SALUDPROFESIONAL

GENERAL CONDITIONS

NUEVAMUTUASANITARIA

CONTENTS

The General Terms and Conditions apply to the products: SALUD PROFESIONAL Familia and SALUD PROFESIONAL Empresa.

General Terms and Conditions SALUD PROFESIONAL

This policy (the "**Policy**") comprises the following documents: Insurance Application, health declarations of the insureds, these general terms and conditions ("**General Terms and Conditions**"), the particular terms and conditions ("**Particular Terms and Conditions**"), their appendices and, where applicable, any addenda that amend the above documents.

These General Terms and Conditions include two sections: section one, which deals with the terms and conditions of the insurance contract, and section two, which contains the description of the services and coverages provided by this insurance contract.

SECTION ONE: CONTRACT TERMS AND CONDITIONS

1.PRELIMINARY CLAUSE

1.1. Insurer and supervisory body thereof

Nueva Mutua Sanitaria del Servicio Médico, Mutua de Seguros a Prima Fija, with registered office in Madrid, Calle Villanueva nº 14, 4ª planta, 28001, is registered with the Madrid Companies Register, Volume 29,864, Folio 40, Section 8, Sheet M-537332, with Tax ID No. V-86444965 (hereinafter, the "Mutual Insurance Company"), and in the Register of the Directorate-General for Insurance and Pension Funds under number: M-380. The Mutual Insurance Company is supervised by the General Directorate of Insurance and Pension Funds and reports to the Ministry of Economic Affairs.

1.2. Applicable Legislation

This contract is governed by the following regulations:

- Law 50/1980 of 8 October on Insurance Contracts (the "**Insurance Contract Act**").
- Law 20/2015 of 14 July on the regulation, supervision and solvency of insurers and reinsurers.

The contract is also governed by all other applicable Spanish legal and statutory provisions, the items agreed in the Policy and by the regulations that may replace or amend those listed here in the future.

2. COMPLAINTS AND CLAIMS

In accordance with prevailing legislation, the Mutual Insurance Company has a Customer Services Department (SAC) that policyholders, insureds, beneficiaries or assignees of any of the above may contact to submit any complaints or claims associated with this Policy. The Mutual Insurance Company has forms at its offices that the above parties may use for such purpose.

Complaints and claims must be submitted in writing and sent to the Customer Services Department using any of the following channels:

- Delivery in person to the offices of the Mutual Insurance Company.

- By post, sent to Calle Villanueva nº 14, 4ª planta, 28001 Madrid.
- By email to: sac@nuevamutuasanitaria.es

The Customer Services Department will acknowledge receipt of any complaints or claims, will issue a decision on the matter in question and explain how it reached said decision within a maximum legal period of one month from the date the complaint or claim was submitted.

The above parties may also write to the Customer Ombudsman (D.A. Defensor, S.L.", at C/ Julián Camarillo, 29, Ed. 2, 4ª pl. izqda. 28037 MADRID, telephone 913 104 043, email: reclamaciones@da-defensor.org.

If the individual who submitted a complaint or claim does not agree with the decision issued by any of the above authorities, or if a response is not received within a period of one month, they may send a complaint or claim to the Complaints Department of the General Directorate of Insurance and Pension Funds. There is a form to do this on the website http://www.dgsfp.mineco.es/. The individual submitting the complaint or claim must prove that a month has passed since they sent their complaint or claim to either the Customer Services Department of the Customer Ombudsman and that, during this time, they have not received a decision on the matter at issue, their communication has not been accepted or their request has been either fully or partially rejected.

Without prejudice to the above actions, interested parties may file the actions they deem appropriate with the ordinary courts.

3. PURPOSE OF THE INSURANCE

Within the limits set by this Policy, the Mutual Insurance Company covers the specialist medical, surgery and hospital care included in the description of the coverage provided by the Policy for all types of illnesses or injuries, provided the relevant Premium has been paid.

Advances made in diagnoses and therapies within medical science during the term the insurance policy is in effect may be covered by this Policy, in accordance with Clause 4 below. Whenever the Policy is renewed, the Mutual Insurance Company will specify which new procedures or treatments will be covered by it in the next period.

Under this Health Insurance Policy, customers cannot choose to receive compensation in cash instead of healthcare services, except where expressly permitted.

4. HOW THE SERVICES ARE PROVIDED

Within the limits and conditions stipulated in the Policy and upon payment of the corresponding Premium, the Mutual Insurance Company makes available to the Insured the authorised healthcare service providers included at any given time in the Medical Network, from whom the Insured may request the medical care described in the coverage clauses.

New diagnostic procedures, therapies and technologies will be included in the Policy in accordance with medical principles once they have been demonstrated to be effective and safe and provided they can be readily offered by the Mutual Insurance Company's approved resources. **Medical procedures, consultations, diagnostic or therapeutic means prescribed or ordered by a medical professional —even if they are part of the Medical Network— will not be covered by this Policy unless they are included among the services covered by it.**

4.1. Through the Medical Network

The Mutual Insurance Company shall cover the costs arising from the healthcare provided by duly authorised healthcare service providers included in the Medical Network at any given time, provided that the claim is covered under this Policy.

Under no circumstances will the Mutual Insurance Company cover the cost of an invoice paid directly by the Insured to any medical services provider, even if said party is part of the Medical Network and the medical services provided are covered by this Policy.

Healthcare will be provided in all areas where the Mutual Insurance Company has authorised healthcare service providers included in its Medical Network. Insureds are free to attend consultations with the specialist and primary care medical professionals who are part of the Mutual Insurance Company's Medical Network.

Upon receiving the necessary services, the Insured must show the Personal Health Insurance Card they have been issued by the Mutual Insurance Company. The Insured must also present their National Identity Document, if requested. **Each time the Insured receives a service covered by the Policy, they shall pay, in the scenarios provided for in the General Terms and Conditions and the Particular Terms and Conditions, the amounts specified therein as a contribution to the cost of the service received (hereinafter, the "copayments or deductibles"). Copayments or excess amounts will be charged to the Policyholder or Insured using the bank account used to pay the premiums by direct debit.**

In general, the Mutual Insurance Company must give prior express authority for surgery, hospital stays and use of the therapies and diagnostic tests defined in **Appendix I, following a prescription issued by one of the medical professionals on the Medical Network.** The Mutual Insurance Company shall grant such authorisation unless it considers that the service in question is not covered by the Policy. Said authority will be financially binding for the Mutual Insurance Company, without prejudice to the copayments or excess amounts the Policyholder or Insured must pay.

The Mutual Insurance Company undertakes to provide home services in those areas where it has approved healthcare service providers, and only at the address stated in the Policy. Any change of address must be duly notified.

When exceptional healthcare needs so require, the Mutual Insurance Company may refer or transfer the Insured to a public hospital for medical treatment or hospitalisation.

4.2. Emergencies

Emergencies will be dealt with by the medical facility that is closest to the Insured's location. If the facility is a public or private one that is not part of the Medical Network, the Mutual Insurance Company will reimburse the Insured, upon justification, for medical care expenses incurred exclusively in emergency situations. The Insured or, where necessary, members of their family, must report the event to the Mutual Insurance Company by any means within a period of 72 hours after it occurs. Whenever the Insured's clinical condition allows, they will be transferred to a facility within the Medical Network.

The Insured must also send the Mutual Insurance Company a written description of the incident within a maximum period of seven days from the time emergency medical care was provided at a facility not included in the Medical Network.

Once the emergency has passed: the Mutual Insurance Company shall not cover the fees of medical professionals who are not part of the Medical Network, nor the costs of hospitalisation or services that may be prescribed by such professionals. In addition, the Mutual Insurance Company will not be liable for the cost of inpatient stays at or services provided by private or public facilities that have not been approved by the Mutual Insurance Company, irrespective of which medical professional ordered the admission or performed the services at issue.

5. PREMIUM PAYMENTS

5.1. The Policyholder is obliged to pay the Premium, which shall be settled by direct debit or by credit card, unless otherwise agreed in the Particular Terms and Conditions.

5.2. **In order to set up the direct debit, the Policyholder will provide the Mutual Insurance Company with their bank account details and will also send their bank the necessary order.**

5.3. In accordance with article 15 of the Insurance Contract Act, the first Premium or instalment will be payable once the Policy has been signed. If the Policyholder fails to pay the first Premium or instalment, the Mutual Insurance Company will be entitled to terminate the Contract or demand payment by means of an enforcement procedure based on the Policy. In any case, If the first Premium or instalment has not been paid before an event occurs, the Mutual Insurance Company will be released from its obligations, unless stipulated otherwise in the Particular Terms and Conditions.

5.4. Premiums will be understood to have been paid when due, unless there are insufficient funds in the customer's bank account to cover payment in the month after the premium became payable. If successive Premiums or instalments are not paid, coverage will be discontinued one month after they become payable. Thereafter, if the Mutual Insurance Company does not demand payment within a period of six months after the amount at issue becomes payable, the Policy will be terminated. If the Policy has not been terminated in accordance with the above, the Policyholder may pay the Premium within a six-month period after the amount at issue becomes payable, in which case, coverage will be effective again twenty-four hours after the Policyholder pays the relevant Premium.

5.5. **The Policyholder will lose the right to pay the Premium in instalments, as may have been agreed in the Particular Terms and Conditions, if they fail to pay an invoice. Thereafter, the Mutual Insurance Company may demand payment of the entire Premium agreed for the remaining insurance period until the next due date.**

5.6. **The Mutual Insurance Company shall only be bound by payment receipts issued by its legally authorised representatives.**

In the event of early termination of the contract, the unused portion of the annual Premium shall remain with the Mutual Insurance Company, except in the event of the Insured's death, in which case the Mutual Insurance Company shall assume the unconsumed premium months of the deceased Insured.

6. OBLIGATIONS, DUTIES AND RIGHTS OF THE POLICYHOLDER AND/OR THE INSURED

The Insurance Policyholder and, where applicable, the Insured is/are subject to the following obligations:

a) To declare to the Mutual Insurance Company, in accordance with the questionnaire it may

provide, all circumstances known to them that may influence the assessment of the risk, as well as to submit all documentation requested for such purpose. The Policyholder shall be exempt from this obligation if the Mutual Insurance Company does not provide a questionnaire, or if it does, where the circumstances that may influence the assessment of the risk are not included therein. In the event of any omission or inaccuracy by the Policyholder or the Insured in this declaration, the Mutual Insurance Company may terminate the Policy by means of a notice addressed to the Policyholder within one month from the date on which it became aware of such omission or inaccuracy. The Premiums corresponding to the period in effect at the time such notice is given shall remain with the Mutual Insurance Company, unless there has been wilful misconduct or gross negligence on its part. If an event occurs before the Mutual Insurance Company notifies the other party that it has rescinded the Policy, the services provided by the Mutual Insurance Company will be reduced in proportion to the difference between the agreed Premium and the Premium that would have been applied if the real risk level had been known. If there was wilful misconduct or gross negligence on the part of the Policyholder, the Mutual Insurance Company shall be released from the obligation to pay the benefit.

b) To inform the Mutual Insurance Company, during the course of the Contract and as soon as possible, of any changes to the factors and circumstances declared in the questionnaire referred to in the preceding section that aggravate the risk and are of such a nature that, had they been known by the Mutual Insurance Company at the time of the conclusion of the Contract, it would not have entered into it or would have done so under more onerous conditions. The Policyholder or the Insured shall not be required to report any changes in the Insured's state of health, as such changes shall in no case be considered an aggravation of the risk.

The Mutual Insurance Company may, within two months from the date the aggravation is declared, propose a modification of the Policy. Thereafter, the Policyholder will have a period of fifteen days from the date the proposal is received to accept or reject it. If the Policyholder rejects the proposal or does not reply, at the end of this period the Mutual Insurance Company may rescind the Policy after notifying the Policyholder and giving them a further period of fifteen days to reply. After this time has elapsed and within the following eight days, the Mutual Insurance Company will notify the Policyholder that the Policy has been permanently rescinded. The Mutual Insurance Company may also rescind the Policy by writing to the Insured within a period of one month from the date it became aware of the increased risk.

If an event occurs before the Insured reports an increase in risk, the Mutual Insurance Company may proportionally reduce any indemnity paid under the same terms as stipulated in the above section.

c) During the term the Policy is in effect, the Policyholder or Insured may report to the Mutual insurance Company any circumstances that reduce risk and the nature of which, had the Mutual Insurance Company been aware of them when the Contract was being drawn up, would have caused it to execute it under more favourable conditions.

Under such circumstance, when the current period covered by the Premium ends, the amount of future Premiums must be reduced proportionally. If this does not happen, the Policyholder will be entitled to terminate the Contract and receive the difference between the Premium paid and the amount that would have been payable from the time it reported the decreased risk.

d) The Policyholder or the Insured shall notify the Mutual Insurance Company, as soon as possible, of any change to the address of the Insured stated in the Particular Terms and Conditions.

e) Notify the Mutual Insurance Company, as soon as possible, of any additions of Insureds made while the Policy is in effect, and of any removals of Insureds **at least one month before the end of the current insurance period.** In general, new Insureds will be added to the Policy on day one of the month after the date the Policyholder provides the relevant information and Insureds will be removed from the Policy on 31 December of the same year, unless stipulated otherwise in the Particular Terms and Conditions. Once these changes have taken place, the Premium will be amended accordingly.

f) If the mother receives assistance during childbirth under the Mutual Insurance Company's Policy under which she is insured, her newborn child shall be entitled to be included in the mother's Policy from the moment of birth. To add them, the Policyholder must inform the Mutual Insurance Company of such circumstance within a period of 15 calendar days after the baby has been discharged from hospital, and at most, within a period of 30 calendar days after the date they were born, by completing an Insurance Application. Requests to add a newborn infant to a Policy that are submitted within the required timeframe will take effect retroactively as of the child's date of birth, and any remaining waiting periods applicable to the mother shall also apply, where relevant.

If an application to add the newborn baby to the Policy is sent after the period indicated in the previous paragraph has ended, a Health Questionnaire must be filled in and the Mutual Insurance Company may refuse to add them to the Policy. If the new Insured is accepted, the qualifying period set forth in the Policy shall apply to them. In any case, the Mutual Insurance company will cover the medical care received by the newborn baby for the first fifteen (15) calendar days of its life, and this coverage will end if an application to add them to the Policy has not been sent in accordance with the requirements of this section.

g) They shall mitigate the consequences of the loss by using the means at their disposal to ensure prompt recovery. If this requirement is complied with in a way that is clearly intended to harm or deceive the Mutual Insurance Company, it will be released from its obligation to provide the medical services that are needed as a result of the event.

h) **The Policyholder and/or the Insured shall be required to use the services of the healthcare service providers that are listed in the Medical Network at any given time.** Details of the Medical Network can be found on the Mutual Insurance Company's website or requested from its offices.

i) The Insured shall facilitate the Mutual Insurance Company's subrogation in their position against the liable third party. Amounts recovered from said party will be split between the Insured and the Mutual Insurance Company proportionally, depending on to what extent each party was involved in providing services. **The Insured must not make any statements or act in a way that could imply that they have waived the aforementioned right. The Insured will be liable for any damages experienced by the Mutual Insurance Company as a result of such statements or actions.**

The right to subrogate may only be exercised against the Insured's spouse, other blood relatives up to the third degree of kinship, adoptive parents or adopted children who live with the Insured, unless there is wilful misconduct or liability covered by an insurance contract and up to the limit of the scope thereof.

j) The Policyholder may file a claim with the Mutual Insurance Company, within one month from the delivery of the Policy, requesting the rectification of any discrepancies between the Policy and the insurance proposal or the agreed clauses, in accordance with Article 8 of the Insurance Contract Act. If the Policyholder does not ask the Mutual Insurance Company to take such action within said timeframe, the terms of the Policy shall prevail.

7. OBLIGATIONS OF THE MUTUAL INSURANCE COMPANY

In addition to providing the agreed healthcare services, the Mutual Insurance Company shall deliver to the Policyholder the documents comprising the Policy or, where applicable, the provisional coverage document.

It shall also deliver to the Policyholder the Personal Health Card corresponding to each Insured included in the Policy.

Upon signing the Policy, the Mutual Insurance Company shall provide the Insured with the Medical Network directory corresponding to their province of residence, specifying the following details: (i) permanent facility or facilities for medical emergencies and surgery; (ii) permanent outpatient care services; (iii)hospitals and clinics; and (iv) the addresses and schedules of the medical professionals and information, emergency and permanent outpatient care services in all the main cities in the other provinces in which the Mutual Insurance Company is present.

The Mutual Insurance Company may update the Medical Network annually by adding or removing physicians, professionals, hospitals, and other facilities that form part of it. The Mutual Insurance Company shall keep the Medical Network up to date on its website.

8. INSURANCE TERM

The insurance shall have the duration set out in the Particular Terms and Conditions and, upon expiry, shall be tacitly renewed for annual periods, **provided that the Policyholder accepts the updated Premium, copayment and excess amount proposed, where applicable, by the Mutual Insurance Company.**

Notwithstanding the above, either party may object to the Policy being extended by writing to the other at least one month before the current insurance period expires in the case of the Policyholder, and two months in the case of the Mutual Insurance Company.

If the Insured is in hospital when the Mutual Insurance Company issues a communication objecting to the Policy being extended, the objection will only take effect with respect to said Insured when they are discharged from hospital, unless they refuse to continue treatment.

If the Policyholder rejects to the Policy being extended within the timeframe stipulated in this Clause, coverage will cease on the date the Premium for the current insurance period is payable, irrespective of whether the Insured is in hospital at the time or not.

9. WAITING PERIOD

All benefits covered under the Policy shall be made available by the Mutual Insurance Company from the effective date of the Contract. **However, the following exceptions shall apply, subject to the waiting periods indicated below:**

- **180 days for hospitalisation and surgical procedures, whether inpatient or outpatient, including childbirth assistance.**
- **180 days for treatments included under the sections on Therapies and Other Services (Clauses 17.4 and 17.5).**

- **The Special Benefits listed in Clause 17.9 of these General Terms and Conditions shall be subject to the following waiting periods:**
    - **24 months for refractive surgery for myopia.**
    - **24 months for infertility diagnosis and treatment.**
    - **180 days for preventive medical check-ups.**
    - **180 days for sleep studies, oncology radiotherapy treatments, dialysis or hemodialysis, lithotripsy, Vacuum-Assisted Biopsy (VAB), capsule endoscopy and fetal DNA test.**
- **24 months for rehabilitation following brain damage (Clause 17.3, section 28).**
- **24 months for metabolic surgery (Clause 17.3, section 10).**
- **180 days, in general, for all therapeutic procedures and diagnostic tests described in Appendix I.**

The above-mentioned waiting periods shall not apply in the event of accidents covered by the Policy, medical emergencies or premature births, provided that, **had the birth not been premature, it would have occurred after the applicable waiting period had elapsed.**

10. LOSS OF RIGHTS, RESCISSION AND UNCONTESTABILITY OF THE CONTRACT

10.1. **The Insured loses the right to receive services under the following circumstances:**

a) If there is a lack of information or an inaccuracy when completing the health questionnaire.

b) If the Policyholder or the Insured deliberately fails to report an increase in risk (as set out in Clause 6b).

c) If the loss occurs before the first Premium has been paid, unless otherwise agreed.

d) If the insured event was caused by the Insured's bad faith.

e) Under any other circumstances provided for by law.

10.2. The Policyholder may rescind the Contract if fifty percent of the specialists listed in the Medical Network for their province of residence are affected by changes. The Policyholder must notify the Mutual Insurance Company of their decision formally and in writing. This rule shall not apply to temporary replacements that take place for a valid reason, or with respect to specialist surgeons, dentists, analysts or radiologists.

10.3. If a medical examination has been carried out or if full rights have been acknowledged, the Policy shall be incontestable with regard to the Insured's state of health, except in cases of wilful misconduct by the Policyholder or the Insured when declaring the risk.

The Policy shall become indisputable ONE YEAR after each of the Insureds has been enrolled in the insurance, unless the Policyholder and/or the Insured has acted in bad faith.

10.4. Failure to declare a person's correct age shall only lead to the Policy being terminated if the person's actual age exceeds the limits for acceptance set by the Mutual Insurance Company.

If, as a result of an inaccuracy in the declared year of birth, the Premium paid has been lower than the amount that should have been paid, the Policyholder shall be required to pay the Mutual Insurance Company the difference between the amounts actually paid as Premium and those that, according to the applicable rates, would have corresponded to their true age for the current insurance period. The Mutual Insurance Company may require the Policyholder to pay this difference at any time.

If the Premium paid is higher than it should have been, the Mutual Insurance Company must refund the Policyholder the excess amount.

11. INFORMATION ABOUT THE PROTECTION OF PERSONAL DATA

1. Data Controller and Data Protection Officer

The data controller responsible for processing your personal data is Nueva Mutua Sanitaria del Servicio Médico, Mutua de Seguros a Prima Fija ("Nueva Mutua Sanitaria"), with registered office at Calle Villanueva 14, 4th floor, 28001 Madrid.

Nueva Mutua Sanitaria has appointed a Data Protection Officer who you can contact about any personal data protection matters by sending an email to dpo@nuevamutuasanitaria.es

2. Why we process your personal data

At NUEVA MUTUA SANITARIA, we process your personal data with the utmost respect and in full compliance with the applicable regulations on personal data protection.

In connection with the contracting of this insurance policy, the personal data of the Policyholder and the Insureds (including sensitive data, such as health-related data) (the "Data"), provided directly to NUEVA MUTUA SANITARIA for the purpose of executing this insurance policy, will be processed by the Company for the following purposes:

a) To assess, execute and monitor the Policy. This includes, among other actions, the possibility of communicating the Data to service providers whose costs are covered under the Policy and requesting from them information—including, where applicable, personal and health-related data—regarding the cause that gives rise to the covered service.

b) To comply with legal obligations;

c) To settle claims; to contribute to statistical and actuarial analysis for risk assessment and underwriting; to conduct technical insurance studies; to prevent fraud; and to disclose the Data to reinsurers for the evaluation, development, performance, monitoring and enforcement of the related reinsurance contractual relationship.

With regard to identification and contact data, and subject to your express consent by ticking the corresponding box in the Particular Terms and Conditions, we may also process such data to send you commercial communications and information (by ordinary mail, email or any equivalent means) regarding NUEVA MUTUA SANITARIA's services and products, special

offers or promotions, as well as preventive healthcare campaigns.

We hereby inform you that your personal data will be processed solely for the purposes mentioned above.

Under no circumstances will automated decisions be made based on your profile.

How long your personal data is kept for

We will process your personal data throughout the term in which your insurance policy is in effect, and will continue to do so after the contractual relationship has ended for the time needed to comply with legal requirements.

If you have given your consent for us to send you marketing information, we will process your personal data until you let us know that you do not wish to continue to receive this information from us.

Legal authority to process your personal data

We have legal authority to process your personal data, as this is necessary in order to perform a contract you are party to.

As regards sending you marketing information, we also have legal authority to process your personal data if you give consent by checking the box provided for such purpose in the Particular Terms and Conditions.

3. Who will your data be communicated to?

- Parties that provide services, when the cost of these services is covered by your Policy, and to request information from them (including personal data about health, where necessary) concerning the reasons why a service covered by the Policy has been provided.

- Reinsurers, in order to assess, develop, comply with, monitor and perform the contractual reinsurance relationship.

- Public authorities and bodies to which we are legally obliged to disclose personal data.

NUEVA MUTUA SANITARIA also works with several entities that provide services requiring access to personal data. As such, these entities act as data processors on behalf of NUEVA MUTUA SANITARIA.

4. The data subject's rights in relation to the processing of their personal data

As the owner of the personal data at issue, either on your own behalf or through a legal or voluntary representative, you can exercise your rights to access, correct or restrict the processing of your personal data, or delete it or object to it being held on file, as well as your right to data portability.

To exercise these rights, you must contact us by email at dpo@nuevamutuasanitaria.es, indicating "Data Protection Rights" in the subject line, or, if you prefer, by post to Nueva

Mutua Sanitaria del Servicio Médico, Calle Villanueva nº 14, 4ª planta, 28001 Madrid. You must specify the right you wish to exercise and include a photocopy of your ID document.

We will reply to your request within a maximum period of 30 days from the date we receive it and will make every effort and use all the channels we can to reduce this time as much as possible. If you do not agree with our response, you can contact the Agencia Española de Protección de Datos [Spanish Data Protection Agency] to ask for your rights to be protected.

We also inform you that you may file a data protection complaint with the Spanish Data Protection Agency. You can find information about this on the agency's website. www.aepd.es.

5. Origin of personal data

The personal data that NUEVA MUTUA SANITARIA processes has been taken from the insurance policy and other associated documents.

The data categories processed are: Identifying data, personal data, data about social circumstances, employment data, academic and social data, economic, financial and insurance data and health data.

12. COMMUNICATIONS

Communications to the Mutual Insurance Company by the Policyholder or the Insured shall be sent to the company's registered office as stated in the Policy. However, if such communications are sent to the agent representing the Mutual Insurance Company who acted as intermediary for the Policy, they shall have the same effect as if they had been sent directly to it.

Communications made by an Insurance Broker on behalf of the Policyholder shall have the same effect as if made by the Policyholder, unless the latter states otherwise.

In any case, the express consent of the Policyholder shall be required in order to take out a new contract or to amend or terminate the insurance contract in force.

Communications from the Mutual Insurance Company to the Policyholder or the Insured shall be sent to the postal address, email address or telephone number provided in the Policy, or to any other contact details subsequently notified to the Mutual Insurance Company in the event of a change. Communications may also be made through the private customer area or the mobile application, if available, on the Company's website.

13. LAW AND JURISDICTION

The competent court to hear any actions arising from the Policy shall be that of the Insured's domicile.

Spanish law shall apply to any disputes arising from this contract.

14. LIMITATION

Proceedings arising from this Policy will be statute-barred five years after the date they can first be filed.

15. ANNUAL UPDATE OF THE POLICY'S ECONOMIC CONDITIONS

The updates to the economic conditions of the Policy for each annual period shall be as follows:

15.1. The Mutual Insurance Company may revise the Premiums, excess amounts and copayments at each renewal date.

Revisions of the Premiums, deductibles and copayments will be carried out based on the technical and actuarial criteria required to assess the impact of rising healthcare service costs, increased frequency of benefits covered under the Policy, the incorporation of new technologies or other events with similar consequences.

15.2. The annual Premium may also change at each renewal date, in accordance with the following criteria: (i) the geographical area where the Insured lives and (ii) the age of each of the Insureds. The Mutual Insurance Company will apply the Premium rates that are in effect at each renewal date.

If the Insured has a birthday during the term of the Contract and enters a new age bracket, the resulting Premium adjustment will be made at the end of the next annual period.

The Mutual Insurance Company will notify the Policyholder of any adjustments two months before the Contract expires, at which point the Policyholder may choose to extend the Contract by accepting the new economic conditions, or terminate it at the end of the current annual period. If the latter option is chosen, the Policyholder must notify the Mutual Insurance Company of their decision in a reliable and written form at least one month prior to the Policy renewal date. **If the Policyholder makes no comment about the economic conditions before this date, it will be understood that they have been accepted and payment of the first instalment of the Premium for the subsequent insurance period will mean that the Policyholder has accepted the new economic conditions of the Policy.**

16. HEALTH INSURANCE CARD

Once the Policy has been arranged, the Mutual Insurance Company will send the Policyholder a Personal Health Insurance Card for each Insured. This card will contain the following information as a minimum requirement:

- Card Number.
- Name and surnames of the Insured.
- Start date.

The Health Insurance Card is owned by the Mutual Insurance Card and is a non-transferable document for personal use.

In the event of loss, theft or damage, the Policyholder and the Insured shall be required to notify the Mutual Insurance Company within seventy-two hours.

The Mutual Insurance Company will then issue a new card, send it to the Insured's address, as it appears on the Policy, and then cancel the card that has been lost, stolen or damaged.

The Policyholder and the Insured are also required to return to the Mutual Insurance Company the Health Insurance Card corresponding to any Insured who has been removed from the Policy.

The Mutual Insurance Company will not be liable if the Health Insurance Card is used unlawfully or fraudulently.

SECTION TWO: COVERAGE DESCRIPTION CLAUSES

17. DESCRIPTION OF COVERAGE

17.1. Primary care

The following primary care services are covered by this Policy:

1. General medicine: medical care provided in the consulting room, ordering and prescription of basic diagnostic tests and mechanisms (analysis, ultrasound scans and general radiology) during the days and times established for such purpose by the medical professional, and at home when, for reasons based solely on the Insured's illness, they are unable to visit the practitioner's clinic. For emergencies, the Insured may either use the permanent emergency services approved by the Mutual Insurance Company, or call the 24-hour Emergency Helpline to request assistance at home.

2. Paediatrics and childcare: includes medical services offered to children aged under 14 at the doctor's clinic and ordering and prescription of basic diagnostic tests and mechanisms (analysis, ultrasound scans and general radiology) under the same conditions as indicated for general medicine.

3. Nursing Service: medical care provided at the clinic and at home following a prescription issued by one of the Mutual Insurance Company's doctors, as indicated in the section on general medicine.

17.2. Emergencies

Emergency medical care provided at the facilities included in the Medical Network, as indicated in the section on this area. Emergencies will be dealt with at the facility closest to where the Insured is located, even if it is a public or private facility that is not part of the Medical Network, as indicated in Clause 4.2.

Where there is due cause, this service may be provided at home by the permanent emergency services. It can be requested by calling the 24-hour Emergency Helpline indicated in the Medical Network section.

17.3. Medical and Surgical Specialties and Diagnostic Tests.

Diagnostic tests shall be carried out by the service providers appointed by the Mutual Insurance Company and shall require a written prescription issued by a medical professional from the Medical Network and, where applicable, prior authorisation from the Mutual Insurance Company.

The following medical specialities, surgery and diagnostic tests are covered by this Policy:

1. Allergies and immunology: **Excluding auto-vaccines and sensitisation tests, which will be paid for by the Insured.**

2. Clinical analysis.

3. Pathological Anatomy. **Second opinion studies in anatomical pathology and molecular pathology are excluded**, except in cases of error or insufficient information in the initial study. In such cases, a report from the physician requesting the second consultation or

study must be provided. Includes performing the following therapeutic targets: BRAF, ALK, K-RAS, N-RAS, C-ERB2/HER2, EGFR and C-Kit prior to the administration of cytostatic drugs, provided the technical data sheet for the drug issued by the Spanish Agency for Medicines and Medical Devices states that these procedures are required. These criteria also apply to genetic studies. Histological markers (immunohistochemistry) or molecular markers with prognostic or predictive value for treatment response or toxicity in oncology are included: Only those that have demonstrated clinical applicability and are listed and recommended in national and international clinical guidelines with Level I evidence will be authorised. **Any other markers or determinations from biological samples that do not meet these criteria will not be covered, as they will be considered under research (e.g., the use of somatic multigene platforms for comprehensive molecular profiling and identification of therapeutic targets).**

4. Anaesthesiology and resuscitation.

5. Angiology and vascular surgery. **Sclerotherapy treatment of varicose veins using foam, microfoam, and radiofrequency is excluded.** Endolaser treatment is covered exclusively for varicose veins with truncal involvement of the saphenous axes.

6. Digestive system. Endoscopic techniques and capsule endoscopy of the small intestine are included exclusively for the diagnosis of anaemias of unknown origin. The FibroScan diagnostic test is covered **once per year** per Insured, and only for assessing the progression of liver fibrosis in cases of chronic liver disease, **excluding those related to alcoholism.** Submucosal endoscopic dissection is covered solely for the treatment of premalignant or early malignant lesions of the gastric or colorectal mucosa, in cases where conventional polypectomy has been ruled out and surgical treatment is being considered. It may only be performed by providers expressly authorised by the Mutual Insurance Company.

7. Cardiology.

8. Cardiovascular surgery.

9. General and digestive system surgery: includes laparoscopies in procedures involving the digestive system when they have been scientifically proven to be more effective than non-laparoscopic procedures. These procedures may only be performed by medical professionals who have been specifically approved by the Mutual Insurance Company to do so. Monitoring of the recurrent laryngeal nerve is included exclusively for thyroid and parathyroid reoperations, surgery for malignant tumours with positive lymph nodes, or procedures involving pre-existing nerve damage.

10. Metabolic surgery: includes surgery under the following guidance:

    a. Adults aged between 18–60 with a Body Mass Index (BMI) of ≥40 kg/m² for more than 5 years.

    b. Adults aged between 18-60 with a BMI of between 35.0 and 39.9 kg/m2 for more than 5 years who have at least one of the following diseases: Type 2 diabetes, obstructive sleep apnea (OSA), hypertension, hyperlipidemia, nonalcoholic fatty liver disease (NAFLD), nonalcoholic steatohepatitis (NASH), pseudotumor cerebri, gastroesophageal reflux disease, asthma or severe urinary incontinence.

Excluded in cases where BMI is below 35, in cases of alcoholism or drug dependence, and in cases of active oncological disease.

11. Oral and maxillofacial surgery. Includes the diagnosis and surgical treatment of diseases and injuries exclusively involving the mandible, maxilla, and facial bones. **Procedures related to the specialty of Dentistry and Stomatology are excluded, as are aesthetic treatments and/or those aimed at functional improvement of the patient's oral and dental area, including, among others, orthognathic, pre-implant, and pre-prosthetic surgery. Complications arising from such treatments and surgeries are also excluded.**

12. Paediatric surgery.

13. Plastic and reconstructive surgery. **Treatments and surgeries for aesthetic or reconstructive purposes are excluded.**

14. Thoracic surgery.

15. Dermatology. **Photodynamic therapy is excluded**, except in cases of actinic keratosis, superficial and nodular basal cell carcinoma, Bowen's disease, and skin diseases (whether tumorous, inflammatory, or infectious).

16. Diagnostic Imaging: Requires a prescription from a Medical Network physician and covers general radiology, ultrasound, computed tomography (CT) scans, magnetic resonance imaging (MRI), angiography, digital arteriography, scintigraphy, bone densitometry, mammography and interventional or invasive radiology procedures. **Dental CT scans are excluded.**

    16.1 Virtual Colonoscopy and Colo-CT are covered exclusively for the evaluation of synchronous colon and rectal cancer in patients with colorectal cancer in whom a complete colonoscopy cannot be performed due to the inability to pass the colonoscope beyond an obstructive tumour, or when the colonoscopy is incomplete, unsuccessful, or contraindicated. It is considered contraindicated in cases of known or suspected perforation, documented acute diverticulitis within the previous 15 days, or fulminant colitis.

    16.2 CT Coronary Angiography or Coronary CT Scan: exclusively for patients with symptoms of coronary artery disease and an inconclusive ischemia test, those undergoing valve replacement surgery, assessment of coronary stenosis after bypass surgery, and cases of coronary artery anomalies. **Assessment of coronary stenosis following stent implantation and coronary calcium scoring are excluded.**

    16.3 Cardiac Magnetic Resonance Imaging (MRI): covered exclusively for:

    - Diagnosis and follow-up of adult congenital heart disease
    - Quantification of cardiac shunts.
    - Congenital or iatrogenic anomalous pulmonary or systemic venous return
    - Study and monitoring of cardiac shunts
    - Aortic aneurysm (including Valsalva sinus) and aortic coarctation

- Vascular Rings.
- In diagnosed ischaemic heart disease: assessment of coronary artery anomalies; evaluation and measurement of ventricular volumes, mass and function; and detection and assessment of myocardial viability following myocardial infarction.
- Detection and characterisation of pericardial or cardiac tumours.
- Hypertrophic Cardiomyopathy Study (apical only).
- Study of dilated cardiomyopathy to differentiate dysfunction related to coronary artery disease.
- Cardiac study in arrhythmogenic dysplasia.
- In valvular heart disease: for the characterisation of cardiac chamber anatomy and function, and quantification of regurgitation Excluded: quantification of stenosis and assessment of prosthetic valves.

16.4 Breast MRI: **Excluded for the assessment of breasts with implants placed for aesthetic purposes.**

16.5 Prostate MRI or Multiparametric MRI: covered exclusively for the following indications:

- Local, regional or remote staging for prostate cancer that has already been diagnosed;
- Detection or guide for diagnostic biopsies in the event of a negative result from previous biopsies;
- Active prostate cancer monitoring;
- Therapeutic monitoring.

17. Endocrinology. **Weight loss treatments are excluded.**
18. Geriatrics: Hospitalisation or medical assistance needed due to social problems are excluded.
19. Gynaecology: includes preventive medicine, with routine examinations to enable early diagnosis of breast and cervical neoplasms. Includes the study, diagnosis and treatment of infertility and sterility, as described in the section on Special Services. Laparoscopic gynaecological procedures and hysteroscopies. Lymphatic drainage immediately following mastectomy due to neoplastic disease, **limited to eight sessions (one per week for a maximum of two months).**
20. Haematology and Haemotherapy.
21. Internal Medicine.
22. Nuclear medicine / Radioactive isotopes.

22.1 **PET and PET/CT** scans are covered under the Policy exclusively for the indications authorised by the Spanish Agency of Medicines and Medical Devices, using the radiopharmaceutical fluorodeoxyglucose (FDG). Specifically, these procedures are as follows:

- Diagnostic Oncology:

  - Characterisation of the solitary pulmonary nodule.
  - Detection of a tumour of unknown origin, evidenced, for example, by cervical adenopathy or liver or bone metastases.
  - Characterization of a pancreatic mass.

- Staging:

  - Head and neck tumours, including assisted guided biopsy.
  - Primary lung cancer.
  - Locally advanced breast cancer.
  - Cancer of the oesophagus.
  - Pancreatic carcinoma.
  - Colorectal cancer, especially in recurrent cases.
  - Malignant lymphoma.
  - Malignant melanoma, with Breslow greater than 1.5 mm or lymph node metastases at initial diagnosis.

- Monitoring of response to treatment:

  - Malignant lymphoma.
  - Head and neck tumours.

- Detection in case of a reasonable suspicion of recurrence:

  - Gliomas with a high degree of malignancy (III or IV).
  - Head and neck tumours.
  - Thyroid cancer (non-medullary): patients with increased serum thyroglobulin levels and a negative radioiodine whole-body scan
  - Primary lung cancer.
  - Breast cancer.
  - Pancreatic carcinoma.

- Colorrectal cancer.
- Ovarian cancer.
- Malignant lymphoma.
- Malignant melanoma.

- Neurology.

- Localisation of epileptogenic foci in the presurgical evaluation of temporal epilepsy.

22.2 **PET TAC PSMA**: exclusively in cases of suspected recurrence of prostate cancer—based on two consecutive increases in PSA levels of ≥ 0.2 ng/ml—after radical prostatectomy or after radiotherapy (either external beam or brachytherapy), with a PSA increase of > 2 ng/ml above the nadir (the lowest point following therapy)..

23. Nephrology.

24. Neonatology. Newborn care: includes health care for the newborn infant in facilities approved by the Mutual Insurance Company and the expenses arising from it. **If delivery of the baby was covered by the Policy, newborn care will be provided for a period of 15 days after the birth and thereafter, when the newborn infant is registered with the Mutual Insurance Company in accordance with the provisions of this Policy.**

25. Pulmonology.

26. Neurosurgery. Including the use of a neuronavigator and ultrasonic aspirator. This procedure may only be performed by service providers who have received express authority from the Mutual Insurance Company to provide this service.

27. Neurophysiology. Includes Video EEG and Sleep Studies. **Polysomnographic studies for CPAP calibration are excluded.**

28. Neurology: Includes rehabilitation for brain damage exclusively caused by stroke and/or newly occurring cerebrovascular accidents in patients with no prior history of such conditions. **Rehabilitation will only be covered in cases of moderate or severe functional deficits secondary to the stroke, provided the patient is in a stable clinical condition and the rehabilitation is initiated within 60 days from the onset of the episode.** Rehabilitation for brain damage may be provided on an inpatient or outpatient basis, with a **maximum coverage period of 30 days. After this period, the service will no longer be covered by Nueva Mutua Sanitaria. Rehabilitation for brain damage resulting from any other condition**—such as cranial/brain trauma, brain tumours, cerebral palsy, spinal cord injuries, traumatic injuries, myelopathies or neurodegenerative diseases—**is excluded.**

    HIFU is covered exclusively for severe essential tremor with inadequate response to medical therapy (after six months of unsuccessful pharmacological treatment).

29. Obstetrics. Includes childbirth preparation classes, one Doppler ultrasound per trimester of pregnancy, and the following prenatal studies: EBA screening, amniocentesis, chorionic villus sampling (CVS), and non-invasive prenatal testing (NIPT) for fetal DNA in maternal

blood for the detection of trisomies 21, 18, and 13, when the risk index in the Combined First Trimester Screening (CFTS) falls between 1/50 and 1/250, or in women with a history of pregnancy affected by aneuploidy in chromosomes 21, 18, or 13, regardless of the CFTS outcome.. **Excluding any other means of diagnosis and genetic testing during pregnancy.**

30. Oral medicine: only includes extractions, dental treatments arising from said extractions and mouth cleanings prescribed by a dentist approved by the Mutual Insurance Company.

31. Ophthalmology: includes laser photocoagulation exclusively for retinal detachment and corneal transplantation. Optometric procedures are covered, provided they are prescribed by an ophthalmologist from the Mutual Insurance Company's authorised network.

    Refractive laser surgery for myopia is also included, as described in the corresponding section under Special Services.

    Intravitreal injections and medication are excluded.

32. Oncology: includes autologous bone marrow or peripheral blood stem cell transplants **exclusively for the treatment of haematological malignancies.** Implantable intravenous perfusion reservoirs used in chemotherapy are included.

33. Otolaryngology (Ear, Nose and Throat – ENT): Includes CO_2 laser and radiofrequency surgery.

34. Family Planning: Only includes consultation, intrauterine device (IUD) insertion (**device cost excluded**), vasectomy, and tubal ligation.

35. Psychiatry.

36. Rheumatology.

37. Interventional or invasive radiology: Requires a written prescription issued by a medical professional who has been approved by the Mutual Insurance Company and authorisation from the latter.

38. Traumatology and orthopaedic surgery: includes arthroscopic surgery, hand surgery, percutaneous nucleotomy, chemonucleolysis as well as bone grafts of biological materials. **Growth factor treatments are excluded.**

39. Urology: Included, exclusively when performed by providers expressly authorised by the Mutual Insurance Company:

    a. The study, diagnosis and treatment of infertility and sterility, as described in the corresponding section under Special Services

    b. Laparoscopic procedures for conditions in which their effectiveness has been proven.

    c. Green laser prostate photovaporisation.

d. Holmium laser-assisted ureteroscopy with lithotripsy (endourethral): comprehensive treatment for ureteral lithiasis.

e. Fusion-guided prostate biopsy: exclusively for patients with PIRADS 3, 4 or 5 lesions on MRI

f. Holmium laser prostatectomy (enucleation), solely for benign prostate hypertrophy with a volume greater than 60cc.

g. Prostate focal cryosurgery therapy: exclusively for recurrent prostate cancer following external radiotherapy or brachytherapy.

h. Micro ultrasound of the prostate for patients:

    1. With PIRADS 3 lesions on MRI.

    2. With a normal MRI and suspicion of prostate cancer due to rising PSA.

Excluded for patients with PIRADS 4 and 5 lesions on MRI.

i. HIFU prostate ablation: Covered for localised prostate adenocarcinoma tumours of low or intermediate risk, either visible on MRI or diagnosed through fusion biopsy, only when located posteriorly and in the absence of poor prognostic criteria (ISUP grade >3, intraductal pattern, extracapsular disease, PSA >20).

The study, diagnosis and treatment (including surgery) of impotence and erectile dysfunction are excluded.

17.4. Therapeutic Methods

To be carried out by the service providers designated by the Mutual Insurance Company and subject to a prior written prescription from a specialist physician within the Medical Network.

The following therapies are covered by this Policy:

1. Aerosol therapy and ventilation therapy: **in all cases medications will be paid for by the Insured.**

2. CPAP and BiPAP: exclusively for the treatment of respiratory failure of neuromuscular or pulmonary origin. **Excluded in the case of obstructive sleep apnea.**

3. Haemodialysis: to be provided on both an outpatient and inpatient basis, exclusively for the treatment of acute kidney failure, **with the maximum treatment period of one year.**

4. Lithotripsy of the urinary system.

5. Phoniatrics: As a rehabilitation treatment for laryngeal nodules or after laryngectomy, **up to a maximum of 24 sessions per year.**

6. Oxygen therapy: to be provided on an inpatient basis or at home. Includes ambulatory oxygen therapy exclusively with a concentrator.

7. Chemotherapy:

The Mutual Insurance Company will provide **cytostatic medication exclusively**, as required by the patient, for as many cycles as necessary. **Immunotherapy treatments are excluded.**

This medication must always be prescribed by the oncology specialist from the Medical Network who is in charge of the patient's care.

Treatments will be paid for by the Mutual Insurance Company on a day patient or inpatient basis, when necessary. In all cases, the specialist responsible for the patient will decide which treatments to offer and how to perform them.

In these treatments, the Mutual Insurance Company will only cover the cost of pharmaceutical products that are **specifically cytostatic**, provided that the following conditions are met:

- They must be prescribed for the indications listed in the product's technical data sheet and authorised by the Spanish Agency of Medicines and Medical Devices (AEMPS).
- They must be authorised by the Ministry of Health and, therefore, marketed in Spain with the corresponding resolution from the AEMPS and an official price/reimbursement decision.
- In all cases, a complete clinical report must be submitted, specifying the diagnosis, indication and proposed treatment(s). A new complete clinical report will be required in the event of a change in the patient's treatment regimen.

Participation in Clinical Trials is excluded from coverage. The Mutual Insurance Company will not cover diagnostic tests or treatments for patients participating in Clinical Trials that are related to or derived from their oncological condition.

Oral medication is excluded from coverage.

The use of medicinal products under "special conditions" (Royal Decree 1015/2009 of 19 June) is excluded. **This includes:**

- **Compassionate use of investigational medicinal products: the use of a medicine before its authorisation in Spain.**
- **Use of authorised medicines under conditions other than those approved: the use of medicines in ways not included in the authorised technical data sheet.**
- **Medicines not authorised in Spain: the use of medicines authorised in other countries but not authorised in Spain (foreign medication).**

Genetic testing for cancer predisposition syndromes is excluded, except in cases where the results may lead to a change in therapeutic management for the affected patient (such therapeutic change must also meet the remaining conditions). Each case must be assessed in a genetic counselling consultation to ensure appropriate pre- and post-test evaluation.

Hyperthermic Intraperitoneal Chemotherapy (HIPEC): HIPEC is covered exclusively for the following indications:

1. Pseudomyxoma peritonei (including disseminated peritoneal adenomucinosis – DPAM)

2. Peritoneal mesothelioma

3. Combined with cytoreductive surgery for the treatment of goblet cell carcinoid tumour (also known as adenocarcinoid, mucinous carcinoma, or crypt cell carcinoma)

The Mutual Insurance Company considers hyperthermia to be experimental and investigational for all other indications, including the following, due to lack of evidence supporting its efficacy in these conditions. **Therefore, these are expressly excluded from coverage:**

1. Deep hyperthermia alone or in combination with radiotherapy

2. Intrapleural mesothelioma

3. Hyperthermic intraperitoneal chemotherapy for appendiceal carcinoma without pseudomyxoma, bladder cancer, clear cell ovarian carcinoma, colon cancer, desmoplastic small round cell tumour, fallopian tube cancer, gastric cancer, hepatocellular carcinoma, mixed germ cell tumour, ovarian cancer, pancreatic cancer, small bowel adenocarcinoma, thymic carcinoma, or uterine leiomyosarcoma

4. Interstitial, intracavitary, and intraluminal hyperthermia

5. Hyperthermic intraperitoneal chemotherapy for peritoneal carcinomatosis of any origin other than pseudomyxoma peritonei or peritoneal mesothelioma

6. Hyperthermic melphalan perfusion for melanoma of the limbs in stages I, IIIB, and IIIAB, as well as regional hyperthermic perfusion for limb melanoma in combination with any other chemotherapy

7. Regional hyperthermic perfusion for any indication other than limb melanoma (e.g., non-small cell lung cancer)

8. Superficial hyperthermia for paranasal sinus and nasal cavity cancer

9. Transrectal ultrasound hyperthermia for prostate cancer

10. Whole-body hyperthermia for testicular cancer and other indications

8. Radiotherapy and Proton Therapy (Proton Radiotherapy):

8.1 Radiotherapy: **covered exclusively for oncological conditions.** Also includes stereotactic radiosurgery for the treatment of tumoural processes (mainly malignant), cerebral arteriovenous malformations, and as a last therapeutic option for trigeminal neuralgia.

8.2 Proton Therapy (or Proton Radiotherapy): covered **exclusively for patients under 15 years of age, in the following cases:**

- Chordomas and chondrosarcomas located at the base of the skull and/or cervical spine.

- Uveal melanomas confined to the eyeball, i.e., without distant metastases (the uvea includes the iris, ciliary body, and choroid).

Coverage is excluded for any other indication.

9. Rehabilitation: Only ambulatory rehabilitation is covered and solely for conditions of musculoskeletal system origin. Treatments must be provided by facilities that have been approved by the Mutual Insurance Company. Up to a maximum of 40 sessions per year can be performed for chronic pathologies and up to 60 sessions per year for acute pathologies caused by trauma or surgery.

Inpatient procedures will only be provided to aid the recovery of the musculoskeletal system secondary to orthopaedic surgery and cardiac recovery after surgery with extracorporeal circulation.

Pelvic floor rehabilitation, exclusively for dysfunctions resulting from pregnancy and childbirth previously covered by the Mutual Insurance Company, **with a maximum coverage period of four months following delivery and a limit of 10 sessions per year.**

Also included is post-mastectomy lymphatic drainage of neoplastic origin, as described in clause 17.3, section 19.

The following are excluded from coverage: home-based rehabilitation; rehabilitation of neurological origin (except for brain damage rehabilitation as defined in clause 17.3, section 28); **outpatient cardiac rehabilitation** (except for patients who have suffered an acute myocardial infarction, and only within the first 60 days following the event); **any rehabilitation using robotic equipment; rehabilitation with INDIBA radiofrequency; and respiratory rehabilitation.**

Shock wave rehabilitation will only be provided for the following pathologies: Calcific tendonitis of the shoulder; humeral epicondylitis; humeral epitrocleitis; plantar fasciitis and delays or failures in the union of fractures (pseudarthrosis). **The maximum number of sessions for this type of treatment is 5 sessions per pathology.**

10. Pain treatment: only implantable reservoirs (port-a-cath type) are included. **Implantable pumps for drug infusion and spinal cord stimulation electrodes are expressly excluded. Iontophoresis is also excluded.**

11. Hyperbaric Chamber Systemic hyperbaric oxygen therapy is covered exclusively for the following conditions, subject to the session limits specified:

1. Acute air or gas embolism: **up to 10 sessions**
2. Acute carbon monoxide poisoning: **up to 5 sessions or until the patient is stabilised**
3. Acute peripheral arterial insufficiency: **up to 10 sessions**
4. Acute traumatic peripheral ischaemia: twice daily for **up to 7 days or a total of 14 sessions**
5. Central retinal artery occlusion (CRAO): acute treatment, **twice daily for up to 7 days, extendable to 10 days if clinically justified by a supporting medical report.**
6. Refractory chronic osteomyelitis unresponsive to standard medical and surgical treatment: **up to 40 sessions**

7. Compromised skin grafts and flaps with hypoxia or reduced perfusion affecting viability: **5 sessions**

8. Decompression sickness: **up to 10 sessions**

9. Gas gangrene (clostridial myositis and myonecrosis): three times during the **first 24 hours, then twice daily for a maximum of 5 days**

10. Idiopathic sudden sensorineural hearing loss: hearing loss greater than 30 dB affecting more than three consecutive pure-tone frequencies, after failure of oral and intratympanic steroids, and provided that treatment is initiated within 3 months of onset: **up to 20 sessions**

11. Infected deep non-healing ulcers (reaching tendon or bone, Wagner grade 3 or higher) in the lower limbs of diabetic adults unresponsive to at least one month of meticulous wound care, documented photographically (with scale).

12. Pneumatosis cystoides intestinalis: **daily treatments lasting 2.5 hours for a maximum of 3 days**

13. Progressive necrotising soft tissue infections: **twice daily until stabilisation, up to 30 sessions**

14. Prophylaxis and treatment of radiation-induced mandibular necrosis in patients undergoing dental surgery on an irradiated jaw: **up to 20 treatments prior to surgery and 10 treatments immediately after**

15. Radiation-induced haemorrhagic cystitis: **daily 90-minute sessions, up to 40 sessions**

16. Radiation necrosis (including cerebral radionecrosis, myoradionecrosis, and osteoradionecrosis — including osteonecrosis of the jaw — as well as other soft tissue radionecrosis affecting areas such as the breast, chest wall, head and neck, and pelvic organs, including the bladder and rectum): **up to 40 sessions, with an additional 10 sessions to support tissue recovery following surgical reconstruction, if performed**

17. Radiation proctitis: **up to 45 sessions**

Use of the hyperbaric chamber (systemic hyperbaric oxygen therapy) is excluded for any other indication.

17.5. Other services

The other services covered by this Policy are as follows:

1. Patient transport: **This service will be provided by land** for urban or interurban transfers in the Insured's province of residence, from their home to the hospital and vice versa. Transfers between hospitals located in different provinces are also included when there are insufficient medical resources in the province where the Insured lives to provide them. This service only covers transfers for hospital admissions or emergency medical care **and does not include transfers required for rehabilitation treatments, diagnostic tests or outpatient medical consultations, even**

if they are prescribed by a doctor who has been approved by the Mutual Insurance Company.

2. Podiatry: only chiropody is covered **and is limited to eight sessions per year.**

3. Psychology: Includes individual psychological care. It includes basic psychological diagnosis and the interpretation of psychometric tests, t**he cost of which shall be borne by the Insured.** Up to a maximum of 4 consultations or sessions per month are covered, with a limit of 24 per year, lasting half an hour per Insured. In exceptional cases where the patient has not been discharged within this period, an extension of two additional months (8 sessions) may be requested, subject to submission of a medical report justifying the need.

4. Home hospitalisation: this will be performed by the health teams appointed by the Mutual Insurance Company when the patient needs special care but does not require hospital admission. A prescription from a doctor from the Medical Network is needed for this service. **Care for social problems is not included.**

5. Prostheses: **only covered when prescribed in writing by a specialist from the Medical Network and performed by physicians appointed by the Mutual Insurance Company. Coverage is limited to the prostheses and "implantable materials" expressly listed below:**

5.1 Ophthalmology:: **All types of materials and lenses are excluded,** except for the simple monofocal lens used in cataract surgery. **Monofocal toric lenses, monofocal plus lenses, extended depth-of-focus lenses, and any other type of advanced monofocal or multifocal lenses are excluded.**

5.2 Traumatology and Orthopaedic Surgery: Hip, knee and other joint prostheses; materials required for spinal fixation; intervertebral discs; intervertebral (or interspinous) interposition materials; materials required for vertebroplasty or kyphoplasty; biological osteoligamentous material obtained from national tissue banks; osteosynthesis materials.

5.3 Cardiovascular: Covers vascular prostheses (stents, peripheral or coronary bypasses, medicalised or not), pacemakers, and cardiac valves implantable via conventional heart surgery. **Percutaneously or subcutaneously implantable valves and cardiac devices, defibrillator pacemakers, artificial hearts, resynchronisation devices, subcutaneous Holter monitors, and all other percutaneously implantable intracardiac devices are excluded.**

5.4 Chemotherapy or pain treatment: **all devices are excluded**, except for infusion reservoirs.

5.5 Other surgical materials: Abdominal meshes, **excluding double-layer meshes used in the treatment of abdominal wall pathologies**; urological suspension systems; cerebrospinal fluid shunt systems (for hydrocephalus); breast prostheses and expanders, **only in breasts affected by prior tumour surgery.**

6. Genetic Studies:

- Includes studies performed to diagnose and treat genetic diseases.
- Includes studies of BRCA1 and BRCA2 genes under the following guidance:

A. For patients with no personal history of breast or ovarian cancer, who meet any of the following criteria:

   - Two or more first- or second-degree relatives under the age of 50 diagnosed with breast cancer.
   - Two or more first- or second-degree relatives diagnosed with ovarian cancer at any age.
   - Two or more first- or second-degree relatives: at least one diagnosed with breast cancer under the age of 50, and another with ovarian cancer at any age.

B. For patients over 50 years of age with a personal history of breast cancer, who meet any of the following criteria:

   - Two or more first- or second-degree relatives under the age of 50 diagnosed with breast cancer.
   - Two or more first- or second-degree relatives diagnosed with ovarian cancer at any age.
   - Two or more first- or second-degree relatives: at least one diagnosed with breast cancer under the age of 50, and another with ovarian cancer at any age.

C. Male patients with breast cancer.

D. Patients aged under 50 with breast cancer.

E. Patients with ovarian cancer and breast cancer.

- **The molecular study of the PCA3 gene is excluded. DNA HLA A B C/DQ/DR typing is excluded** (the latter is excluded except for transplantation in affected patients).

17.6. Hospitalisation

Hospitalisation will take place at clinics or hospitals designated by the Mutual Insurance Company. The patient will be accommodated in a standard single room with a companion bed, e**xcept in cases of psychiatric hospitalisation, ICU admissions or incubator care**. The Mutual Insurance Company will cover the cost of treatment, hospital stay, patient meals, care and related materials, as well as operating theatre expenses, anaesthetic products and medication.

This Policy covers the following types of hospitalisation:

(i) Medical hospitalisation: provided for individuals over the age of 14, subject to a written prescription issued by a doctor from the Mutual Insurance Company, and carried out at medical centres designated by the same.

(ii) Paediatric hospitalisation: provided for individuals under the age of 14, subject to a written prescription issued by a doctor from the Mutual Insurance Company, and carried out at medical centres designated by the same. It includes both standard hospitalisation and incubator care **(in**

the latter case, a bed for a companion is not included).

(iii) Psychiatric hospitalisation: admission requires a written prescription issued by a specialist from the Mutual Insurance Company and will take place at psychiatric facilities designated by the same. Patients will be accommodated in a single room if clinically required, and **no companion bed will be provided.** Covers the costs of stay, medication, and appropriate medical treatments. **This service will only be provided for the treatment of acute episodes in patients who are not chronically ill, and hospitalisation will be limited to a maximum period of thirty (30) days per year.**

(iv) ICU hospitalisation (Intensive Care Unit): Hospitalisation in an ICU (Intensive Care Unit): this service will take place at appropriate facilities designated by the Mutual Insurance Company, following a prescription issued by a physician from the same centre. **No companion bed is included.**

(v) Surgical hospitalisation: surgical procedures requiring hospitalisation will be carried out at a clinic or hospital designated by the Mutual Insurance Company, following a prescription issued by a doctor from the Medical Network. Dystocic and premature deliveries will receive the same care.

(vi) Obstetric hospitalisation (maternity clinic delivery): attended by an obstetrician, assisted by a midwife, and includes delivery room expenses. **Water births and deliveries at home and by alternative means are expressly excluded.**

If the doctor who prescribes the admission is not part of the Medical Network, it may be authorised at the expense of the Mutual Insurance Company under the following conditions:

- **The patient will be responsible for covering the fees charged by medical professionals (surgeon, assistants, anaesthetist, etc.) as well as for prostheses and diagnostic prescriptions issued by them.**

- **At most, the following hospital stays may be authorised: births and small surgical procedures, 3 days; 4 days for medium-size procedures (groups 4, 5 and 6 of the WTO Classification); 8 days for large procedures (groups 7 and 8 of the WTO Classification), which is the maximum coverage provided by the Mutual Insurance Company for these types of admissions.**

- This coverage will be valid for all the affiliated hospitals listed in the Medical Network that have not expressed opposition to this type of agreement and that expressly accept the authorisation issued by the Mutual Insurance Company.

17.7. 24-hour Helpline

A telephone service that offers information on the Medical Network as well as advice in emergency situations. The service is provided by a team of medical experts 24 hours a day, 365 days a year.

17.8. Healthcare abroad

Emergency healthcare outside Spain is provided through a group travel insurance policy that includes the following coverage:

- Payment or reimbursement of medical, surgery, pharmaceutical and hospitalisation expenses.

- Transportation or repatriation of the Insured in the event of illness or an accident and transportation or repatriation of the remaining Insureds if they are not able to travel using the channels that were originally arranged.

- Transportation or repatriation of a deceased Insured and their Insured companions to their home.

- Transportation of an individual away from the place where an accident occurred if they cannot immediately return home or be repatriated due to their state of health.

- Early return of the Insured due to serious illness, a serious accident or death of a relative.

The terms and conditions of this travel insurance group policy are included as Appendix II to this Policy.

Services for high-risk and competitive sports and the practice of dangerous activities are excluded from this coverage.

17.9. Special services

This Policy covers the following special services:

1. Refractive surgery for myopia: Excimer Laser treatment will be available to Insured persons who have completed the applicable waiting period and have **more than four diopters of myopia in each eye, with up to 50% of astigmatism allowed to be combined. This service will only be provided by the facilities that have been approved to provide this coverage.**

2. Diagnosis and treatment of infertility: **To begin the process, both members of the legally recognised couple must be enrolled with the Mutual Insurance Company and must have completed the applicable waiting period. The cost of treatment will not be paid for women aged over 40**, with the exception of patients who donate eggs. This coverage includes diagnosis by gynaecologists from the Medical Network, who will refer patients to an authorised specialist facility. Infertility treatment coverage includes the following procedures: Artificial Insemination (AI), In Vitro Fertilisation (IVF), and combined treatments.

Number of cycles:

- AI as a single procedure: **a maximum of three cycles.**

- IVF-ICSI as a single procedure: **a maximum of three cycles.**

- Combined treatment: a **maximum of AI (two cycles) and IVF (up to three cycles).**

For the purposes of coverage limits, a "cycle" is:

- Artificial insemination from a spouse or donor.

- Induction with follicular puncture.

- Induction with follicular puncture and IVF laboratory.

- Induction with follicular puncture, IVF laboratory and embryo transfer.
- Induction with follicular puncture, IVF laboratory, embryo transfer and first cryotransfer.
- All cryotransfers from the second one.

Neither induction nor interrupted induction are considered a "cycle".

- Egg donation: **Always paid for by the patient.**

- Sperm freezing: the Mutual Insurance Company will pay for the cost of freezing sperm for **a maximum period of one year. From then on the patient must pay this cost.**

- Embryo freezing: the Mutual Insurance Company will pay for the cost of freezing embryos for **a maximum period of one year**. **From then on the patient must pay this cost.**

- Ultrasounds: the Mutual Insurance Company will cover the costs of all the ultrasound procedures needed to perform the treatment. Once gestation has occurred, **up to three gestational ultrasound scans are covered.**

- This cover also includes:

- Extended cultivation:
- Biopsy with/without sperm retrieval.
- Motile sperm recovery (REM) semen analysis
- Study of lost pregnancies.
- FISH technique spermatozoa (justification with report).
- Spermatozoa fragmentation (justification with report).
- Preimplantation Genetic Diagnosis (justification with report).
- In these last three cases, the service is covered if one member of the couple presents chromosomal abnormalities, for couples who experience several miscarriages (three or more) and when IVF/ICSI fails (after three or more cycles without pregnancy). **Diagnosis of molecular abnormalities is not covered.**

All types of surgical procedures are expressly excluded, as well as any medication required to carry out any cycle. Oocyte freezing is not covered.

The Mutual Insurance Company will not cover the diagnosis or treatment of infertility under the following circumstances:

- **once the number of cycles has been completed.**
- **once a pregnancy has been held to term (i.e. a live baby is born).**

3. Preventive medical checkups: This is a special service that comprises a first consultation with an internal medicine specialist so they can obtain a complete medical history and perform

a first examination of the Insured. Depending on the results of the first consultation, the specialist will then arrange a number of diagnostic tests based on age, sex, risk factors and the data obtained from the Insured's medical history. A second consultation with the specialist will then be performed to examine the results, provide a report, and assess therapeutic options if necessary.

This check-up will be performed at a Medical Network facility that has been specially approved for this purpose. It is subject to the copayment described in the Particular Terms and Conditions, which covers both the consultations and the diagnostic tests.

Any treatments that are needed as a result of the diagnosis from this check-up will be performed under the standard coverage of this Policy.

4. Special Services include: Sleep studies, oncological radiotherapy treatments, dialysis or haemodialysis, lithotripsy, vacuum-assisted biopsy (VAB), capsule endoscopy, brain damage rehabilitation, metabolic surgery, holmium laser prostatectomy, focal prostate cryotherapy, and non-invasive fetal DNA testing using maternal blood.

18. EXCLUSIONS

Without prejudice to any other exclusion duly highlighted in the terms and conditions of this Policy, the following items are expressly excluded from the coverage of this Policy:

1. All kinds of diseases, injuries or ailments, constitutional or congenital disorders, deformities, medical conditions or situations (such as pregnancy or gestation) that exist on the date each Insured is added to the Policy that are known about but have not been declared in the health questionnaire, and/or any such conditions that are the consequence of accidents or illnesses and their sequelae that originated before each Insured was added to the policy, which the Insured also knew about but did not declare in the health questionnaire.

2. Expenses arising from healthcare services provided by private facilities, Social Security centres or institutions within the National Health System that are not included in the Medical Network, except for emergency healthcare expenses as outlined in Clause 4.2.

3. Cross-border healthcare.

4. Healthcare arising from chronic alcoholism, drug addiction, intoxication due to alcohol abuse, psychotropic drugs, narcotics or hallucinogens.

5. Suicide attempts and self-harm. Healthcare for illnesses or accidents caused by the Insured's wilful misconduct.

6. Pharmaceutical products that are not administered in hospital (except chemotherapy performed by a health professional at an approved facility), vaccines of any kind and health and beauty products.

7. Diagnostic and therapeutic procedures whose clinical safety and efficacy have not been scientifically proven or that have been clearly surpassed by other available options. Procedures that are of an experimental nature or that have not been sufficiently proven to effectively contribute to preventing, treating or curing diseases, maintaining or improving life expectancy or self-worth, or eliminating or reducing pain and suffering and procedures that are prescribed for the purposes of leisure, rest or comfort or due to sporting activities. For

the purposes of this policy, a diagnostic, surgical or therapeutic procedure is deemed to be safe and effective when it has been approved by the European Medicines Agency and/or the Spanish Agency for Medicines and Medical Devices. Furthermore, a procedure is deemed to be universally adopted and consolidated when it is routinely performed in standard clinical practice at public hospitals in at least nine Autonomous Regions in Spain, and not only at referral hospitals.

8. Spa treatments and rest cures, even if they are prescribed by doctors.

9. Procedures used to treat sterility or infertility in both sexes ("in vitro" fertilisation, artificial insemination, etc.,) in Insureds aged over 40 and voluntary pregnancy interruptions, as well diagnostic tests related to said interruptions. The study, diagnosis and treatment (including surgery) of impotence and erectile dysfunction are also excluded.

10. Transplants of organs, tissues, cells or cellular components are excluded, except for autologous bone marrow or peripheral blood stem cell transplants for haematological tumours, and corneal transplants.

11. Hospitalisation due to social problems.

12. General preventive medical examinations, except those included in the Preventive Medicine Campaigns promoted by the Mutual Insurance Company, and the provisions of these General Terms and Conditions as regards preventive medical check-ups.

13. Analyses, inspections and any other examinations that are solely performed in order to issue reports, certificates or documents, rather than to provide the medical and surgical services that are the object of this Policy.

14. Special home healthcare services are also excluded whenever this is not deemed to be included under clause 17.1 of these General Terms and Conditions. **Expenses incurred to receive help at home to eat, wash laundry, purchase food, take medication, to be monitored or for health professionals to remain at the Insured's home are likewise excluded.**

15. Educational therapy, such as language education in congenital procedures or special education for patients with mental disorders.

16. Root canal treatments, fillings, placement of dental prostheses, orthodontic and periodontal treatments, implants, and any other dental procedures not included in the Description of Coverage section.

17. Also excluded are prostheses of any kind or nature, except those expressly listed in section 17.5, point 5. **Any type of orthopaedic, biological or synthetic materials, grafts** (except bone grafts made of biological materials) **and artificial hearts, which will be paid by the Insured. All types of lenses used in cataract surgery are excluded,** except for the standard monofocal lens**. This includes bifocal lenses, trifocal lenses, and toric or advanced-generation monofocal lenses.**

18. Chronic dialysis and haemodialysis treatments.

19. Psychological or psychiatric treatments, other than those included in section 17.5, point 3.

20. Travel expenses, except patient transport under the terms provided for by the Description of Coverage section and the terms of Clause 17.8 on Healthcare Abroad.

21. Refractive surgery of any type for myopia of less than 4 dioptres, hyperopia and astigmatism.

22. Surgical techniques or therapeutic procedures involving laser technology are excluded, except for: laser photocoagulation **exclusively for retinal detachment**; Excimer laser **for refractive myopia surgery** as described in Clause 17.9, section 1; CO_2 laser in Otorhinolaryngology and Gynaecology; devices used in musculoskeletal rehabilitation; green and holmium lasers in Urology; and Endolaser, **exclusively for varicose veins affecting trunkal saphenous axes.**

23. Any surgery required by unborn infants.

24. Surgery for Parkinson's and Epilepsy.

25. Genetic mapping assessments aimed at identifying the predisposition of the Insured or their current or future ascendants or descendants to develop certain diseases related to genetic alterations, except for the fetal DNA test in maternal blood, as described in the Obstetrics section of Clause 17.3, paragraph 29. Genetic maps of tumours and pharmacogenetics, genetic studies for Cancer predisposition syndrome are also expressly excluded, except in cases where the result could produce a therapeutic change in the affected patient (as long as the therapeutic change is covered by the Policy).

26. Sex change surgery.

27. Any surgery that uses robotic surgery equipment.

28. New diagnostic procedures, surgery and treatments that are not included in this Policy.

29. Participation in any type of clinical trial, as this involves the experimental evaluation of a product, substance, medicine, diagnostic or therapeutic technique without scientific evidence of its effectiveness, as well as any diagnostic tests and therapeutic procedures related to, necessary for or resulting from participation in such clinical trial.

30. Surgical procedures, injections and treatments, as well as any other intervention carried out for aesthetic or cosmetic purposes. Any type of pathologies or complications that could appear at a later date and that are directly and principally caused by the Insured having received any of the aforementioned aesthetic or cosmetic procedures, injections or treatments are also expressly excluded.

31. Treatments to prevent hair loss.

32. Procedures involving plasma that is rich in platelets or growth factors.

33. Any type of service related to pathologies, surgeries, diagnostic procedures, treatments or any other medical or healthcare act not covered by the Policy, as well as any complications arising therefrom.

34. Illnesses, injuries or ailments resulting from the professional practice of any sport, as well as those arising from clearly hazardous sports and activities. The following activities are

considered clearly dangerous: mountaineering, climbing, paragliding, parachute jumping, bungee jumping, boxing, martial arts, rugby, motocross, go-karts, quad-bikes, motor vehicle racing, diving and any other activities that could be considered as such.

35. Alternative medicines, naturopathy, homoeopathy, acupuncture, hydrotherapy, pressotherapy, ozone therapy and any therapy not officially recognised in Spain as a medical specialty, unless expressly stated otherwise in the Specific Terms and Conditions of the Policy.

36. Physical damage caused by wars, riots, acts of terrorism, military manoeuvres and declared epidemics.

37. Healthcare in the event of illnesses, injuries, deformities or defects that are directly or indirectly related to radiation or nuclear accidents, earthquakes, volcanic eruptions, floods and other seismic and meteorological phenomena.

38. Any type of service that is directly related to medical procedures that are not covered by the Policy.

GLOSSARY OF TERMS

For the purposes of this Policy, the below terms are as follows:

ACCIDENT: Bodily injury sustained while the Policy is in force, resulting from a violent, sudden, and external cause beyond the Insured's intent or control.

INSURED: The natural person or persons designated as such in the Particular Terms and Conditions on whom the Policy is established.

SPECIAL HEALTHCARE AT HOME: Care given to the Insured by a general practitioner or family doctor and/or registered nurse when the patient's pathology requires special care without actually requiring hospital admission and always after a doctor's prescription.

CONSULTATION: Healthcare interaction between patient and physician, taking place at the same time and in the same space, requiring the physical presence of both parties, except in the case of video or telephone consultations.

COPAYMENT: The Insured's share of the cost of the medical act or group of acts, to be paid directly to the Mutual Insurance Company.

MEDICAL NETWORK: List of professionals and healthcare facilities that are owned or have been approved by the Mutual Insurance Company in each province. The Medical Network includes healthcare professionals and facilities for each province, as well as information services and helpline numbers available to the Insured throughout Spain. The professionals and facilities listed in the Medical Network act with full independence of judgement, autonomy, and sole responsibility in the provision of the healthcare services for which they are qualified.

HEALTH QUESTIONNAIRE: Statement made and signed by the Policyholder or Insured before the the Policy is arranged to assess the risk covered by the insurance Policy.

Qualified Nurse: Person who has been legally trained and authorised to provide nursing services.

ILLNESS: Any alteration in an individual's state of health caused by a pathology that is not the result of an accident, provided that it is diagnosed and confirmed by a legally recognised doctor or dentist, its first symptoms appear while the Policy is in effect, and it requires medical attention.

CONGENITAL DISORDER: A disorder that exists when a person is born as a consequence of hereditary factors or conditions acquired during pregnancy up to the time of birth. A congenital condition can appear and be recognised immediately after birth, or it can be discovered later, at any time during the individual's life.

PRE-EXISTING CONDITION: A condition the Insured has before the Policy is arranged or before they are added to it, which may or may not be the result of an accident.

HOSPITALISATION: When the Insured is admitted to hospital as a patient and stays there for a minimum of 24 hours to receive medical treatment or surgery.

DAY HOSPITALISATION: When an individual is hospitalised for a period of less than 24 hours in order to receive a specific treatment or because they have been under the effects of anaesthesia.

STANDARD ROOM: Single room or a cubicle in a hospital that is equipped with medical

equipment. Suites or rooms with a foyer are not considered standard rooms.

HOSPITAL: Any public or private facility legally authorised to treat illnesses, ailments or bodily injuries, equipped with the material and human resources needed to carry out diagnoses and surgical procedures, and with permanent medical presence. For the purposes of the Policy, hotels, nursing homes, spas, facilities used mainly to treat chronic illnesses and similar institutions are not considered hospitals.

SURGERY: Any operation needed for diagnostic or therapeutic purposes that is performed through an incision or other internal approach and carried out by a surgeon at an approved facility (which may or may not be a hospital) and that normally requires the use of a room that has been specifically equipped for such purpose.

INJURY: Any pathological change that occurs in a healthy tissue or organ and that involves anatomical or physiological damage, i.e. a disturbance in the physical integrity or functional balance thereof.

OSTEOSYNTHESIS MATERIAL: Metal parts or elements, or those of any other nature that are used to join the ends of a fractured bone or to weld joint ends.

ORTHOPAEDIC EQUIPMENT: Anatomical components or elements of any nature that are used to prevent or correct deformities of the body.

MEDICAL PROFESSIONAL: Doctor or medical graduate who has been legally trained and authorised to practice medicine.

CONSULTANTS: Physicians who are part of the Mutual Insurance Company's Medical Network and have been specifically designated as consultants. A consultation with one of these physicians requires prior authorisation from the Mutual Insurance Company, based on a reasoned request from one of its specialist doctors.

INSURER OR MUTUAL INSURANCE COMPANY: Nueva Mutua Sanitaria del Servicio Médico, Mutua de Seguros a Prima Fija, the entity that assumes the contractually agreed risk.

DENTIST: A healthcare professional who holds a degree that qualifies them to carry out prevention, diagnosis and treatment of anomalies and diseases affecting the teeth, mouth, jaws and adjacent tissues.

CHILDBIRTH: The full delivery of one or more newborn infants and placenta from the uterus. Normal or term delivery occurs between 37 and 42 weeks from the last menstruation date.

PREMATURE BIRTH: A birth is considered premature when it occurs before the 37th week of gestation.

WAITING PERIOD: Period (calculated in months or days from the date the insurance policy entered effect) in which some of the coverage provided by the Policy is not effective.

CONTESTABILITY PERIOD: Period during which the Mutual Insurance Company may deny coverage or contest the policy on the grounds of pre-existing conditions of the Insured that were not disclosed by them. After this period, the Mutual Insurance Company may only exercise this right if the Policyholder and/or the Insured acted fraudulently.

PRE-EXISTENCE: State or condition of health (illness, injury or defect), not necessarily pathological, suffered by the Insured prior to the date of their inclusion in the Policy.

SERVICE PROVISION: The healthcare provided as a result of a claim. This is the care or treatment the patient receives.

PREMIUM: The price of the insurance, that is, the amount the Policyholder or the Insured must pay to the Mutual Insurance Company. The instalment will also include applicable charges and taxes.

PROSTHESIS: Any element, regardless of its nature, that temporarily or permanently replaces the physiological function of an absent organ, tissue, body fluid, limb, or part thereof. By way of example, mechanical or biological elements such as cardiac valve replacements, joint replacements, synthetic skin, intraocular lenses, biological materials (cornea), synthetic or semi-synthetic fluids, gels and liquids that replace body fluids, drug reservoirs and ambulatory oxygen therapy systems, etc., are considered as such.

PSYCHOLOGY: Science that involves the practical application of knowledge, skills and techniques to diagnose, prevent or solve personal or social problems, especially as regards the individual's interaction with their physical and social environment.

NEWBORN INFANTS: Human beings during the stage of life that runs from the time they are born until they are four weeks old.

REHABILITATION: Treatment prescribed by a physician from the Medical Network and performed by a rehabilitation specialist or physiotherapist, aimed at restoring the functionality of a part of the body that has been damaged due to an accident or illness.

24-HOUR EMERGENCY HELPLINE: Information offered by a team of medical professionals to provide the Insured with details about the Medical Network and resolve any urgent medical questions 24 hours a day, 365 days a year. The medical information provided by this means is for guidance only. It should only be used in emergencies and cannot replace direct medical care.

SERVICES PROVIDED AT HOME: Home visits requested by the Insured from a family doctor (general practitioner), paediatrician/childcare specialist, or qualified nurse (A.T.S. or D.U.E.), in cases where, due to illness, the Insured is unable to travel to the consulting room.

HOME EMERGENCY SERVICES: Emergency medical care provided at the Insured's home by a general practitioner and/or qualified nurse.

LOSS EVENT: Any event where the consequences are totally or partially covered by the Policy.

INSURANCE APPLICATION: The document given to the Policyholder so they can arrange to take out an insurance policy with the Mutual Insurance Company.

POLICYHOLDER: The natural person or legal entity who signs this contract in conjunction with the Mutual Insurance Company and who is responsible for the obligations arising from it, except those that must be performed by the Insured due to their nature.

EMERGENCY: A situation that requires immediate medical attention, as any delay could pose a life-threatening risk or cause irreparable harm to the patient’s physical integrity.

APPENDIX I: BENEFITS SUBJECT TO WAITING PERIOD AND BENEFITS REQUIRING PRIOR AUTHORISATION FROM THE MUTUAL INSURANCE COMPANY

A) BENEFITS SUBJECT TO WAITING PERIOD

ALLERGOLOGY: provocation tests with food and medicines.

PATIENT TRANSPORT: only for non-urgent transfers.

ANALYSIS: molecular biology, karyotypes, genetics, immunohistochemistry, Sperm count and mobility seminograms.

PATHOLOGICAL ANATOMY: all tests except basic cytologies.

ANGIOLOGY AND CARDIOLOGY: catheterisations, Doppler tests, electrophysiology, ergometry, therapeutic varicose sclerosis, transesophageal echocardiograms, plethysmography and tilting table tests.

DIGESTIVE SYSTEM: manometries, phmetries, breath tests and intestinal capsule endoscopies.

SURGERY: all types of inpatient and outpatient surgery.

DERMATOLOGY: computerised digital dermoscopy.

ENDOSCOPIC STUDIES of any kind.

GYNECOLOGY AND OBSTETRICS: amniocentesis and similar procedures, fetal monitoring, childbirth preparation, diagnosis and treatment of infertility, examinations under anaesthesia.

HAEMATOLOGY: all procedures and tests.

HOSPITALS: all admissions, outpatient care and home hospitalisation.

NUCLEAR MEDICINE: all examinations.

NEPHROLOGY: dialysis.

PNEUMOLOGY: all therapies and tests, except spirometry tests.

NEUROPHYSIOLOGY: all tests and treatments (sleep studies, EEG and

EMG scans, evoked potentials tests, etc.).

NEUROLOGY: neurological assessment, neuropsychological studies and lumbar punctures.

OPHTHALMOLOGY: angiographies, refractive surgery for myopia, orthoptics, retinography, photocoagulation, pachymetry and corneal topography.

ONCOLOGY: chemotherapy and radiotherapy (all procedures).

EAR, NOSE AND THROAT MEDICINE: microscopic examinations, otoemissions, videonystagmography, rhinomanometry, olfactometry, stroboscopy and swallowing studies.

OXYGEN THERAPY: all procedures, including aerosol treatments.

PSYCHOLOGY: therapies.

RADIODIAGNOSIS: densitometry, orthopantomography, vascular radiology, MRI, CT, PET scans and colour doppler tests.

REHABILITATION: all procedures.

PAIN TREATMENT: all treatments.

UROLOGY: lithotripsy, hyperthermia and urodynamic procedures.

CHIROPODY.

PREVENTIVE MEDICINE CAMPAIGNS, including check-ups.

B) BENEFITS THAT REQUIRE PRIOR AUTHORISATION FROM THE MUTUAL INSURANCE COMPANY*

- Complex diagnostic tests: Genetic studies, PET-CT, PET-MRI, PET-CT PSMA, scintigraphy, therapeutic target studies, video EEG monitoring, polysomnographic studies, coronary CT, and all types of infiltrations.
- Any medical procedure involving the administration of medication without admission or the implantation of prosthetic material.
- Hospital admissions (including day hospital and outpatient admissions).
- Surgical procedures
- Oncological treatments
- Complex therapeutic procedures:
    - **Vascular, Cardiac and General Surgery**: therapeutic sclerotherapy for varicose veins (per session), pacemakers, implantation of reservoirs for chemotherapy or dialysis.
    - **Digestive System**: digestive stents, mucosectomies, complex non-diagnostic endoscopic resections.
    - **Cardiology**: diagnostic and therapeutic haemodynamics; electrophysiological studies and treatments; any type of pacemaker.
    - **Multiple specialities**: therapeutic infiltrations.
    - **Diagnosis and treatment of infertility.**
    - **Oxygen therapy: C.P.A.P. and B.P.A.P.**

- **Interventional radiology.**
- **Rehabilitation**: rehabilitation not related to the locomotor system, neurological rehabilitation, pelvic floor rehabilitation and cardiac rehabilitation.
- **Pain management.**
- **Urology**: fusion prostate biopsy, cryosurgery, photovaporisation, hyperthermia, micro-ultrasound and holmium laser of the prostate, intravesical instillations.

- Special benefits
- Preventive medical check-up

* To authorise these benefits, a **clinical report** from the prescribing physician **must always be provided**. It will be assessed by the **Medical Department** for authorisation.

Likewise, a medical report may be requested to justify any type of benefit, even if it does not require prior authorisation, for insured persons with less than one year of continuous membership with the Mutual Insurance Company.

NUEVAMUTUASANITARIA

NUEVAMUTUASANITARIA

APPENDIX II TO THE GENERAL TERMS AND CONDITIONS

INTERNATIONAL TRAVEL ASSISTANCE POLICY

Assistance Phone Number

(+34) 91 290 80 78

January 2022

1. DEFINITIONS

ACCIDENT

Bodily injury or property damage that occurs while the contract is in effect and that arises from a violent, sudden, external cause and that is not intended by the Insured.

INSURED

Individual whose habitual residence is in Spain, who is insured with Nueva Mutua Sanitaria, and who has been reported to IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U.

INSURER

IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U., which assumes the risk defined in this contract.

MAIN RESIDENCE

The Insured's main residence is their usual place of residence in Spain, which is recorded in the travel documents and from which the journeys covered by this contract are made.

SERIOUS CONDITION

Any sudden change in the state of health of an individual that requires hospitalisation and that makes it impossible for the Insured to start a trip, prevents them from continuing it on the scheduled date, or that involves the risk of death.

SUDDEN ILLNESS

Change in an individual's state of health during the course of a journey covered by the contract, the diagnosis and confirmation of which is performed by a legally recognised doctor or dentist and that requires medical attendance.

LUGGAGE

Set of clothes and household goods for personal use and hygiene that are needed during the journey, which must be contained inside the luggage.

FOREIGN COUNTRY

For the purpose of insurance guarantees, a foreign country is understood to be a country other than the country where the Insured's Main Residence is.

COVERED DIRECT FAMILY MEMBERS

Spouse, domestic partner entered in the relevant official register, parents, parents-in-law, children and siblings of the Insured.

INSURANCE POLICY HOLDER

Nueva Mutua Sanitaria, which enters into this contract with the Insured and which is subject to the obligations arising from the same, except those that must be met by the Insured due to their nature.

JOURNEY

A journey is any trip the Insured makes outside their Main Residence, from the time they leave to the time they return to the same.

2. OBJECT OF THE CONTRACT

To provide coverage for the risks that are specifically covered by this contract and that occur as a result of an accident during the course of the journey outside the Main Residence and within the covered geographical area, under the limits set forth in the contract. The protection provided by the contract will cease to be effective once the journey ends and the Insured has returned to their Main Residence.

3. GEOGRAPHICAL AREA

The coverage provided by this contract will be valid worldwide (except Spain), except in cases involving the kilometre-based deductible established and/or as defined in the specific terms of the benefit or service, where it shall not apply.

No assistance will be guaranteed in countries that, although included within the contracted geographical area, are in a state of war, insurrection or armed conflict of any kind or nature at the time of travel, even if not officially declared. In such cases, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. will reimburse covered expenses that are duly justified with the original supporting invoice.

4. MINIMUM DISTANCE IN KILOMETRES

Medical assistance will be valid 35 km from the Insured's Main Residence (15 km in the Balearic and Canary Islands).

5. DURATION OF THE JOURNEY

Cover will be provided for journeys of no more than 90 days.

6. PROCEDURE IN THE EVENT OF A CLAIM

If an event occurs that could give rise to the provision of any of the guarantees covered by this contract, it is an essential requirement to notify the claim immediately by calling 91 290 80 78, or through any other means that provides proof of such notification.

As a general rule, any services that have not been previously notified to IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U., as well as those for which the corresponding authorisation has not been obtained, are expressly excluded.

If the event cannot be communicated due to force majeure, it must be reported immediately as soon as the event preventing such communication ends.

Once contact has been established, the Insured must provide: **their full name, current location, contact telephone number**, and details of the circumstances of the claim and the type of assistance requested.

Once the notification has been received, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. will issue the necessary instructions to ensure that the required service is provided. If the Insured acts against the instructions given by IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U., they will be responsible for any expenses incurred as a result of such non-compliance.

For the reimbursement of any expenses, the Insured may contact IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU., where they will be provided with access to their file to submit the documentation and invoices for reimbursement. In all cases, it will be essential to submit the original invoices and supporting documents, should IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. request them.

Reimbursements made by IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. shall comply with Spanish legislation, particularly the regulations concerning cash payments and capital outflows from Spanish territory. Accordingly, if the Insured has paid for covered expenses in cash outside of Spain, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. will only reimburse amounts equal to or greater than 10,000 euros (or the equivalent in foreign currency) if a bank receipt confirming the cash withdrawal outside Spain is provided, or if the transaction has been declared in accordance with Article 34 of Law 10/2010 on the prevention of money laundering.

7. COMPLAINT PROCEDURE FOR THE INSURED

IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. provides Insured parties with a Complaints Service, the Regulations of which may be consulted on the website: www.irisglobal.es/home. Policyholders, insureds, beneficiaries, injured third parties and assignees of any of the above may submit complaints under the "Customer Service" section on the website, or by writing to the Claims Department:

Address: IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U.

Customer Service Department

C/ Ribera del Loira 4-6, 2ª Planta 28042 Madrid

This department, which functions independently, will deal with and resolve written complaints that are addressed directly to it within a period of two months, in compliance with Law ECO/734/2004 of 11 March and Law 44/2002 of 22 November.

If the Customer Service Department is unable to resolve the issue in question, the claimant can submit a complaint to the Commissioner for the Defence of Insureds and Pension Fund Participants (governed by the General Directorate of Insurance and Pension Funds), whose address is:

Pº de la Castellana, 44 28046- MADRID

8. SUBROGATION

IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. shall be subrogated, up to the total cost of the services it has provided, to the rights and actions available to the Insured against any person responsible for the events that led to its intervention. When the guarantees issued under this Contract are covered, either in full or in part, by another Insurer, the Department for Social Security or any other institution or individual, GLOBAL SEGUROS Y REASEGUROS S.A. will assume the rights and actions of the Insured

with respect to said company or institution. To that end, the Insured undertakes to actively cooperate with IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U., providing any assistance or issuing any documents that may be deemed necessary.

In any case, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. shall be entitled to use, or to request from the Insured the delivery of, any unused travel document (such as a train or plane ticket), whenever the return travel expenses have been covered by IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U.

9. LIABILITY

After a loss event has occurred, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. shall assume no liability for any decisions or actions taken by the Insured that are contrary to the instructions issued by IRIS GLOBAL or its Medical Department.

10. LEGISLATION AND JURISDICTION

The Insured and IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. submit to Spanish legislation and jurisdiction for the purposes of this contract. The court of competent jurisdiction to hear actions deriving from this contract shall be the court located in the judicial district where the Insured has their Main Residence.

11. GUARANTEED LIMITS

The economic amounts featured as the limits in each of the allowances included in this contract are the maximum amounts that can accumulate during a journey.

COVERED GUARANTEES

1. MEDICAL EXPENSES ABROAD

If the Insured suffers an unexpected illness or accident while travelling abroad, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. will cover, during the validity of the Contract and **up to a limit of EUR 15,000** per contracted period and per Insured, the following expenses:

- Medical fees.
- Medications prescribed by a doctor or surgeon during the first medical assistance provided. Excluded from this coverage are successive payments for medications or pharmaceutical costs deriving from the prolongation in time of the treatment that was initially prescribed, as well as the cost of any procedure used to treat chronic illness.
- Hospitalisation costs.
- Cost of an ambulance ordered by a doctor for transportation within the local area.

The amounts covered by the policy in Spain and abroad are not additional.

If IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. has not been directly involved, in order for such expenses to be reimbursed, the corresponding original invoices must be submitted, together with a full medical report including background, diagnosis and treatment, that allows the nature of the sudden illness to be determined.

In all cases, the costs incurred shall give rise to subrogation by IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. to any payments the Insured is entitled to from Social Security or any other social welfare scheme or private insurance system to which they are affiliated.

A European Health Insurance Card is required in European Union countries. In other nations, the relevant document must be shown. Dental Expenses.

Under the "Medical Expenses Abroad" coverage and within the specified limit, urgent dental expenses are covered, excluding endodontics, aesthetic reconstructions of previous treatments, prostheses, crowns and implants, up to a limit of 60 euros.

2. MEDICAL TRANSFER OF PATIENTS AND CASUALTIES

If the Insured suffers a sudden illness or accident while the contract is in force and as a result of being away from their usual place of residence, and if said illness or accident prevents them from continuing their journey, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U., as soon as it is notified, will organise the necessary communication between its medical team and the doctors treating the Insured.

If the medical team of IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. authorises the transfer of the Insured to a hospital that is better equipped or specialised, located near their usual residence in Spain, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A.U. will carry out the transfer, depending on the severity of the case, by means of:

- Special medical aircraft.
- First class train.
- Air ambulance (helicopter).
- Ambulance.
- Scheduled flight.

Special medical aircraft will only be provided **within Europe and countries bordering the Mediterranean.**

Only medical requirements will be taken into account to choose the means of transport and the hospital where the Insured will be admitted.

If the Insured refuses to be transferred at the time and under the conditions determined by the medical department of GLOBAL SEGUROS Y REASEGUROS S.A., all coverage and any expenses

arising from that decision will be automatically suspended.

For the purposes of repatriation, the address indicated in the policy will be considered to be the Insured's address in Spain.

3. TRANSFER OF MORTAL REMAINS

If the Insured dies during a trip covered by this contract, GLOBAL SEGUROS Y REASEGUROS S.A. will organise and cover the transfer of the mortal remains to the place of burial in Spain, within the municipality of their habitual residence, as well as the costs of embalming, the legally required minimum coffin, and the necessary administrative formalities. **Under no circumstances shall this coverage be extended to include funeral and burial expenses.**

This coverage shall be applied, irrespective of the cause of the Insured's death.

For these purposes, the address indicated in the policy will be considered to be the Insured's address in Spain.

ORIGINAL INVOICES AND RECEIPTS MUST BE SUBMITTED FOR THE REIMBURSEMENT OF ANY EXPENSE.

4. RETURN OF ACCOMPANYING INSUREDS

When the Insured has been transferred due to a sudden illness or accident under the “Medical transfer of patients and casualties” guarantee, or in the event of their death, and this circumstance prevents the remaining Insureds from returning to their home using the initially planned means of transport, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU. will bear the cost of transporting them to their habitual residence or to the place where the transferred Insured is hospitalised, by means of a regular flight (tourist class), train (first class) or any other suitable means of transport.

5. REINSTATEMENT OF TRAVEL PLANS

If the Insured has been transferred under the guarantee “Early return of accompanying insureds”, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU. will provide them with a return ticket, by train (first class), regular scheduled flight (tourist class) or any other appropriate means of transport, to resume their originally planned journey, provided the contract is still in effect and the maximum period between both trips does not exceed seven days.

6. RELOCATION OF ONE PERSON TO ACCOMPANY THE HOSPITALISED INSURED

If the Insured must be hospitalised for more than five days during the trip and no Direct Family Member is present, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU. will

provide a round-trip ticket from their habitual residence in Spain for a companion, by regular scheduled flight (tourist class), train (first class), or any other suitable means of transport.

7. LIVING EXPENSES FOR ONE PERSON TO ACCOMPANY THE HOSPITALISED INSURED

If the Insured must remain hospitalised for more than five days during the trip and no Direct Family Member is present, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU. will cover hotel accommodation costs, upon submission of the corresponding original invoices, **up to a limit of EUR 30/day and for a maximum of 10 days.**

8. RETURN OF THE INSURED IN THE EVENT OF THE DEATH OF A FAMILY MEMBER

If a Direct Family Member covered by this policy dies in Spain while the Insured is on a trip covered by this contract, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU., once notified of the event, will organise and provide the Insured with a ticket to attend the funeral (within a maximum of 7 days from the date of death), by regular scheduled flight (tourist class), train (first class) or any other appropriate means of transport, to the place of burial in Spain.

9. ACCOMPANYING MORTAL REMAINS

If no one is available to accompany the mortal remains of the Insured who has died during a trip covered by this contract, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU. will provide the person designated by the legal heirs with a round-trip ticket by train (first class), regular scheduled flight (tourist class), or any other appropriate means of transport to accompany the deceased to the place of burial.

10. EARLY RETURN FOLLOWING A SERIOUS EVENT

If, during a trip, a serious event occurs (fire, theft or flood) at the Insured's habitual residence or place of business (if the Insured is the legal representative of the affected company and/or their presence is strictly necessary), IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU. will provide them with a round-trip ticket by regular scheduled flight (tourist class) or train (first class) to their residence in Spain.

11. RETURN OF THE INSURED IN THE EVENT OF THE HOSPITALISATION OF A FAMILY MEMBER

If a Direct Family Member covered by this policy is hospitalised in Spain due to a serious accident or illness, and said hospitalisation is expected to exceed five days, while the Insured is on a trip covered by this contract, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU., once notified, will organise and provide the Insured with a return ticket by regular scheduled flight

(tourist class) or train (first class) to the hospital where the individual has been admitted.

12. SEARCHING FOR AND LOCATING LUGGAGE

If the Insured suffers a delay or loss of luggage, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU. will assist in locating and recovering it, including guidance in filing the appropriate report. If the luggage is located, IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU. will send it to the Insured's habitual residence in Spain, provided that the presence of the owner is not required for its retrieval.

13. INFORMATION SERVICE

IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU. will provide all Insureds with a free, uninterrupted 24-hour service, available every day of the year, to offer all types of information related to tourism, administrative procedures, medical information, travel and local conditions, transportation, accommodation, restaurants, etc., as well as information related to vehicles such as repair shops, petrol stations, and insurance companies.

14. EXCLUSIONS

These guarantees shall cease to be effective when the Insured returns to their habitual residence or has been repatriated by IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU. to their home or a hospital close to it. In general, any expenses not previously communicated to IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU. and those for which the corresponding authorisation was not obtained shall be excluded.

In any case, the insured coverage excludes damages, situations, expenses and consequences arising from the following (unless they are expressly included in the coverage):

1.Illnesses, injuries or pre-existing or chronic conditions suffered by the Insured before the start of the trip, which become apparent during the course of the same.

2.The Insured's voluntary refusal, delay or anticipation of the medical transfer proposed by IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, SAU. and agreed upon by its medical department.

3.Mental health disorders, preventive medical checkups (screening), thermal treatments, cosmetic surgery, Acquired Immunodeficiency Syndrome (AIDS), and cases in which the purpose of the trip is to receive medical treatment or undergo surgery, alternative medicine treatments (homeopathy, naturopathy, etc.), the cost of physiotherapy and/or rehabilitation treatments, as well as any related expenses

Also excluded are the diagnosis, monitoring and treatment of pregnancies, voluntary terminations and childbirth, unless urgent action is required and always before the sixth month of pregnancy.

4.The Insured's participation in bets, challenges or fights.

5.The consequences of practising winter sports.

6.The practise of competitive sports or motorised competitive sports (races or rallies), as well as doing any of the dangerous or hazardous activities listed

below:

- Boxing, weightlifting, wrestling (the different categories thereof), martial arts, mountaineering with access to glaciers, sledding, diving with breathing apparatus, caving and ski jumping.

- Aerial sports in general.

- Adventure sports such as rafting, bungee jumping, hydro-speeding, canyoning and similar. In these cases, GLOBAL SEGUROS Y REASEGUROS S.A. will only intervene and pay the expenses incurred by the Insured once their treatment at a medical centre starts.

7.Suicide, attempted suicide or self-harm by the Insured.

8.Rescue of people at sea, in mountains, from chasms or in deserts.

9.Illnesses or accidents resulting from the consumption of alcohol, narcotics, drugs or medication, unless the latter have been prescribed by a doctor.

10.Wrongful acts committed by the Policyholder, Insured or assignees of the same.

11.Epidemics and/or infectious diseases of sudden onset and rapid spread throughout populations, as well as those caused by pollution and/or air pollution.

12.Wars, demonstrations, insurrections, popular movements, acts of terrorism, sabotage and strikes, whether or not such acts have been officially declared. Transmutation of an atomic nucleus and radiation caused by the artificial acceleration of atomic particles. Earthquakes, floods, volcanic eruptions and, in general, events caused by the forces of nature. Any other phenomenon of an extraordinary or catastrophic nature, or event that, due to its magnitude or severity, is classified as a disaster or calamity.

Irrespective of the above, the following situations are specifically excluded:

1. The medical transfer of patients or casualties with conditions or injuries that can be treated "in

situ".

2. The cost of glasses and lenses, as well as the acquisition, implementation-replacement, removal and/or repair of prostheses and anatomical or orthopaedic components of any type such as neckbraces.

3. The reimbursement of medical, surgery or pharmaceutical costs of less than Euros 50.

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