always as a consequence of a written indication from a doctor on the INSURER's 'List of physicians'. This does not include emergency services, ***so long as they are submitted for authorisation by the INSURER within seventy-two hours*** **from the date they initiated**. These emergencies must therefore be justified before the INSURER within the deadline indicated. ***Once this time has elapsed, no claims against the INSURER will be accepted.***

16. Any of the INSURER's physicians may charge the fees due for issuing certificates, reports and any other kind of professional document without a clear healthcare function.

17. ***The INSURER will not be responsible for medical fees for anyone not included in the 'List of physicians' or for any healthcare service requested by them***.

18. The valid 'List of physicians' will be the last revised and updated version available to the INSURED PERSON. In view of the complexity of the services and the number of the INSURER's physicians, the details of the list may vary, for which reason we recommend that in case of eventuality you consult the INSURER or his/her web site: www.asc.cat.

CLAUSE EIGHT: TERMS OF THE CONTRACT

1. The application and the 'Health Questionnaire' filled in by the POLICYHOLDER and/or the INSURED PERSON, as well as the proposal by the INSURER, if applicable, together with this Policy and the corresponding **Annexes** and **Supplements**, form a single whole, the terms of the insurance which only comprises, within the limits and conditions stipulated, the risks described therein.

2. This Contract has been agreed on the basis of the statements made by the POLICYHOLDER and/or INSURED PERSON in the 'Health Questionnaire' completed by the INSURED PERSON, as a result of which the INSURER has accepted the risk, the obligations arising from the Contract and the amount established as the PREMIUM.

3. The INSURER may rescind the Contract by means of a statement addressed to the POLICYHOLDER and/or INSURED PERSON, in the space of one month from knowing of information withheld or misrepresentation by the POLICYHOLDER and/or INSURED PERSON, as foreseen in **Article 10 of the Law.**

   When the withholding or misrepresentation responds to fraud or gross negligence on the part of the POLICYHOLDER and/or INSURED PERSON, the INSURER will be freed from any obligation under this Contract, according to the provisions of **Article 10 of the Law.**

4. Should the content of this Policy differ from the insurance proposal, if there is one, or from the agreed clauses, the POLICYHOLDER and/or INSURED PERSON may call on the INSURER, in the space of one month from the date of issue of the Policy, to solve the discrepancy. At the end of this time, if the request has not been made, the provisions of the Policy will prevail, in accordance with **Article 8 of the Law.**

CLAUSE NINE: RIGHTS OF THE POLICYHOLDER AND, IF APPLICABLE, THE INSURED PERSON

1. These are detailed in **ANNEXE I 'DESCRIPTION OF SERVICES'**, in Clause **SEVEN: PROVISION AND USE OF THE SERVICES** and in the **Particular Conditions**.

2. The INSURED PERSON has the right to confidentiality in all the information the INSURER may have access to in relation to his/her state of health or illness or his/her treatment and stays in the INSURER's partner health facilities.

   His/her personal data will be guaranteed and protected by the INSURER as the responsible party for treating these data, in accordance with the object of this Contract.

3. The POLICYHOLDER and/or the INSURED PERSON may present complaints to the INSURER with relation to their legally recognised rights and interests arising from this Contract, from the regulations on transparency and protection of the insured person or from good practices and customs in matters of insurance, especially from the principle of contractual equity. The procedure for complaints is as follows:

3.1. Internal complaints: These will be settled by the INSURER's Customer Services, with registered offices at Avinguda Josep Tarradellas, no. 123-127, ground floor, Barcelona 08029, and e-mail: atencioalclient@asc.cat.

The INSURER has the obligation to settle complaints and claims in the term established by law, in accordance with the procedure detailed in the Customer Service Regulations. A copy of these regulations can be consulted at the offices of the INSURER and on its website: www.asc.cat.

3.2. External complaints: In the event of dissatisfaction with the settlement by the Customer Service, the POLICYHOLDER and/or INSURED PERSON may resort to the Complaints Service of the Directorate General of Insurance and Pension Funds located at Paseo de la Castellana, 44, Madrid 28046 or in virtual office: www.dgsfp.mineco.es.

The rules on transparency and protection of the insured person appear under:

- Law 44/2002, of 22 November, on Measures to Reform the Financial System.
- Order ECC/2502/2012, of 16 November, regulating the procedure for submitting complaints before the complaints services of the Bank of Spain, the National Securities Market Commission and the General Directorate of Insurance and Pension Funds.
- Order ECO/734/2004, of 11 March, on Customer Services and Departments and the Financial Ombudsman.

3.3. At all events, conflicts between the POLICYHOLDER and/or INSURED PERSON and the INSURER will be settled by the competent courts and tribunals.

In accordance with **Article 24 of the Law**, "*The competent judge for hearing the events arising from the Insurance Contract will be the one at the domicile corresponding to the insured person and any agreement to the contrary will be null and void*".

4. In the event of a Contract with more than one insured person, each INSURED PERSON included, in case of marriage, may preserve all the rights acquired and his/her continuity benefits if he/she formalises a new Insurance Contract within one month of the marriage. After this time, he/she will lose all his/her acquired rights.

   If the new Contract provides services not included in the original one that are subject to waiting periods for their use, these periods will be respected as though it were a new admission.

5. In the event of childbirth, the INSURED PERSON will have thirty days in which to apply for the child to be insured. Registration will take effect on the first day of the month of birth. In this case no waiting periods longer than those remaining for the father and/or mother will be applied and the situation chosen will be the one that best favours the child.

   At all events, the INSURER guarantees that the child's registration will be accepted during this thirty-day period, even if it has a congenital illness or malformation. Once this time has passed, the INSURED PERSON will be deemed to have waived this right and the INSURER will not be responsible for the healthcare occasionally given to the new-born.

CLAUSE TEN: OBLIGATIONS AND DUTIES OF THE POLICYHOLDER AND, IF APPLICABLE, INSURED PERSON

1. Payment of the PREMIUM:

a) Date of payment: The POLICYHOLDER, in accordance with **Article 14 of the Law**, is obliged to pay the PREMIUM once he/she has signed the Contract.

The POLICYHOLDER is responsible for paying any taxes or surcharges incurred by law jointly with the PREMIUM.

b) Uniqueness: The PREMIUM is **a single amount** and corresponds to the total duration of the Contract. The PREMIUM is payable in full on the first day of currency of the Contract without prejudice to the Particular Conditions allowing payment to be divided up into separate, non-cancelling instalments.

c) Place of payment: If the **Particular Conditions** do not establish where the PREMIUM is to be paid, it will be understood to be payable at the domicile corresponding to the POLICYHOLDER, as foreseen in **Article 14 of the Law**.

d) Consequences of non-payment of the initial PREMIUM: If the initial PREMIUM has not been paid on the date due through the fault of the POLICYHOLDER and/or the INSURED PERSON, the INSURER has the right to cancel the Contract or require the payment of the overdue PREMIUM by means of an enforcement procedure, in accordance with **Article 15 of the Law**, according to the terms of the Policy.

At all events, if the PREMIUM has not been paid before a loss takes place, the INSURER is released from his/her obligation.

e) Consequences of non-payment of successive PREMIUMS: In the event of non-payment of the second and subsequent PREMIUMS, insurance cover is suspended one month after the date due. If the INSURER does not claim the payment within six months of the date the PREMIUM is due, the contract is deemed to have terminated, in accordance with **Article 15 of the Law**. Said termination does not preclude the demand for payment of the PREMIUM in the space of five years foreseen in **Article 23 of the Law**.

If the Contract has not been terminated in conformity with the preceding paragraphs, cover will be resumed **TWENTY-FOUR HOURS** after the date the POLICYHOLDER or the INSURED PERSON pays the outstanding PREMIUM. At all events, if the Contract is suspended, the INSURER may only demand payment of the corresponding PREMIUM for the current period, in accordance with **Article 15 of the Law**.

f) If periodical premiums have been agreed in the **Particular Conditions**, non-payment of any instalment incur cancellation of the remaining premiums for the current period and the same consequences described in the two preceding paragraphs.

Any payment will necessarily be allocated to the earliest unpaid instalment of the PREMIUM.

g) PREMIUM payment receipt: The INSURER is only bound by those receipts issued by management or by its legally authorised representatives.

h) Direct debit payment: If PREMIUM payments by direct debit are agreed, the following rules shall apply:

The INSURER may require the POLICYHOLDER and/or the INSURED PERSON the delivery of an express authorisation of the corresponding payment operations.

The PREMIUM or instalments thereof shall be considered paid on expiry, unless, having tried to collect within the grace period of one month foreseen in **Article 15 of the Law**, it cannot be charged to the account of the POLICYHOLDER and/or INSURED PERSON for whatever circumstances attributable or not to him/her. In this case, the INSURER must notify him/her by post that payment is due at the domicile corresponding to the INSURER and that he/she is obliged to satisfy the PREMIUM at this domicile.

If the INSURER lets one month go by from the date due without submitting the bill for payment and, on doing so, payment of the PREMIUM is not made for whatever reason, the INSURER must notify this fact to the person

obliged to pay via **registered** letter or other reliable means, and grant a further period of one month in which to satisfy payment at the INSURER's registered address, branch or agency. This period must be counted from the date of the registered letter or notification to the last postal and/or email address reported to the INSURER.

2. Making COPAYMENT: The POLICYHOLDER and/or INSURED PERSON is obliged to make the COPAYMENT indicated in the Particular Conditions, until the total reaches the annual limit established for each INSURED PERSON, for each calendar year the Contract is in force.

   COPAYMENT will be subject to the same conditions and non-payment to the same consequences indicated for the PREMIUM in the previous section.

3. Declare to the INSURER, in keeping with the 'Health Questionnaire' required of him/her, all the circumstances known to him/her that could influence the risk assessment.

   He/she is not obliged to declare these circumstances if the INSURER does not ask him/her to complete the 'Health Questionnaire' or if they are not included in it, even though they could influence the risk assessment, in accordance with **Article 10 of the Law**.

4. Inform the INSURER, during currency of the Contract and as soon as possible, of any circumstances which, in accordance with the 'Health Questionnaire' presented by the INSURER before conclusion of the Contract, aggravate the risk and could be of such a nature that if the INSURER had known of them at the time the Contract was drawn up he/she would not have entered into it or would have concluded it under more onerous conditions, as foreseen in **Article 11 of the Law**.

   In these cases, the INSURER may modify or rescind the Contract in accordance with **Article 12 of the Law**. The POLICYHOLDER, during the life of the Contract, may also inform of circumstances that reduce the risk. In this case, the provisions of **Article 13 of the Law** shall apply.

5. Inform the INSURER as soon as possible of any change of postal and/or email address.

6. Minimise the consequences of the loss using all available means to bring about a rapid recovery. Failure to comply with this requirement with clear intention to prejudice or deceive will absolve the INSURER of any obligations arising from the loss in application of **Article 17 of the Law**.

7. Having attended to the costs of the loss, the INSURER is **subrogated** to this amount in the rights and actions corresponding to the INSURED PERSON before liable third parties in those cases where this is necessary, as established in **Articles 43** and **82 of the Law**.

   The INSURED PERSON may not **prejudice** this **right** of the INSURER and is responsible for the **damage** his/her acts or omissions may cause the INSURER in their **right** of subrogation.

   The INSURER may not execute the **right** of subrogation in detriment of the INSURED PERSON.

   Should the INSURER and the INSURED PERSON act together against a liable third party, the repayment obtained will be divided between them in proportion to their respective interests, in accordance with the provisions of **Articles 43 and 82 of the Law.**

CLAUSE ELEVEN: OBLIGATIONS OF THE INSURER

1. The INSURER undertakes to provide the healthcare subscribed and provide cover for insured risks in accordance with the **General** and **Particular Conditions** of the Contract.

   In services subject to COPAYMENT the INSURER's obligations arise as from the amount established for them in the Particular Conditions. Once the maximum annual limit established for each INSURED PERSON has been covered, the INSURER's obligation arises, with full cover, from the moment the loss occurs.

2. The INSURER must provide the POLICYHOLDER with the Policy or, if applicable, the provisional cover document or the corresponding document according to **Article 5 of the Law** and other documents subscribed to by the POLICYHOLDER.

3. Similarly, the INSURER must issue the POLICYHOLDER and/or INSURED PERSON with a document accrediting this condition, the 'List of physicians' and the national network of partner organisations mentioned in Clause **FOUR**.

4. The INSURER undertakes to preserve total confidentiality of data obtained referring to the health of the INSURED PERSON and, as the person responsible for their treatment, to take the necessary measures to guarantee their security, avoiding their alteration or loss as well as access to them or unauthorised treatment.

   In addition, the INSURER guarantees the INSURED PERSON's exercise of right of access and rectification, erasure or cancellation, objection, restriction of processing and portability as laid down in Regulation (EU) 2016/679 of the European Parliament and Organic Act 3/2018, of 5 December on Personal Data Protection and Guarantee of Digital Rights.

   In all cases, since personal data and health details are necessary to maintain and fulfil the Insurance Contract, if the POLICYHOLDER and/or the INSURED PERSON exercise the right to cancellation – except in the case of misrepresentation – and opposition to the treatment of data, this will be understood as opposition to renewal of the Contract, which will terminate on expiry. The date of expiry (end of the current or following year) will be determined by the moment the rights of erasure or cancellation, limitation or opposition are exercised in attention to the obligatory warning period foreseen in Clause TWELVE.

   At all events, once the Contract has been terminated, the data will be treated as foreseen in Article 32 of Organic Act 3/2018, of 5 December on Personal Data Protection and Guarantee of Digital Rights.

CLAUSE TWELVE: EXECUTION AND LEGAL EFFECTS OF THE CONTRACT AND DURATION

1. The Contract is executed when consent is manifested by the subscription of the Policy by the contracting parties. The subscribed cover and its amendments or additions will have no effect until payment of the PREMIUM or of the initial instalment of the PREMIUM has been made, unless there is agreement to the contrary in the **Particular Conditions**.

   In the event of a delay in fulfilling either of the two requirements, the INSURER's obligations begin at MIDNIGHT on the day they are fulfilled.

2. The duration of the Contract is established in the **Particular Conditions**, which establish the date and time the guarantees take effect and expire. Unless expressly mentioned in the **Particular Conditions**, the Contract expires on 31 December each year.

3. At the end of the period indicated in the **Particular Conditions** of this Policy, the Contract will be deemed to be tacitly renewed for the space of one year and so on successively at each annual expiry date.

   The parties may oppose renewal of the Contract by giving written notice to the other party at least one month in advance of the end of the current insurance period, when the party objecting to the extension is the POLICYHOLDER and/or the INSURED PERSON, and two months when it is the INSURER.

4. **A unilateral wish to cancel expressed by the POLICYHOLDER will be understood as opposition to a renewal of the Contract with the consequences and date of coming into effect foreseen in the preceding section.**

5. In any case of opposition to renewal, the POLICYHOLDER will have to continue paying the INSURER the PREMIUM until the date of expiry of the Contract. The date of expiry (end of the current or next annual period) will be determined by the moment of effective opposition exercised in relation to the obligatory one-month warning period.

CLAUSE THIRTEEN: REVIEWING THE FINANCIAL CONDITIONS

The INSURER may review the PREMIUM, the amount of the **COPAYMENT** for each service and the maximum annual limit for each INSURED PERSON annually on the basis of the necessary technical and actuarial calculations to determine their effect on the financial and actuarial balance of the insurance, taking into account changes in healthcare costs, the frequency of services covered and the addition to the cover of new services and complementary diagnostic and therapeutic techniques.

In the same way and according to the same principles, the INSURER may add new services to the cover under the Insurance Contract (with or without COPAYMENT) or make services already included subject to COPAYMENT.

The INSURER must notify the POLICYHOLDER and/or INSURED PERSON of the PREMIUM applicable during the next yearly period, variations in the amounts of the **COPAYMENT** and the maximum annual limit for each INSURED PERSON, two months before the end of the current period for the POLICYHOLDER and/or INSURED PERSON to exercise, if applicable, his/her right of opposition to renewal in the terms foreseen in **Article 22 of the Law**.

CLAUSE FOURTEEN: RESCISSION, TERMINATION AND EXPIRATION

A. RESCISSION. The INSURER may cancel the Insurance Contract in the following cases:

– **Withholding information or misrepresentation**

In cases of withholding information or of misrepresentation by the POLICYHOLDER and/or the INSURED PERSON regarding the 'Health Questionnaire' required of him/her, in accordance with the procedure foreseen in **Clause EIGHT,** 3 with regard to **Article 10 of the Law.**

The premiums for the current period correspond to the INSURER, except in case of fraud or gross negligence on his/her part, from the moment the POLICYHOLDER declares his/her intention to rescind.

B. TERMINATION. The INSURER may terminate the Insurance Contract in the following cases:

– **Non-payment of the PREMIUM**

In the event that the initial instalment of the PREMIUM has not been paid when due, in accordance with **Article 15 of the Law**. In this case, in the event of a loss, the INSURER is released from their obligations.

The INSURER may also terminate the Contract in the event of non-payment of the amounts due for services subject to **COPAYMENT.**

C. EXPIRATION

– **Opposition to renewal**

The Contract terminates on the date of expiry of the Policy in the event of opposition to renewal by either party and, especially, in those cases foreseen in Clause **ELEVEN, 4**, or **TWELVE**.

– **Failure to claim unpaid PREMIUM**

In the event of non-payment of any part of the PREMIUM other than the initial payment, the Contract will expire **six months** after the PREMIUM is due if the INSURER does not pursue payment, in accordance with **Article 15 of the Law**.

CLAUSE FIFTEEN: LOSS OF RIGHTS

The right to guaranteed services is lost:

1. In cases of withholding information or of misrepresentation in filling in the 'Health Questionnaire', if there was fraud or gross negligence on the part of the POLICYHOLDER and/or INSURED PERSON - **Article 10 of the Law**.

2. In the case of increased risk, if the POLICYHOLDER or INSURED PERSON fails to inform the INSURER and acts in bad faith – **Article 12 of the Law**.

3. If the loss occurs before payment of the initial PREMIUM, unless there is agreement to the contrary – **Article 15 of the Law**.

4. If the loss occurs while the Contract is suspended due to non-payment of successive PREMIUMS – **Article 15 of the Law.**

5. If the POLICYHOLDER and/or INSURED PERSON do not provide the INSURER with information on the circumstances and consequences of the loss and fraud or gross negligence were involved – **Article 16 of the Law**.

6. If the POLICYHOLDER and/or the INSURED PERSON fail to fulfil their obligation to minimise the consequences of the loss and with clear intention to deceive or prejudice the INSURER **– Article 17 of the Law**.

7. When the loss is a result of bad faith on the part of the INSURED PERSON – **Article 19 of the Law**.

8. The Contract will be null and void, except in those cases foreseen in the Law, if at the moment of its conclusion the accident has already occurred.

CLAUSE SIXTEEN: PRESCRIPTION

Actions arising from the Contract become statute-barred after **five years** as from the date they can be taken – **Article 23 of the Law.**

CLAUSE SEVENTEEN: NOTIFICATIONS

For the purposes of this Insurance, the loss is deemed to have been notified when the INSURED PERSON requests the service.

In case of non-fulfilment, the INSURER can claim damages for the lack of notification, unless he/she hears of the loss by some other means, all in accordance with **Article 16 of the Law**.

Notifications to the INSURER by the POLICYHOLDER and/or INSURED PERSON must be addressed to the registered office of the INSURER as stated in the Policy.

Notifications to the INSURER made by an insurance broker on behalf of the POLICYHOLDER and/or INSURED PERSON will have the same effect as if they had been made by the POLICYHOLDER and/or the INSURED PERSON, in accordance with **Article 21 of the Law.**

Notifications by the POLICYHOLDER and/or INSURED PERSON to the insurance agent will have the same effect as if they had been made directly to the INSURER.

Notifications by the INSURER to the POLICYHOLDER and/or INSURED PERSON must be made to the last postal and/or email address notified to the INSURER.

The Insurance Contract and its **Annexes** or **Supplements**, along with any amendments, must be in writing, in

accordance with **Article 5 of the Law**, on paper or on any other durable medium in accordance with the First Additional Provision of the Law.

CLAUSE EIGHTEEN: JURISDICTION

Any conflicts arising between the POLICYHOLDER and/or INSURED PERSON, on one hand, and the INSURER, on the other, will be heard by the competent judges and courts.

The competent judge to hear actions arising from the Insurance Contract will be that corresponding to the domicile of the POLICYHOLDER and/or INSURED PERSON and any agreement to the contrary will be null and void, as laid down in **Article 24 of the Law**.

ANNEXE I: DESCRIPTION OF THE SERVICES

1. GENERAL PAEDIATRICS AND CHILDCARE

For people under 18. Attention at home and at the doctor's surgery. ***Service subject to COPAYMENT***.

2. GENERAL MEDICINE

Home and surgery visits. ***Service subject to COPAYMENT***.

3. NURSING CARE

Includes parenteral administration of treatments at the doctor's surgery and at home in those cases prescribed by the doctor on the INSURER's 'List of physicians'. ***Service subject to COPAYMENT***.

4. SPECIALITIES

Visits to specialist pysicians subject to COPAYMENT.

- Allergies.
- Clinical tests.
- Anatomical pathology.
- Anaesthesia and reanimation.
- Angiology and vascular surgery.
- Digestive system.
- Respiratory system – Pulmonology.
- Cardiology
- Cardiovascular surgery
- General and digestive surgery.
- Maxillofacial surgery. ***Excluding osseointegrated implants.***
- Paediatric surgery.
- Plastic and reconstructive surgery. ***Excluding aesthetic surgery and treatments.***
- Thoracic surgery.
- Dermatology. ***Excluding cosmetic dermatology.***
- Endocrinology and nutrition.
- Gynaecology and obstetrics. ***Excluding abortion, even in those cases allowed by current legislation.***
- Haematology and haemotherapy.
- Internal medicine.
- Nuclear medicine **(*).**
- Nephrology.
- Neurosurgery.
- Clinical neurophysiology.
- Neurology.
- Odontostomatology. ***Includes only extractions and one session of tartar removal (*) a year in case of oral pathology.***
- Ophthalmology. ***Excluding refractive surgery.***
- Medical oncology.
- Radiotherapy oncology.
- Otorhinolaryngology.
- Psychiatry. ***Excluding psychoanalysis, hypnosis, individual or group psychotherapy, psychological tests, sophrology, outpatient narcolepsy and treatment for drug addiction or alcoholism.***

- Radiodiagnosis. ***Excluding contrast media***.
- Rehabilitation. (*) ***Excluding maintenance and occupational physiotherapy, and rehabilitation after chronic illnesses when injuries have stabilised.***
- Rheumatology.
- Trauma and orthopaedic surgery.
- Urology.

(*) As well as the written request from the doctor on the 'List of physicians', these services also require authorisation from the INSURER's administrative services.

5. SPECIAL TECHNIQUES

These always require a written prescription from a doctor on the INSURER's 'List of physicians'. ***Service subject to COPAYMENT***.

As well as the written request from the doctor on the 'List of physicians', these services also require authorisation from the INSURER's administrative services.

5.1. DIAGNOSTIC SERVICES

This service comprises the usual diagnostic means recognised by medical practice at the time this Contract was subscribed.

- Angioradiology.
- Objective audiometry.
- Molecular biology.
- Bilateral computed campimetry.
- Coronary catheterisation.
- Bone densitometry.
- Doppler and echo Doppler.
- Ultrasound scan.
- Electromyography.
- Electrooculogram.
- Electroretinogram.
- Endoscopies (digestive, pulmonological, urological).
- Scanner.
- Polysomnography.
- Radioisotope tests.
- Urodynamic tests.
- Fluoresceinography.
- Vascular and cardiac haemodynamics.
- Holter.
- Immunohistochemistry.
- Mammography.
- Neuroradiology.
- Evoked potentials.
- Allergy tests.
- Stress tests.
- Digestive functional tests:
    - Manometry.
    - pH-measuring.
- Magnetic resonance.

- Spect.
- Optical coherence tomography (OCT).
- Positron emission tomography (PET) ***Limited to the list of indications in oncology with public cover, published by the Catalan Assessment Agency for Medical Technology and Research (Agència d'Avaluació de Tecnologia i Recerca Mèdica de Catalunya).***

5.2. THERAPEUTIC SERVICES

This service comprises the usual therapeutic techniques recognised by medical practice at the time this Contract is subscribed.

- Coronary angioplasty.
- Hyperbaric chamber.
- Therapeutic endoscopy.
- Ophthalmic laser photocoagulation.
- Renal lithotripsy.

6. BLOOD AND PLASMA BANK

The medical act of transfusion is covered by the INSURER in all cases, as well as the blood and/or plasma for transfusions in the operating theatre and elsewhere.

7. OXYGEN THERAPY

In hospital for all admissions and at home. ***Home visits subject to COPAYMENT.***

As well as the written request from the doctor on the 'List of physicians', these services also require authorisation from the INSURER's administrative services.

8. EMERGENCIES

Round-the-clock attention through our Permanent Emergency service. ***Service subject to COPAYMENT***.

9. HOSPITAL ADMISSIONS

As well as the written request from the doctor on the 'List of physicians', these services also require authorisation from the INSURER's administrative services.

This takes place when the nature of the treatment so requires and following a request by a doctor on the INSURER's 'List of physicians' and always in the INSURER's partner facilities. ***Service subject to COPAYMENT***. They can give rise to:

9.1. SURGICAL HOSPITALISATION

For all types of surgery and/or trauma surgery covered by the policy cover. It comprises:

- Hospital stay for the patient, of unlimited length, in a single room, **so long as the characteristics of the hospital allow**.
- Surgery rights.
- Medication and treatment material, in the operating theatre and out of it.
- Medication in the operating theatre and out of it.
- Anaesthetic drugs.
- Surgical staples.
- Laser surgery in proctology and otorhinolaryngology.
- Laser surgery for the treatment of varicose veins and respiratory stenosis.

- Stays in intensive care units, special treatments and coronary unit.

9.2. MEDICAL HOSPITALISATION

Hospital admission for those illnesses or conditions not requiring surgical intervention but which in the opinion of the doctor on the 'List of physicians' cannot be treated at the patient's home with the proper technique and require hospitalisation. There is no time limit and it comprises:

- Hospital stay for the patient in a single room**, so long as the characteristics of the hospital allow.**
- Treatment material.
- Medication.
- Antineoplastic chemotherapy in hospitalised patients, with the criteria and the limits established in the **Particular Conditions.**
- Stays in intensive care units, special treatments and coronary unit.

In no case will problems of a social nature be accepted as a cause for hospitalisation.

9.3. NEONATAL HOSPITALISATION

Hospital admission for new-borns **if they have previously been registered within the established time frame as an INSURED PERSON**. There is no time limit and it comprises:

- The stay in the neonatal unit.
- Surgical rights.
- Treatment material and medication, in the operating theatre and outside.
- Anaesthetic drugs

9.4. PSYCHIATRIC HOSPITALISATION

Hospital admission in specialised facilities, ***up to a maximum of 90 days per calendar year***, in the acute phase of chronic mental disorders and, in general, any acute condition which in the opinion of the doctor on the 'List of physicians' cannot be treated at the patient's home and requires hospitalisation. It comprises:

- Hospital stay for the patient.
- Medication.

Cover does not include the accompanying person in the hospital.

In no case will problems of a social nature be accepted as a cause for hospitalisation.

9.5. MAJOR OUT-PATIENT SURGERY

It comprises:

- The stay in the outpatient surgical unit.
- Surgical rights.
- Treatment material, in the operating theatre and out of it.
- Medication in the operating theatre and out of it.
- Anaesthetic drugs.

10. PREGNANCY AND CHILDBIRTH

As well as the written request from the doctor on the 'List of physicians', these services also require authorisation from the INSURER's administrative services.

Service subject to COPAYMENT.

It comprises the following services:

- Monitoring of the pregnancy by an obstetrician who will also attend normal, dystocic and premature deliveries.
- Maternal education and preparation for childbirth.
- Prenatal detection of chromosomal disorders and defects of the neural tube (first or second trimester biochemical screening, amniocentesis, chorionic villus sampling).
- Midwife.
- Ultrasound scan during pregnancy, always according to the criterion of the doctor on the 'List of physicians', ***up to a maximum of three***, except for high-risk pregnancies.
- Placental Respiratory Reserve. ***Only in high-risk pregnancies and with a medical prescription.***
  Physiotherapy for postpartum recovery of the pelvic floor (***up to six months after the birth***).

10.1. Hospital admission for any type of childbirth with the following cover: ***Service subject to COPAYMENT***.

- The stay in an individual room for the mother, **so long as the characteristics of the hospital allow**.
- The right to the delivery room or operating theatre in the case of caesarean section.
- Treatment material, in the operating theatre and out of it.
- Medication in the operating theatre and out of it.
- Anaesthetist's fees and anaesthetic drugs.
- Anti-D vaccine.
- Under the terms of the mother's Policy, nursery service and, in the same service, paediatric attention to the new-born, ***up until discharge of the mother or for ten days, whichever is sooner.***
- Should the new-born require neonatological admission, the INSURER will be responsible for the loss **if it has previously been registered within the established time frame as an INSURED PERSON.**
- Transfer in a duly equipped ambulance to the right facilities if the hospital where the birth takes place does not have an incubator service.

11. OTHER SERVICES

As well as the written request from the doctor on the 'List of physicians', these services also require authorisation from the INSURER's administrative services.

Service subject to COPAYMENT.

- Orthoptics and pleoptics.
- Ventilotherapy and aerosols.
- Early diagnostic of breast cancer by mammography.
- Family planning surgery: tubal sterilisation and vasectomy.
- Child speech therapy ***up to a maximum of 20 sessions***.
- Phoniatric treatment, surgical cases, ***up to 15 sessions***.
- Clinical psychology for adults, ***up to the age of 65***, and for children and adolescents, ***up to the age of 18,*** on prescription by a psychiatrist or paediatrician included in the "Directory of Medical Professionals" ***up to 20 sessions per year.***
- New and complementary diagnostic or therapeutic techniques which in future may prove their effectiveness will be added to the cover under the Policy by means of supplements in the **Particular Conditions** establishing the amount of the **COPAYMENT** and reviewing the PREMIUM, if applicable.