GENERALI HEALTH CHOICE

General Conditions
and Special Conditions

GENERALI

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Reimbursement Medical Insurance

SA161 /GEN

General and Special Conditions

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Information Clause

This INFORMATION is provided in compliance with the terms of article 96 of Law 20/2015 of 14 July on the Organisation, Supervision and Solvency of Insurance and Reinsurance Companies and article 122 of Royal Decree 1060/2015 of 20 November approving the implementing Regulations, regarding the Insurer's general duty to inform the Policyholder and the Insured.

Name and Address of the Insurance Company

Name. GENERALI ESPAÑA, S.A. DE SEGUROS Y REASEGUROS (hereinafter, the Compañía, Generali, the Insurer or the Insurance Company, interchangeably)

Registered address: Calle Orense nº 2, 28020 MADRID, Tax ID A.28007268. Registered in the Madrid Commercial Registry on page M-54,202.

Regulatory Authority with Control Over Insurer

The Ministry of Economy and Competitiveness, through the Directorate General of Insurance and Pension Funds, is responsible for overseeing the insurance sector and for protecting the Insured's freedom to decide on the purchase of insurance and maintaining the contractual equilibrium of existing insurance contracts.

Lodging complaints and dispute procedure to be followed

The Insurer provides the policyholder, Insureds, beneficiaries, injured third parties or their rightful claimants with a Complaints and Claims Service whose Regulations can be consulted on the website www.generali.es.

The Policyholder, insureds, beneficiaries, injured third parties or their rightful claimants may present complaints and claims related to their legally recognised rights and interests by writing to the Complaints and Claims Service. They should include in the letter their personal details, signature, address, policy or claim number and the reason for the complaint or claim, which should be sent to:

Complaints and Claims Service
Generali España, S.A. de Seguros y Reaseguros Calle Orense, nº 2
28020 Madrid

Or by email to: reclamaciones.es@generali.com

The Complaints and Claims Service, which operates autonomously and independently, will acknowledge receipt of the complaint and must respond to the complaint within two months according to the provisions of Law 44/2002 of 22 November on Financial System Reform Measures and Order ECO/734/2004 of 11 March regulating customer service departments and the customer ombudsman of financial institutions.

The decisions of the Complaints and Claims Service shall be binding on the Insurer. If the complaint is not resolved by the company's Complaints and Claims Service within two months of receiving the complaint, or if the request is denied, the affected parties may submit

their complaints to the Customer Service Area of the Directorate General of Insurance and Pension Funds at:
Pº de la Castellana, 44
28046 MADRID
http://www.dgsfp.meh.es/reclamaciones/index.asp

The foregoing is without prejudice to the rights of Policyholders, Insureds, Beneficiaries, Injured Third Parties or their rightful claimants to file a complaint with the competent judges and courts at any time.

Legislation applicable to the Insurance Contract

This Insurance Contract is governed by Law 50/1980 of 8 October (which, pursuant to article 11 of Law 20/2015 of 14 July on the Organisation, Supervision and Solvency of Insurance and Reinsurance Companies, shall not be mandatory if this is considered a large risk insurance policy), by the previously mentioned Law 20/2015, by Royal Decree 1060/2015 of 20 November approving the Regulation on the Organisation, Supervision and Solvency of Insurance and Reinsurance Companies, by any regulations that develop, amend or supplement the aforementioned laws and by the clauses of the Contractual Conditions, including all annexes, supplements and appendices, and in the insurance application and risk assessment questionnaire signed by the Policyholder, which are the fundamental documents on the basis of which the Insurer has given its consent to issue the policy and set the policy conditions.

Article 1. Contractual Parties

1.1. **Policyholder:** the individual or legal entity that takes out this policy with the Insurer and assumes the rights and obligations derived therefrom, except for those which, by their nature, must be assumed by the Insured.

1.2. **Insured/Beneficiary**: the person for whom the insurance is taken out and who is named as such in the particular conditions of the contract. The Insured may at his or her discretion assume the duties and obligations of the Policyholder.

1.3. **The Company or Insurer**: the legal entity that assumes the contractually agreed risk.

Article 2. Contractual documentation

The policy is the set of documents containing the terms and conditions of the contract. It comprises:

2.1. These General and Special Conditions regulate the rights and duties of the parties in relation to the inception, duration and termination of the contract and the various events and situations that may occur during these stages.

The Policy also regulates the scope of the guarantees under each type of insurance provided by the Insurer based on what the Policyholder/Insured Party has requested in the Insurance Application and what is set forth in the Particular Conditions.

2.2. The Particular Conditions, which include the individual covenants under each contract and the clauses agreed upon by the contracting parties to supplement, substitute or modify the general conditions, as permitted by law.

2.3. The policy may be subsequently amended by agreement with the Policyholder as often as necessary, through consecutively numbered and duly signed appendices. The Insurer will provide the Policyholder with an identification card for each Insured. The Premium Medical Directory with the names, addresses and phone numbers of the physicians and services contracted, by specialism, is continuously updated on the Generali website.

2.4. The Special Conditions of the Generali Salud Reimbursement Medical Insurance are indicated in the Particular Conditions.

Article 3. Basic contractual regulations

3.1. This contract is regulated by Law 50/1980 of 8 October 1980 on Insurance Contracts and Law 20/2015 of 14 July 2015 on the Regulation, Supervision and Solvency of Insurance and Reinsurance Companies (LOSSEAR). It is also governed by the applicable regulatory provisions and by the terms of the Particular Conditions of the contract. Clauses that limit the Insured's rights without having be explicitly accepted by the Insure through additional agreements to the Particular Conditions are invalid.

Mere transcriptions or references to mandatory legal or regulatory precepts do not require explicit acceptance.

3.2. The Insurer has entered into the contract and written the policy based on the Policyholder's Application and their answers to the insurance Questionnaire, as well as the Insured's statements about their state of health on the medical Questionnaire or medical examination, which is the only information available to the Insurer and hence the importance of an accurate and truthful declaration.

Article 4. Communications between the parties to the contract

4.1. Rules and methods for communications and notifications between the parties in relation to this contract:

All communications and notifications between the parties in relation to this contract, its fulfilment and performance, and/or to exercise the rights and obligations assumed herein must always be in writing and will be governed by the provisions of this article of the policy.

Exceptionally, when the rules do not require the communications to be in writing, telephone communications between the Insurer and the Policyholder will be valid and fully effective as long as they are recorded on a durable medium that guarantees their integrity, provided that the recipient explicitly consents to the recording in advance.

4.2. Methods of communication and notification:

The Insurer may communicate and send the notifications referred to in point 1 above to the Policyholder, the Insured, their beneficiaries and any of their assigns, which will be legally and contractually valid and effective when sent by post, burofax, fax, e-mail or text message (SMS) sent to a cell phone.

In order for these communications and notifications to be effective when sent by post or burofax, they should be sent by the Insurer to the address stated in the policy for the Policyholder and/or the Insured or to any address notified by the Policyholder and/or the Insured to the Insurer once the policy has been issued.

When the communications and notifications referred to in the previous paragraph are sent by fax, text message (SMS), or e-mail, they should be sent to the fax number, cell phone number, or e-mail address, respectively, stated in the policy by the Policyholder and/or the Insured Party, or to any others that may be notified to the Insurer or the broker responsible for arranging the policy, after the policy is issued.

The communications and notifications sent by the Policyholder and/or the Insured to the Insurer should always be sent to the Insurer's registered address stated in the policy, or to any of its branch offices open to the public. All of this is without prejudice to the provisions of point 4 below on communications made through an insurance broker.

4.3. Effective date of the notifications and communications between the parties:

The communications and notifications sent by the parties to each other will take effect once received by the addressee, regardless of whether or not the recipient reads them.

However, communications sent through the post or by burofax are fully effective vis-à-vis the contract as soon as the postal service first attempts to deliver them to the addressee at his address (as established in point 2 above), regardless of whether or not such attempt is unsuccessful for any reason. Communications or notifications sent by e-mail or text message (SMS) to a mobile phone will be contractually effective from the date on which they are received at the recipient's email address or cell phone number, regardless of whether or when the recipient opens the emails and/or SMS messages.

4.4. Communications through insurance brokers

Communications sent by the Policyholder to the insurance agent who has assisted in arranging the policy are just as effective as if they had been sent to the insurance company directly.

Notices sent by an Insurance Broker to the Insurer on behalf of the Policyholder will have the same effects as if they were made by the Policyholder himself, unless otherwise indicated.

Communications and notifications sent by the Insurer to the Policyholder or the Insured through the agent or broker who arranges or assists in the arrangement of the policy are just as effective as if they had been sent by the Insurer directly.

Article 5. Execution, effective date, term of the contract, and premium payment

5.1. This contract is executed with the consent of both parties and signed by the Insurer and the Policyholder. The guarantees under the contract come into force on the date indicated in the Particular Conditions of the policy, once the contract has been signed and the one-time premium or the premium for the first insurance period or any fraction thereof has been paid.

5.2. The term of the contract is specified in the Particular Conditions of the policy. At the end of this period and unless otherwise agreed, the contract will be automatically renewed for one year, and so on successively at the end of each insurance period.Both the Policyholder and the Insurer may oppose this tacit renewal by giving written notice to the other party at least one month's notice in the case of the Policyholder and two months' notice in the case of the Insurer prior to the end of the current insurance period. The Insurer will notify the Policyholder at least two months before the end of the current policy period of any changes to the insurance contract.

Unless otherwise agreed, the insurance policy is terminated with respect to each insured:

a) If the insured moves abroad or does not reside for a minimum of 180 days of the year in national territory.

b) If the insured dies.

5.3. The insurance premium covers one year, unless the term of the policy is shorter. Instalment payments may be arranged and all instalments must necessarily be paid until the premium for the contractual period in question is paid in full.

The first premium payment will be made when the contract is signed and successive payments will be made on the due dates indicated in the Particular Conditions of the policy. If the Policyholder fails to pay the initial premium or any fraction thereof, where applicable, the Insurer may declare the contract terminated and without effect or demand payment of the first premium by the Policyholder through enforcement proceedings, based on the policy. If the first premium or any part thereof is not paid before a loss occurs, the Insurer willshall be released from all obligations.

For the payment of successive annual premiums or fractions thereof there will be a grace period of one month form the due date, at the end of which the guarantees under the contract will be suspended until twenty-four hours after the date on which the premium is paid. The Insurer may demand payment of the premium up to six months after the due date of the annual premium or any instalment payments.If the Insurer does not demand payment within six months of the due date of the premium payment, the contract will be terminated.

Either way, once the contract is suspended the Insurer may only demand payment of the annual premium for the current period.

The address for payment of the premiums is that of the Policyholder, unless otherwise stipulated in the Particular Conditions of the policy.

If it is agreed that premium payments are to be direct debited, Policyholder will provide the Insurer with a letter addressed to the bank giving the appropriate order to that effect and must notify the Insurer of any changes to the direct debit. Non-payment resulting from non-compliance with this obligation will not cause any harm to the Insurer, and the consequences will be governed by the provisions established for non-payment of premiums.

The payment of legally applicable taxes of any kind, existing now or created in the future, accruing as a result of this Insurance policy or in connection therewith, shall be paid by the Policyholder or, where appropriate, by the Insured.

Article 6. Effective date of contracted services Waiting periods

6.1. The benefits to be provided by the Insurer under this policy will take effect once the policy is signed or, where appropriate, on the effective date of the policy as specified in the Particular Conditions.

As an exception to this and unless otherwise agreed, the following waiting periods will apply, starting from the inclusion date of the insured:

a) Three months for surgical procedures, whether or not they require hospitalisation, and non-surgical hospitalisations.

b) Three months for the coverage of complementary diagnostic tests, except for simple analyses and x-rays, and abdominal or gynaecological ultrasounds. Consequently, during this time, other complementary diagnostic tests (such as radioactive isotopes, CAT-scans, gammagraphy, electroencephalogram, endoscopy, arthroscopy, and others of a similar nature) will be subject to the three-month waiting period.

c) Three months for any special treatment (such as: Radiotherapy, Chemotherapy, Cobalt therapy, Oxygen therapy, Physiotherapy, Functional Rehabilitation, Haemotherapy, and similar) and for the coverage of Hospitalisation for Illness and Accident, from the inception date of the coverage, as indicated in the Particular Conditions.

d) Eight months for any service related to pregnancy and childbirth, and for the coverage of pregnancy-related Hospitalisation for Illness and Accident, from the inception date of the coverage, as indicated in the Particular Conditions. However, in cases of medical emergencies involving labor dystocia and premature births, the waiting period for obstetrics coverage are waived.

e) **Three months until the Insured can make use of Preventive Medicine services, except Preventive medicine for children, in which case there is no waiting period.**

The waiting periods will be waived automatically in the event of a life-threatening emergency a claim arising from an accident.

Article 7. Basis for the contract. Declarations of the Policyholder or the Insured

7.1. This contract is based on the declarations made by the Policyholder and on the insurance Application or the Insurer's Proposal, as well as the Questionnaire completed by the Policyholder, all of which are the basis upon which the Insurer has accepted the risk and the which have determined the rights and obligations assumed by both parties under this contract.

Should the contents of the policy differs from the Insurance Application or proposal, the difference can be corrected as long as the Policyholder makes it known within one month of receiving the policy. After that, if no such claim has been raised the provisions of the policy will apply.

7.2. Before signing the contract, the Policyholder must declare all circumstances known to him or her that could influence the Insurer's assessment of the risk, in particular by answering in detail the questions on the Questionnaire presented to him or her by the Insurer.

7.3. During the term of the contract, the Policyholder must report:

a) Any circumstances that aggravate the risk and are of such consequence that had the Insurer been aware of them before signing the contract it would not have agreed to cover the risk, or would have done so under more burdensome conditions for the Policyholder. In this case, the Insurer may propose a modification of the contract within two months of the declaration of the aggravation by the Policyholder. The Policyholder has fifteen days to accept or reject this proposal. In the event of a rejection or silence on the part of the Policyholder, the Insurer may cancel the contract after the fifteen days, granting the Policyholder a new fifteen-day period, after which and within the following eight days the Insurer must notify the Policyholder of the definitive cancellation. The Insurer may also cancel the contract by notifying the Policyholder in writing within one month of the day on which it became aware of the aggravation of the risk. If any inaccuracy in the declarations of the Policyholder or the Insured or any aggravation of the risk had is not declared before a loss occurs, the benefit payable by the Insurer will be reduced in proportion to the difference between the agreed premium and the premium that would have applied had such circumstances been known, provided that the Policyholder or the Insured acted in good faith.

If the Policyholder or the Insured have acted in bad faith, the Insurer will be released from covering the loss.

b) The Policyholder or the Insured may also report any circumstances that reduce the risk and are of such consequence that if they had been known to the Insurer when the contract was concluded, it would have been concluded under conditions more favourable for them. In this case, at the end of the insurance period in progress the Insurer will reduce the amount of future premiums proportionally, and the Policyholder or Insured will be entitled to terminate the contract and be reimbursed for the difference between the premium paid and the premium that would have been payable from the time when the Insurer is informed of the reduction in risk.

7.4. Any change in the circumstances of the risk that aggravates or reduces it must be reliably reported to the Insurer by the Policyholder or the Insured as soon as possible.

7.5. Furthermore, the Policyholder must always declare the existence of any other insurance contract(s) covering the same or similar risks as the ones covered in this policy, indicating the name of the Insurer(s).

7.6. The Policyholder or Insured must facilitate the Insurer's assumption of their position in the policy.

Article 8. Definitions

The following definitions apply in this contract:

Accident: Bodily injury sustained during the validity of the policy deriving from a violent, sudden, external cause beyond the Insured's control.

Calendar year: The period between 1 January and 31 December.

Social assistance: assistance not associated directly with treatable medical pathologies or disease due to old age.

Disease: an alteration of the state of health from a common or accidental cause that requires medical care, confirmed by a legally recognised physician.

Congenital illness, injury, defect or deformity: A condition that exists at birth as a consequence of hereditary factors or conditions acquired during gestation. A congenital condition can manifest and be recognised immediately after birth or discovered later at any time during the insured's life.

Pre-existing Condition: an alteration of the state of health that causes evident symptomatology or reasonable suspicion of the existence of the condition before the date on which the affected Insured was added to the policy.

Deductible: the percentage of the total amount of the costs to be reimbursed under the insurance that must be paid by the Insured, with the maximum limits established in the policy.

Day hospital: the area within a hospital or clinic where patients can receive the necessary medical and surgical care without being admitted to hospital, for a period of time never exceeding 24 hours.

Hospitalisation or hospital admission: the period of time spent in a clinic or hospital for more than 24 hours during which a person receives medical care for the diagnosis or treatment of their pathology or illness.

Medical Hospitalisation: admission to a clinic or hospital in order for the person to receive medical treatment that does not require surgery.

Psychiatric Hospitalisation: admission to a clinic or hospital for psychiatric treatment. Such admission takes place in specialised sanatoriums or specially designated units within clinics or general hospitals.

Surgical Hospitalisation: admission to a clinic or hospital in order for the person to receive a surgical procedure.

Members of the Family Unit: the persons with family ties who live at the address designated as the habitual residence in the Particular Conditions of the contract and who are listed in the policy as Insureds/Beneficiaries.

Premature birth: any birth that occurs before the full 37 weeks of gestation and after 22 weeks.

Grace period: the period of time starting when the insured is added to the policy during which some of the coverages under the policy are not in effect.

Prosthesis: any auto, homo, hetero or alloplastic part, as well as any device used to replace an organ or part of an organ or its functionality.

Loss: any event having consequences that are covered by any of the guarantees under the policy.

Vital emergency: an acute situation that requires immediate medical attention because the patient's life is imminent danger. It should not be confused with a serious illness, as the latter does not necessarily imply a vital emergency.

Article 9. Object of the Insurance

a) Within the limits and under the conditions stipulated in the policy and in consideration for the premium payable in each case, the Insurer agrees to cover the medical, surgical and hospital care required for all kinds of illnesses or injuries included in the specialties and modalities listed in Article 10 of these General Conditions by making available to the Insured a series of health care providers included on the Premium Medical Directory. In event of a claim and in accordance with the provisions of the Particular Conditions of the policy, the Insured may choose the service provider from among the options included in the Premium Medical Directory.

b) Within the limits and according to the conditions stipulated in the policy, the Insurer will reimburse the Insured for all reasonable and usual medical expenses for medical, surgical and hospital care for any kind of illness or injury covered under the policy in guarantees 10.1. Primary Care; 10.2 Medical and Surgical Specialties; and 10.4 Preventive Medicine that appear in Article 10, and with the scope established in these General Conditions, the Particular Conditions and the Special Conditions of Reimbursement of the policy.

The maximum amount of the insured capital to be reimbursed per insured and for all types of expenses covered under the policy guarantees is established in the Particular Conditions and Special Conditions of the policy.

c) Unless otherwise agreed in the Particular Conditions, the Insurer will not reimburse the cost of medical services when the Insured uses the services listed on the Premium Medical Directory provided by the Insurer.

d) According to the terms of Article 103 of the Insurance Contract Act, the Insurer must cover necessary emergency care in accordance with the policy conditions.

Article 10. Description of the services and guarantees

The cover provided by the Insurer is grouped into the following guarantees:

1. **Primary Care**
2. **Medical and Surgical Specialties**
3. **Travel Assistance**
4. **Preventive Medicine**
5. **Reimbursement of Medical Expenses**
6. **Indemnity for Hospitalisation due to Illness and Accident**
7. **Dental Assistance**

Including the services detailed below:

10.1. Primary Care:

- **General Medicine.**
- **Paediatrics,** for children up to 14 years of age.
- **Healthcare Technician - Registered Nurse**
- **Podiatry.** ***Limited to six sessions per year, except for foot pathologies.***
- **Emergency Medical Service at home.**
- **Psychology.** Cover is provided for individual psychological consultations prescribed exclusively by a psychiatrist for the treatment of psychological pathologies, simple psychological diagnosis or psychometric tests. The Insured must pay the cost of the forms. There is a **limit of 4 sessions per month and 20 sessions per year**. **Psychoanalysis, psychoanalytic therapy, hypnosis, narcolepsy and psychosocial or neuropsychiatric rehabilitation services are excluded.**

10.2. Medical and Surgical Specialties.

- **Allergology.**
- **Clinical, Anatomopathological, Biological and Biochemical Analysis, for diagnostic purposes only.**
- **Anaesthesiology and Resuscitation.**
- **Angiology and Vascular Surgery.**
- **Digestive System.**
- **Cardiology.**
- **Permanent Emergency Centre.**
- **Cardiovascular Surgery.**
- **General and Digestive Surgery.**
- **Maxillofacial Surgery.**
- **Paediatric Surgery.**
- **Plastic Reconstructive Surgery.**
- **Thoracic Surgery.**
- **Medical and Surgical Dermatology and Venereology.**
- **Endocrinology and Nutrition.**
- **Stomatology.** Includes stomatological treatment and extractions. **Excludes fillings, endodontics, prostheses and orthodontic and periodontic treatments.**
- **Geriatrics. Excludes social assistance.**
- **Haematology and Haemotherapy.**
- **Internal Medicine.**
- **Nuclear Medicine.**
- **Nephrology.**
- **Neonatology.**
- **Pneumology.**
- **Neurosurgery.**
- **Clinical Neurophysiology.**
- **Neurology.**
- **Obstetrics and Gynaecology.** Includes prenatal obstetric care, delivery by obstetrician assisted by a midwife, childbirth preparation and epidural anaesthesia.
- **Ophthalmology.** Includes laser in photocoagulation treatments as well as intraocular ophthalmic surgery for diseases other than ocular refraction defects.
- **Medical oncology**, including orientation and treatment by a physician specialising in the subsidiary diseases of this speciality.

- **Oncological radiation therapy**: cobalt therapy, radiotherapy.
- **Otorhinolaryngology.**
- **Psychiatry.**
- **Radiodiagnostics/Radiology.** Includes X-rays, tomography, urography, cystography and all kinds of radiographic explorations for diagnostic purposes. Includes special scans for surgical techniques such as ventriculography, arteriography, encephalography, etc.
- **Rheumatology.**
- **Traumatology and Orthopaedics.**
- **Urology.** Includes renal lithotripsy.
- **Ambulance.** For emergency transport to the nearest hospital or transport to the surgical facility from the patient's home with a physician's prescription.
- **Haemodialysis**: only in acute and reversible cases, as well as in exacerbations of chronic processes, with a maximum of 15 sessions.
- **Other diagnostic tests.** Electrocardiograms, audiometries, electroencephalograms, endoscopy, functional tests of the kidney and liver, ultrasound scans, CAT scans, scintigraphy and Nuclear Magnetic Resonance.
- **Oxygen and Ventilation Therapy.** At home only in acute and reversible cases, as well as exacerbations of chronic processes. Both in the clinic and at home under medical prescription.
- **Aerosol Therapy**. At home only in acute and reversible cases, as well as exacerbations of chronic processes, with a maximum of 30 days. Both in the clinic and at home under medical prescription. The Insured pays for all medication.
- **Prostheses**, including internal osteosynthesis material and the following prostheses: heart valves, pacemakers, hip prostheses, vascular by-pass and internal traumatological prostheses, abdominal meshes, port-a-cath, intra-ocular lens in cataract surgery as well as breast prostheses after radical mastectomy.
- **Chemotherapy**, on both inpatient and outpatient basis. This includes the cost of cytostatic drugs that are sold on the national market and are duly authorised by the Ministry of Health.
- **Blood Transfusions.** The Insurer will pay for the transfusion procedures in all cases as well as the blood and/or plasma to be transfused in hospitalised patients.
- **Rehabilitation.** Outpatient rehabilitation to restore the patient to his or her functional state before the pathological process, when medically possible, **so maintenance rehabilitation is excluded.** Included for illnesses contracted after the Insured was added to the policy. Laser is included as a musculo-skeletal rehabilitation technique.
- **Phoniatrics**, exclusively for speech rehabilitation after surgical or oncological processes.

- **Medical Hospitalisation.**
- **Surgical Hospitalisation.**
- **Paediatric Hospitalisation.** Includes neonatal hospitalisation.
- **Hospitalisation in ICU/SDU.**
- **Psychiatric Hospitalisation. There is a limit of 60 days per insured per year.**
- **In room Companion**, accommodation only, as long as the facility offers this service. **Excluded from this coverage are psychiatric hospitalisations, ICU and STU hospitalisations, and newborn hospitalisations.**
- **Medication outside the operating theatre** during the hospitalisation period.
- **Couples infertility treatment.** The following conditions must necessarily be met in order for the fees, tests and medical costs of the treatment to be covered:
  - **Both partners must be insured.**
  - **Each one must have been insured for at least 24 months.**
  - **One of the partners must have been diagnosed with primary or secondary sterility which is preventing pregnancy.**
  - **The woman may not be more than 42 years of age when the treatment begins in order to be eligible for treatment**

  There is a limit of 3 attempts at homologous or donor Artificial Insemination and 2 complete cycles of In Vitro Fertilisation with freezing, including I.C.S.I. (sperm microinjection), if necessary. This coverage is not renewable annually and therefore the limits apply regardless of the number of times the policy is renewed.

  The following medical acts are included in the artificial insemination attempt:
  - Gynaecology consultations for initiation of treatment and follow-up.
  - Ultrasound and analytical diagnostic tests as required for the treatment.
  - Ovulation stimulation.
  - Sperm preparation.
  - Donor sperm, if necessary.
  - Insemination.

  Included in each I.V.F. cycle. (In Vitro Fertilisation):
  - Gynaecology consultations for initiation of treatment and follow-up.
  - Ultrasound and analytical diagnostic tests as required for the treatment.
  - Ovulation stimulation.
  - Ovarian puncture and embryo culture.
  - Embryo transfer.
  - Intracytoplasmic sperm injection (ICSI).

- Testicular sperm extraction (TESE).
- Cost of freezing and maintaining embryos for a maximum of 2 years.
- Transfer of frozen embryos.
- Ovarian puncture and embryo culture in oocyte donation.

Scope of coverage of couples' infertility treatment:

- **Two failed attempts at ovulation stimulation using any of the covered techniques will result in the rest of the treatment not being covered by the Insurer.**
- **The cost of maintaining frozen embryos once the IVF cycle is complete, from the second year onwards, will be paid by the Insured.**
- **For IVF, the transfer of frozen embryos from a previous attempt covered by the policy will not be considered a new attempt. However, only one new attempt will be covered.**

Transfer of frozen embryos from a previous IVF. If this is unsuccessful, a second and final attempt at IVF will be available, if the Insured is eligible.

- **Unless otherwise agreed in the Particular Conditions of the Policy, treatment is not covered if the infertility of one or both partners has occurred voluntarily or is a consequence the natural physiological process of the person having reached the end of their reproductive life.**
- **Any other diagnostic test or procedure not included in this description is expressly excluded.**
- **Medication used for treatment is not included, in accordance with Article 12 of the policy.**

The scope of the assisted reproduction techniques is bound by the laws in force at any given time and will be carried out at the Insurer's expense in the clinics and hospitals and by the professionals appointed and arranged by the Insurer. The Insurer's express authorisation will always be required before the treatment begins.

Medical expenses charged for this service by duly accredited professionals and medical facilities may be reimbursable, subject to the laws in force at any given time, even when the service is not arranged by the Insurer.

The limits on the reimbursement of medical expenses are set out below and there is no deductible:

a) **For three attempts at artificial insemination, a maximum limit of €600 is established for each attempt and for all duly accredited medical expenses.**

b) **For the two attempts at in vitro fertilisation, a maximum limit of €4,000 is established for each attempt and for all duly accredited medical expenses.**

For the reimbursement of medical expenses, the Insured must provide receipts and demonstrate the payment of original, official invoices itemising the services rendered. They must also provide any medical documentation required by the Insurer that specifies and confirms the treatment received. The reimbursement payment will be made within 20 days of receiving all necessary documentation.

10.3. Travel Assistance

The coverage included under this guarantee is valid:

a) throughout Spain, starting from the border of the province where the Insured's habitual residence is located, except in the Balearic and Canary Islands, where the limit is more than 10 km from the habitual residence.

b) in the rest of the world for the term of this contract. To be eligible for the guaranteed benefits, the Insured must have a permanent residence in Spain and reside there on a regular basis. The time spent away from this habitual residence may not exceed 90 days per trip or journey.

Description of coverage

Medical expenses outside the Country of Residence

If the Insured becomes ill or has an accident during a trip outside their country of residence, **EUROP ASSISTANCE** will cover the expenses listed below for the duration of the Contract and **up to a limit of €35,000** per insurance period and Insured:

- Medical fees.
- Medicines prescribed by a physician or surgeon during the initial visit. Successive payments for such medicines or pharmaceutical expenses arising due to a prolongation of the initially prescribed treatment over time, as well as those related to any process that becomes chronic in nature are excluded.
- Hospitalisation expenses.
- The cost of an ambulance ordered by a physician for a local journey.

The amounts guaranteed for the different areas are not in addition to one another.

If **EUROP ASSISTANCE** does not intervene directly and in order for such expenses to be reimbursable, original invoices must be presented, along with a full medical report that includes the medical history, diagnosis and treatment, so that the nature of the illness can be established.

Once the expenses are reimbursed, EUROP ASSISTANCE will assume the Insured's position in connection with any Social Security benefits or settlements to which the Insured may be entitled under private insurance schemes.

Dental Expenses

Within the "Medical expenses outside country of origin/residence/contract" and "Medical expenses in country of origin/residence/contract/" guarantee and subject to the limit specified therein, emergency dental expenses are covered **up to a limit of €2,000,**

excluding endodontics, aesthetic reconstructions of previous treatments, prostheses, caps and implants.

Medical Expenses in Country of Residence

If the Insured becomes ill or has an accident during a trip within their country of residence, EUROP ASSISTANCE will cover the expenses listed below for the duration of the Contract and up to a limit of €2,000 per insurance period and Insured:

- Medical fees.
- Medicines prescribed by a physician or surgeon during the initial visit. Successive payments for such medicines or pharmaceutical expenses arising due to a prolongation of the initially prescribed treatment over time, as well as those related to any process that becomes chronic in nature are excluded.
- Hospitalisation expenses.
- The cost of an ambulance ordered by a physician for a local journey.

The amounts guaranteed inside and outside the country of residence are not in addition to one another.

If EUROP ASSISTANCE does not intervene directly and in order for such expenses to be reimbursable, original invoices must be presented, along with a full medical report that includes the medical history, diagnosis and treatment, so that the nature of the illness can be established.

Insureds travelling to a country for which they have a valid passport will receive in that country the guarantees described in the policy for travel within their country of residence.

The payment of medical expenses in the country of residence is excluded in those cases where the Insured person is a Social Security recipient. An exception is made in emergency situations in which the Insured must be transferred to a hospital that does not belong to the Social Security network.

Once the expenses are reimbursed, EUROP ASSISTANCE will assume the Insured's position in connection with any Social Security benefits or settlements to which the Insured may be entitled under private insurance schemes.

Prolongation of hotel stay due to illness or accident

When the nature of the supervening illness or accident makes it impossible for the Insured to continue the trip, but admission to a clinic or hospital is not necessary, EUROP ASSISTANCE will pay the cost of the extended hotel stay when prescribed by a doctor, up to a limit of €200 euros/day for a maximum of 10 days.

Medical transfer of sick and injured

In the event of sudden illness or accident of the Insured, during the term of the contract and as a result of a journey from their usual place of residence, and provided that this makes it impossible for them to continue their journey, EUROP ASSISTANCE shall, as soon as it is notified, organise the necessary contacts between its medical service and the doctors treating the Insured.

When the medical services of EUROP ASSISTANCE authorise the transfer of the Insured to a better equipped or specialised hospital near his or her Habitual Residence or to his or her Habitual Residence, depending on the seriousness of the situation EUROP ASSISTANCE will transfer the Insured by:

- Air ambulance.
- First class train.
- Medical helicopter.
- Ambulance.
- Regular airliner.

Air ambulances will only be used in Europe and countries bordering the Mediterranean.

Only medical requirements will considered when choosing the mode of transport and the hospital where the Insured should be taken.

If the Insured refuses to be transferred at the time and under the conditions stipulated by EUROP ASSISTANCE's medical services, all guarantees and expenses resulting from this decision will be automatically suspended.

For repatriation purposes the address stated in the policy will be considered the Insured's habitual residence.

Transfer of mortal remains

If the Insured dies in the course of a trip covered under this contract, EUROP ASSISTANCE will organise and pay the cost of transferring the mortal remains to the place of burial or cremation in Spain in the municipality where the habitual place of residence is located, along with the cost of embalming, the minimum compulsory coffin and administrative formalities. Under no circumstances are funeral and burial expenses covered.

If the heirs or beneficiaries of the Insured or anyone with legal decision-making authority choose to have the Insured cremated, EUROP ASSISTANCE will pay for the cremation and will arrange the transfer of the urn with the ashes, at its own expense. If the urn must be accompanied by someone for legal or organisational reasons, EUROP ASSISTANCE will organise and pay for the return trip by regular airline (economy class), train (first class) and/or any other suitable mode of transport for a person designated by the beneficiaries or relatives.

This coverage applies regardless of the Insured's cause of death.

For these purposes, the address that appears in the policy will be considered the address in Spain.

Return of Insured's companions

When the Insured is transported due an illness or accident covered under the "Medical transfer of the sick and injured" guarantee or due to death, and this prevents the rest of the Insureds from returning home as initially planned, including cases where they are unable to return because they must stay to handle the situation caused by the Insured's circumstances, EUROP ASSISTANCE will cover the cost of transporting them to their

habitual place of residence or to the place where the transferred Insured is hospitalised by air (economy class ticket), rail (first class) and/or any other suitable mode of transport.

Rejoining the scheduled travel

If the Insured is immobilised due to an illness or accident covered by any of the guarantees under this contract and for that reason is unable to continue with the scheduled trip as planned, EUROP ASSISTANCE will, with the prior authorisation of the medical team and at the Insured's request, once the Insured has recovered, organise and pay for the Insured's transfer and that of the insured companion so that they can rejoin the trip if it is not yet over.

The return of the insured companion will also be covered when the companion has had to accompany the transferred Insured covered under the "Medical transfer of the sick and injured" guarantee if the companion wishes to rejoin the scheduled trip.

Sending medicines abroad

If the Insured requires a medicine whose active ingredient cannot be purchased in the place where he or she is located, EUROP ASSISTANCE will source and send it to the Insured as quickly as possible and in accordance with local laws.

The Insured must reimburse EUROP ASSISTANCE for the cost of the medicine upon presentation of the invoice.

Excluded are cases in which the medicine has been discontinued and is unavailable from distribution channels in Spain and those for which there is a medicine with the same active ingredient in the country where the Insured is located.

Transfer of a person to accompany the hospitalised Insured

If the Insured has to be hospitalised for more than five days during the trip and no immediate family member is with them, EUROP ASSISTANCE will provide a companion with a round trip ticket on a commercial airline (economy class), train (first class) and/or any other suitable mode of transport originating from the Insured's habitual country of residence.

Cost of accommodations for companion of hospitalised Insured

If the Insured has to be hospitalised for more than five days while travelling and no immediate family member is with them, EUROP ASSISTANCE will pay for a companion's hotel accommodations upon presentation of an original invoice, up to a limit of €200 per day for a maximum of 10 days.

Cost of Insured's return travel when an immediate family member dies

If an immediate family member of the Insured who is also covered under this policy should die in the Insured's habitual country of residence while the Insured is travelling, EUROP ASSISTANCE, upon being notified of the event, will make arrangements for the Insured to attend the funeral (no later than 7 days after the death), by providing a round

trip ticket on a commercial airline (economy class), train (first class) and/or any other suitable mode of transport to the place of burial in the country of the Insured's usual place of residence.

Companion of minor children or dependent persons

If an Insured travelling with dependents or minors under the age of 14 who are also Insureds is unable to take care of them due to illness or accident covered under this contract, EUROP ASSISTANCE will arrange and pay for a round trip ticket (by train (first class), commercial airline (economy class) and/or any other suitable mode of transport), for a person residing in the Insured's habitual country of residence designated by the Insured or by his or her family, or a person designated by EUROP ASSISTANCE, who will accompany the minors or dependents on their return to their usual place of residence as quickly as possible.

Companion to accompany transfer of mortal remains

If there is no one to accompany the mortal remains of an Insured who has died on a trip covered under this contract, EUROP ASSISTANCE will provide the person designated by the beneficiaries with a round trip ticket by train (first class), commercial airline (economy) and/or any other suitable mode of transport to accompany the remains to the burial place.

Insured's return when an immediate family member is hospitalised

If an immediate family member of the Insured who is also covered under this policy is hospitalised in the Insured's habitual country of residence due to accident or grave illness while the Insured is travelling, and if the hospitalisation is expected to last for more than five days, EUROP ASSISTANCE, upon being notified of the event, will provide the Insured with a round trip ticket on a commercial airline (economy class), train (first class) and/or any other suitable mode of transport to the place of hospitalisation.

Extension of the companion's hotel stay due to hospitalisation of the Insured.

When the Insured has to be hospitalised on doctor's orders and in agreement with EUROP ASSISTANCE's medical services, EUROP ASSISTANCE will pay the cost of the insured companion's extended hotel stay, up to a limit of €60 per day for a maximum of 10 days.

Telephone Advice and Social Counselling

EUROP ASSISTANCE will provide support with possible referral to municipal social services to prevent situations of risk and abuse.

Guidance and advice will be provided on:

- General and specific social and welfare resources in the municipality and the community.
- Guardianship of the Elderly.
- Tele-assistance, Home help, Day centres, Senior residences, Technical assistance.
- Incapacitation.

- Social and family risk situation.
- Locating resources.
- Dependency and degenerative disorders: Social and health resources, Volunteers, Associations.

This service is available at the beneficiary's request from 9:00 am to 7:00 pm, Monday to Friday (except national holidays). (Spanish mainland times).

Search for and location of luggage

If the Insured's luggage is delayed or lost, EUROP ASSISTANCE will assist him or her in searching for and locating it and provide advice on how to file the pertinent claim. If the luggage is located, EUROP ASSISTANCE will send it to the Insured's usual place of residence, provided that the owner's presence is not required to claim it.

Payment of legal assistance costs in a foreign country

Under the benefit titled "Advance payment of criminal bail required by a foreign country", EUROP ASSISTANCE will pay up to €600 for lawyers' and solicitors' fees for legal assistance in connection with traffic accidents.

If this benefit is offered under the auto policy, it will be considered an advance payment under the same conditions as the benefit "Advance payment of criminal bail required by a foreign country".

Transmission of urgent messages (derived from the guarantees)

EUROP ASSISTANCE offers a 24-hour service for processing and transmitting urgent messages from the Insured, provided that the Insured has no other way of getting the message to its destination and that the message is related to a guarantee covered under the contract.

Shipment of personal belongings

EUROP ASSISTANCE will organise and pay for the shipment of essential items that were forgotten at home before the start of the trip (contact lenses, prostheses, glasses, credit cards, driver's licence, ID card and passport). This benefit also applies to home delivery of these same items when they are left behind during the trip or recovered following a theft while travelling.

EUROP ASSISTANCE only arranges and pays the cost of delivering parcels weighing up to 10 kilograms.

Advance of funds

EUROP ASSISTANCE will advance the Insured up to €5,000 in cash, if needed.

EUROP ASSISTANCE will ask the insured for some kind of guarantee or surety to secure the repayment of the advance. In any case, the advanced funds must be returned to EUROP ASSISTANCE within 30 days at the most.

Advance payment of criminal bail required by a foreign country

If the Insured is imprisoned or prosecuted as a result of a traffic accident occurring abroad, EUROP ASSISTANCE will advance the bail bond required by the authorities, up to a limit of €12,000.

EUROP ASSISTANCE reserves the right to request a guarantee or surety from the Insured to secure repayment.

In any case, the advanced funds must be returned to EUROP ASSISTANCE within 30 days at the most.

Over-the-phone interpretation service abroad

EUROP ASSISTANCE will provide the Insured with over-the-phone interpretation services in several languages (English, French and German) and facilities for contacting interpreters.

Information on card cancellation procedures

At the Insured's request, EUROP ASSISTANCE will explain the procedure for cancelling bank and non-bank cards issued by third parties in Spain if they are lost or stolen.

Advance payment to hospitals and/or admissions procedures

The Insured will receive assistance with payments for medical services, and even an advance up to €6,000 for services that require a guarantee and/or advance payment.

EUROP ASSISTANCE reserves the right to ask the Insured for some kind of guarantee or surety to secure the repayment of the advance. In any case, the advanced funds must be repaid within 30 days at the most.

Digital end-of-life management

Purpose of the service

This service allows the legal heirs of the deceased Insured to request that EUROP ASSISTANCE take the steps necessary to remove the Insured's presence on:

- Social media.
- Professional networks.
- Blogs.
- E-mail accounts.

Assistance and advice is also available to complete the Google form: "Request for removal of search results under European data protection regulations".

Disclaimer of liability

EUROP ASSISTANCE declines any liability for the type of information stored or retrieved as well as for the loss of information due to causes beyond the control of EUROP ASSISTANCE.

The provision of the service is excluded in cases of conflicts between the Insured's legal heirs.

Search and rescue missions

If the Insured gets lost, is involved in an accident or goes missing during an organised trip, EUROP ASSISTANCE will reimburse up to €1,500 of the cost of the search and/or rescue mission, upon presentation of the original invoices.

Rescue missions in the mountains, at sea or in the desert are excluded.

Loss, damage and theft of checked luggage

If checked luggage is definitively lost or seriously damaged during travel, due to a cause attributable to the transport company or due to theft, EUROP ASSISTANCE will pay up to €1,000 in compensation.

To be eligible for compensation, the original proof of loss or damage issued by the carrier must be submitted.

If the luggage was stolen, the Insured must submit the police report filed at the place where the theft occurred.

In all cases a detailed list of the lost, stolen or damaged items and their prices must be provided, along with the original boarding pass.

No compensation will be paid for separate parts of a set or accessories of an item.

Theft or misplacement of cash, jewellery, electronic and digital equipment, documents, luggage or personal items in vehicles or tents, as well as any type of unchecked luggage are excluded.

Delayed luggage

If the delivery of the checked luggage is delayed by more than 12 hours or overnight due to the carrier, the cost of purchasing the personal items needed until the baggage is recovered will be reimbursed up to a limit of €300 (upon presentation of the original invoices, the original boarding card and the original proof of the delay issued by the carrier).

This compensation will be deducted from the settlement for "Loss, damage and theft of luggage" if the items are definitively lost.

This coverage does not apply if the delay or the purchase of necessary personal items takes place in the province where the Insured habitually resides.

Reimbursement of travel delay expenses

The reimbursement of actual and necessary expenses incurred in the place where a delay of more than 6 hours occurs at the start of the journey due to a delay in the public transit system that runs on an established timetable is guaranteed upon presentation of the original invoices and the original proof of the delay issued by the public transit company, up to a limit of €300.

Compensation for delays on non-scheduled flights is excluded from this coverage.

Cancellation of a trip that has already begun (holiday interruption)

In the event of interruption of holidays due to one of the justified causes indicated below:

- Death of the Insured.
- Bodily injury due to accident or serious illness involving hospitalisation for at least one night which makes it medically impossible to continue the trip.
- Hospitalisation or death of a Covered Direct Relative.
- Serious damage caused by fire, explosion, theft or force of nature to the Insured's primary or secondary residence, or professional premises if the Insured is an independent professional or runs a company and his or her presence is absolutely necessary.
- Non-disciplinary dismissal of the Insured or forced transfer that entails a change of residence.
- Taking a job in a new company where the Insured has not been employed in the previous six months. Multiple contracts through temporary employment agencies (ETT) to work for other companies will be considered contracts for the companies where the worker is employed.
- Summons as a party or witness in a trial or jury duty.
- In order for this coverage to apply, the triggering events must occur after the start of the covered trip.

EUROP ASSISTANCE will reimburse the cost of the unused days at the Temporary Residence, up to a limit of €60 per unused day and a maximum of €600 for all Insureds. In order to be reimbursed, the Insured must present the document confirming the arrangement of the accommodation.

Private liability insurance

The Insurer will pay up to €30,000 in pecuniary damages which the Insured may be obligated to pay as a private citizen if found civilly liable for the bodily injury or property damage involuntarily caused to third parties, their animals or their property during a trip, in accordance with articles 1,902 to 1,910 of the Civil Code or similar provisions in foreign legislation.

The Policyholder, the rest of the Insureds under this policy, their spouses, domestic partners registered as such in an official local, regional or national register, parents, children or other family member who live with any of them, as well as their partners, employees and anyone else who in fact or in law depends on the Policyholder or the Insured, while acting within the scope of such dependence, are not considered third parties.

This limit includes the payment of legal costs and expenses, as well as the bonds required of the Insured by the courts.

EXCLUSIONS

Not covered under this guarantee:

a) The Insured's Liability for operating motor vehicles, aircraft and watercraft, or liability for the use of firearms.

b) Civil Liability arising from any professional, labour, political or association activity.

c) Fines or penalties imposed by Courts or other authorities.

d) Liability arising from the practice of dangerous or high-risk sporting activities.

e) Damages to objects entrusted to the Insured for any reason.

Missed flight connections

In the event of a missed connection of a scheduled flight involving a wait of more than 6 hours due to causes beyond the Insured's control and attributable to the airline, upon presentation of the original receipt issued by the carrier, the actual and necessary expenses incurred at the place where the missed connection occurred will be reimbursed upon presentation of the original invoices, up to a limit of €300.

Compensation for delays on non-scheduled flights is excluded from this coverage.

Information service

EUROP ASSISTANCE will offer domestic and, to the extent possible, international information to all Insureds, free of charge, 24 hours a day and 365 days a year on:

Health Information

At the Insured's request, EUROP ASSISTANCE will provide information on:

1. Addresses and telephone numbers of:
   - National hospitals and other medical facilities, professional associations, national associations and foundations:
   - Public health organisations.
   - National academic health institutions such as Faculties, Royal Academies and Schools.
   - Pharmacies, including on-call pharmacies.
   - Vaccination centres: within national territory authorised by the WHO.
   - Health insurers.
   - International health organisations located in national territory.
2. Addresses and telephone numbers of:
   - Health-related entry requirements by destination country for Spanish nationals.

Leisure Information

At the Insured's request, EUROP ASSISTANCE will provide information on:

1. Addresses and telephone numbers of:
    - National cinemas and theatres, art galleries, museums and monuments (national and international).
    - Theme parks (national and international).
    - Recreational centres, casinos (national and international), bingo halls.
    - Restaurants (national and international) by name, category and/or type of food.
    - Bars, cafes, outdoor cafes, discotheques.
    - Food delivery
    - Specialised gastronomic establishments: Bakeries, ice-cream parlours, monastic cuisine, gastronomic specialities by region.
2. Popular festivals and celebrations: information.

Miscellaneous Useful Information

At the Insured's request, EUROP ASSISTANCE will provide information on:

1. Addresses and telephone numbers of:
    - Spanish and foreign banks and savings banks in Spain, Spanish banks and savings banks abroad.
    - Insurance companies.
    - NGOs.
    - Utility companies: gas, electricity, telephone, water, TV.
    - Spanish government agencies:Ministries, Official registries, Police stations, Consumer organisations, Courts, Notaries, Town halls, Post offices.
    - National education centres such as academies, universities, institutes, colleges, schools.
    - Official white goods services (kitchen appliances) as well as brown goods (sound and image electronics).
    - Department stores, Supermarkets, Hypermarkets, Shopping centres, Shops.
    - Telephone numbers of national card cancellation entities.
2. Regular opening hours of shops and banks in Spain and abroad.
3. Dates and location of fairs and congresses in Spain.
4. Postal codes.

Sports Information

1. Addresses and telephone numbers of:
    - Stadiums and sports complexes.
    - Associations and federations.
    - Sports clubs and centres (national and international).
    - Ski resorts.

- Golf courses (national and international).

2. Information on hiking, cycling and horse riding routes; mountain sports and cycling rallies.
3. Information on places to practice adventure sports such as diving, rafting, windsurfing, paragliding, hang gliding.

Information: **Travel, Transit and Tourism**

At the Insured's request, EUROP ASSISTANCE will provide information on:

1. Addresses and telephone numbers of:
   - Tourism Institutions and Entities: Ministries, Chambers, Provincial Councils, Tourist Offices (Spanish and foreign with offices in Spain), Embassies and Consulates (foreign offices in Spain and Spanish offices abroad).
   - Hotels and accommodation in Spain and abroad: Hotels, rural hotels, Paradors, hostels, monastic accommodation, campsites, spas: categories of hotel establishments will also be provided.
   - Commercial airlines and international airports.
   - Spanish maritime companies and boat trips (Spain).
   - Car rental companies (national and international).
   - Bus stations and companies in Spain.
   - Train stations in Spain.
2. Administrative formalities: police, entry requirements by country: information on administrative formalities required by the authorities for Spanish citizens travelling abroad.
3. Generic country information: geographical location, currency, language, land area, population, local holidays, religion, bank and shop opening hours.
4. Transportation options from the airport to the city centre (international).

Car-related information

At the Insured's request, EUROP ASSISTANCE will provide information on:

1. Addresses and telephone numbers of:
   - Official garages and dealerships and services open 24 hours a day.
   - Service stations. Insurance companies.
   - MOT centres.
   - Provincial traffic headquarters.
   - Toll motorways (national).

Home health visits

At the Insured's request, EUROP ASSISTANCE can send health professionals (healthcare technicians, registered nurses, nursing assistants, physical therapists) to provide any special care and treatment required by the Insured, depending on the Insured's

problems and level of dependency or illness as a way of improving quality of life and saving them from having to travel.

For the correct provision of this service, a medical report prescribing the specific treatment will always be required.

The services offered include:

- Administration of special medication.
- Vital sign monitoring.
- Wound treatment.
- Rehabilitation of lower and upper limbs.
- Speech and language rehabilitation.

The fees of these professionals and their travel expenses will be paid by the Insured.

Companion service

At the Insured's request, EUROP ASSISTANCE offers a companion service for people with no psychological or physical disability or condition requiring specialised personnel who would like someone to accompany them on outings, errands, hospital appointments, shopping or inside the home.

The fees of these professionals and their travel expenses will be paid by the Insured.

Special services

At the Insured's request, EUROP ASSISTANCE can arrange for a professional service provider (hairdresser, chiropodist) to visit the Insured in their home with the equipment required to perform the requested service.

The fees of these professionals and their travel expenses will be paid by the Insured.

Home catering service

At the Insured's express request, EUROP ASSISTANCE can provide catering service at the Insured's home as often as desired, for a fee to be determined in advance.

All costs will be paid by the Insured.

This service is available at the beneficiary's request from 9:00 am to 7:00 pm, Monday to Friday (except national holidays). (Spanish mainland times).

Pet information service

Only dogs and cats owned by the Insured that are fitted with a chip are considered pets and covered under this contract. For Autonomous Communities where chips are not required for cats, the Insured must provide documentation confirming ownership of the pet.

Only one animal per Insured is covered. Pet information service

At the Insured's request, EUROP ASSISTANCE will provide general information over the phone on aspects related to pets, such as:

- Pet shelters.
- Hotels where dogs and cats are allowed.
- Holiday homes for dogs and cats.
- Documentation required to travel with dogs and cats.
- Compulsory insurance and registration of dangerous dog breeds.
- Breeding clubs and breeders' associations.
- Documentation necessary to obtain a pedigree.
- Beauty and behavioural contests.
- Pet cemeteries.
- Veterinary care.
- Bathing and grooming service.
- Death care service.
- Kennels.
- Delivery of fodder and food.

And any other query related to pet ownership.

Household cleaning service.

At the Insured's request, EUROP ASSISTANCE can provided cleaning professionals to provide general housecleaning and laundry services.

Carpet and upholstery cleaning is excluded.

The fees of these professionals and their travel expenses will be paid by the Insured.

This service is available at the beneficiary's request from 9:00 am to 7:00 pm, Monday to Friday (except national holidays). (Spanish mainland times).

Telephone pharmacy service nighttime/holiday prescription filling

The service consists of a EUROP ASSISTANCE employee (duly identified) going to the Insured's home to collect the prescription and going to the pharmacy to have it filled. The employee will then deliver the prescription to the Insured, who will pay the cost of the product as shown on the invoice at that time. No cheques, promissory notes or cards.

The Insured must always provide the commercial name of the product and the presentation format (tablets, ampoules, capsules, emulsions, etc.). Expressly excluded are cases where the medicine has been discontinued or is unavailable through regular distribution channels in Spain, or cases where than ID is required to purchase the medicine and narcotics that require a special prescription.

Telepharmacy prescription service

The service consists of a EUROP ASSISTANCE employee (duly identified) going to the Insured's home to collect the prescription and going to the pharmacy to have it filled. The employee will then deliver the prescription to the Insured, who will pay the cost of

the product as shown on the invoice at that time. No cheques, promissory notes or cards.

The Insured must always provide the commercial name of the product and the presentation format (tablets, ampoules, capsules, emulsions, etc.). Expressly excluded are cases where the medicine has been discontinued or is unavailable through regular distribution channels in Spain, or cases where than ID is required to purchase the medicine and narcotics that require a special prescription.

Nighttime/holiday OTC medicine purchases

The service consists of a EUROP ASSISTANCE employee (duly identified) going to the pharmacy to purchase the medicine requested by the Insured. The employee will then deliver the prescription to the Insured, who will pay the cost of the product as shown on the invoice at that time. No cheques, promissory notes or cards.

The Insured must always provide the commercial name of the product and the presentation format (tablets, ampoules, capsules, emulsions, etc.). Expressly excluded are cases where the medicine has been discontinued or is unavailable through regular distribution channels in Spain, or cases where than ID is required to purchase the medicine and narcotics that require a special prescription.

Over-the-counter pharmacy service

The service consists of a EUROP ASSISTANCE employee (duly identified) going to the pharmacy to purchase the medicine requested by the Insured. The employee will then deliver the prescription to the Insured, who will pay the cost of the product as shown on the invoice at that time. No cheques, promissory notes or cards.

The Insured must always provide the commercial name of the product and the presentation format (tablets, ampoules, capsules, emulsions, etc.). Expressly excluded are cases where the medicine has been discontinued or is unavailable through regular distribution channels in Spain, or cases where than ID is required to purchase the medicine and narcotics that require a special prescription.

Home security in the event of robbery or fire

If as a result of theft, fire, flood or explosion, the Insured's home is easily accessible from the outside, EUROP ASSISTANCE will provide security personnel at its expense until the incident has been resolved, up to a maximum of 24 hours.

24-hour legal assistance service

EUROP ASSISTANCE will provide the Insured with legal assistance which is limited to the objective existence of an emergency situation such as a breathalyser test, traffic accident, theft or detention.

This is an over-the-phone service which excludes the drafting of reports or opinions.

Over-the-phone legal advice

EUROP ASSISTANCE will respond to any legal question posed by a client concerning their own personal situation and limited to Spanish legislation.

The service is available from 9:00 am to 7:00 pm from Monday to Friday (except holidays). There is a maximum response time of 24 hours (except for national holidays and weekends), always by telephone.

This is an over-the-phone service which excludes the drafting of reports or opinions.

Access to the Network of Law Firms

The Insured will be entitled to an initial in person consultation, free of charge, at one of the law firms in the EUROP ASSISTANCE network and may use their services under special conditions once the case has been entrusted to them.

Consumer protection

EUROP ASSISTANCE will defend the Insured's rights as a consumer using accredited solicitors for pre-trial defence. The services necessary for the Insured's legal defence including telephone calls, preparation and presentation of written documents and formalities with the government.

This service is available 9:00 am to 7:00 pm, Monday to Friday (except national holidays).

Choice of Lawyer and Solicitor

Insureds have the right to choose their own lawyer and solicitor to represent and defend them in all kinds of proceedings, but if the chosen lawyer does not reside in the judicial district where the proceedings covered by the policy are to be held, the Insured will be responsible for the travel expenses, allowances and other costs incurred by the professional and included on his or her invoice.

Insureds also have the right to freely choose their own lawyers and solicitors when there is a conflict of interests between the parties to the contract.

Lawyers and solicitors appointed by Insureds are never bound by the instructions of EUROP ASSISTANCE.

Before appointing them, the Insured must inform the Insurer of the name of the chosen lawyer or solicitor.

The Insurer will pay the fees charged by the lawyer to defend the Insured according to the recommended fee schedule of the professional association.

The maximum fees allowed will be the ones recommended by the pertinent professional association for the purposes of cost appraisals and lawyers' sworn accounts, without the total cost exceeding the quantitative limit established for each guarantee.

If there is a conflict of interest between the parties, EUROP ASSISTANCE will inform the Insured so that the latter can decide whether to appoint a lawyer or solicitor they deem appropriate to defend their interests.

Under no circumstances will EUROP ASSISTANCE pay any fees and expenses arising from unfounded claims that lack sufficient evidence to make them viable, or which are meritless in terms of the liability for the accident, as well as those which are manifestly disproportionate to the assessment of the damages sustained. However, in the latter case, EUROP ASSISTANCE will pay the cost

if the Insured takes legal action and obtains a favourable ruling or compensation in an amount similar to their initial claim.

Dispute settlement

The Insured will have the right to submit to arbitration any dispute that arises with the Insurer concerning the insurance contract.

Arbitrators may not be appointed before the dispute arises.

Contract drafting and review

At the Insured's request, EUROP ASSISTANCE will draft or review the following types of contracts and documents in which the Insured is named as a party:

- Purchase and sale of property.
- Mortgage loan.
- Land registry reports.
- Deposits or earnest money.
- Claim letters for delays or hidden defects.
- Property leases.
- Complaint letters as landlord or tenant.
- Notification letters as landlord or tenant.
- Complaint or notification letters to the Homeowners Association.
- Domestic service employment contract
- Letter to cancel or correct personal data.
- Purchase and sale of a vehicle.

This service is available 9:00 am to 7:00 pm, Monday to Friday (except national holidays).

EXCLUSIONS FROM TRAVEL ASSISTANCE COVERAGE

This coverage will cease when the Insured returns to their habitual place of residence or once they are repatriated by EUROP ASSISTANCE to their home or a nearby hospital. Expenses not been previously notified to EUROP ASSISTANCE and those that have not been authorised in advance are generally excluded.

Unless expressly included in the guarantee, the insured guarantees do not cover damages, situations, expenses or consequences deriving from:

1. ***Pre-existing or chronic disease, injuries or conditions contracted by the Insured before the beginning of the trip which manifest during the course of the trip.***
2. ***Voluntary waiver, delay or bringing forward by the Insured the medical transfer proposed by EUROP ASSISTANCE and agreed by its medical services.***

3. *Mental illnesses, preventive medical check-ups, thermal cures, cosmetic surgery and medical or surgical tourism, alternative medicine treatments (homeopathic, naturopathic, etc.), the cost of physical therapy and/or rehabilitation treatments and similar.*

   Diagnosis, monitoring and treatment of pregnancy and the voluntary interruption of pregnancy and childbirth are also excluded, except in emergencies, and always prior to the sixth month.

4. *The participation of the Insured in bets, challenges or fights.*
5. *The practice of competitive sports or motorised competitions (races or rallies), as well as the practice of the dangerous or risky activities listed below:*
   - *Boxing, weightlifting, wrestling (in its different classes), martial arts, mountaineering with access to glaciers, sledding, diving with breathing apparatus, caving and skiing with springboard jumps.*
   - *Aerial sports in general.*
   - *Adventure sports such as rafting, bungee jumping, hydrospeeding, canyoning and similar. In these cases, EUROP ASSISTANCE will only become involved and pay for the expenses incurred by the Insured from the moment they are under treatment in a medical facility.*
6. *Suicide, attempted suicide or self-harm by the Insured.*
7. *Rescue missions in mountains, chasms, oceans or deserts.*
8. *Illness or accidents caused by the consumption of alcoholic beverages, narcotics, drugs or medicines, except when prescribed by a physician.*
9. *Fraudulent acts of the Policyholder, the Insured or their assignee.*
10. *Sudden onset epidemics and/or infectious diseases that spread rapidly among the population, as well as those caused by pollution and/or atmospheric contamination.*
11. *Wars, whether or not officially declared, demonstrations, insurrections, popular uprisings, acts of terrorism, sabotage and strikes. Nuclear transmutation of an atom and radiation caused by the artificial acceleration of atomic particles. Earthquake, flood, volcanic eruptions and in general any event unleashed by the forces of nature. Any other extraordinary catastrophic phenomenon or event qualified as a catastrophe or calamity due to its magnitude or seriousness.*
12. *Theft or misplacement of cash, jewellery, documents, luggage or personal items in vehicles or tents.*

Irrespective of the above, the following situations in particular are excluded:

1. *The medical transport of sick or injured persons caused by illnesses or injuries that can be treated "in situ".*

2. ***The cost of glasses and contact lenses, as well as the purchase, implantation, replacement, extraction and/or repair of prostheses and/or anatomical and orthopaedic parts of any kind, such as neck braces.***
3. ***The reimbursement of medical, surgical and pharmaceutical expenses.***

EXCLUSIONS FROM LEGAL DEFENCE GUARANTEES

- ***Expenses not been notified to the Insured in advance are generally excluded.***
- ***Events occurring before the entry into force of the contract.***
- ***Consultations and legal proceedings involving the application of foreign laws, and actions involving rights or benefits claimed by the Beneficiary against the corresponding College.***
- ***Events caused deliberately or in bad faith by the Beneficiary, including claims related to vehicles owned by the Beneficiary.***
- ***The cost of unfounded claims and those which are manifestly disproportionate to the damages sustained. This exclusion does not apply if the Beneficiary takes legal actions and obtains a favourable decision in which the total indemnity sought is awarded.***
- ***Compliance with the obligations imposed on the Beneficiary by a court or government resolution. Payment of fines and penalties plus interest and/or surcharges.***

10.4. Preventive Medicine

The Insured will be entitled to the benefits indicated in each one of the following sections:

10.4.1. Paediatric Preventive Medicine.

This includes preventive medicine for Insureds up to the age of 14, including:

- General check-up by a paediatrician every month during the first trimester of life, every two months up to 18 months of age and annually up to the age of 14.
- Administration of vaccinations according to the official schedule in each autonomous community such as Diphtheria, Tetanus, Pertussis, Poliomyelitis and MMR.
- Eye exam by an ophthalmologist at age 3 or 4 and at age 10 or 11.
- Hearing screening at age 3 or 4 and at age 10 or 11.
- Dental screening at the age of 6 and at the age of 10 or 12 for the assessment of correct oral and dental development.
- Screening for hearing loss in newborns (newborn deafness screening).

10.4.2. Adult Preventive Medicine.

This includes preventive medicine for Insureds between the ages of 14 and 65, including:

- General check-up by a primary care doctor every two years up to the age of 35 and then once a year up to the age of 65. Includes: complete anamnesis and

medical history, blood pressure, height, weight, skin examination, cardiorespiratory examination, abdominal examination, assessment of the state of health and risk of disease.

- Lab tests at the physician's discretion following the medical examination including: blood counts, ESR, blood glucose, cholesterol, urea, creatinine, uric acid, albumin and urine sediment, GOT and GPT.
- Prevention of obesity, arterial hypertension and hyperlipaemia, starting with the medical visit.
- Prevention of coronary heart disease starting with the medical check-up and general analysis from the age of 30, including: Baseline ECG for men, reviewed by cardiologist; and every five years from the age of 35 to 65, depending on cardiovascular risk factors: Stress test and monitoring by cardiologist.
- Annual gynaecological check-up and cytology; annual mammography starting at age 45.
- Amniocentesis in pregnant woman who are 35 years of age or older.
- Family planning for women, including consultation with a gynaecologist and fitting of an intrauterine device (excluding the cost of the IUD, diaphragm or medication); for men, consultation with a urologist. Tubal ligation and vasectomy. Basic study to diagnose the causes of infertility and sterility in couples, including: complete gynaecological examination, hormonal analysis, complete ultrasound and seminogram or spermogram.
- Preventive dental care: dental check-up by a dentist and annual dental hygiene.
- A colonoscopy may be performed every two years by prescription.
- Tetanus prevention: administration of the vaccine if medically indicated.
- Prevention of deafness with hearing test by audiometry if medically indicated.
- Prevention of eye diseases with a visual acuity test at 25 and 35 years of age and a visual acuity test and tonometry every two years from the age of 40.
- Childbirth preparation classes.

10.4.3. Geriatric Preventive Medicine.

This includes preventive medicine for Insureds over the age of 64 on an annual basis, including:

- General medical check-up by primary care doctor.
- Blood and urine tests
- Gynaecological check-up with annual cytology.
- Influenza prevention: administration of the vaccine if medically indicated.
- Tetanus prevention: administration of the vaccine if medically indicated.
- Preventive dental care: dental check-up by a dentist and annual dental hygiene.

- A colonoscopy may be performed every two years by prescription.
- Prevention of deafness and eye disease, including check-ups by an otolaryngologist and an ophthalmologist.
- Breast cancer prevention: mammography; gynaecological: cytology; digestive: occult blood at physician's discretion.

10.5. Reimbursement of Medical Expenses

Within the limits and according to the conditions stipulated in the policy, the Insurer will reimburse the Insured for all reasonable and usual medical expenses for medical, surgical and hospital care for any kind of illness or injury covered under the policy in guarantees 10.1. Primary Care, 10.2 Medical and Surgical Specialities and 10.4 Preventive Medicine, with the scope established in these General Conditions, in the Particular Conditions and in the Special Conditions of Reimbursement of the policy.

Reasonable and customary expenses are understood to mean the fees for medical, surgical and hospital care that do not exceed the usual fees charged by the same service provider or by other providers of a similar level in the same geographical area for a comparable service.

The scope of the guarantee of medical expense reimbursement is regulated in the Special Conditions of Reimbursement specified in the Particular Conditions of the policy, always based on the amount paid by the Insured, which must be duly accredited, as indicated in these General Conditions.

Unless otherwise agreed in the Particular Conditions, the Insurer will not reimburse the cost of medical services when the Insured uses the services listed on the Premium Medical Directory provided by the Insurer.

10.6. Indemnity for Hospitalisation due to Illness and Accident

The Insurer guarantees the Insured the payment of the Insured Amount per day for the duration of the event, in accordance with the provisions of the Particular Conditions.

If the Insured must be hospitalised due to illness or accident during the Indemnity Period established in the Particular Conditions, the Insurer guarantees the payment of the Insured Amount for this coverage as stipulated in the Particular Conditions for each uninterrupted stay in a medical facility, clinic or hospital.

Successive hospitalisations for the same cause will be considered a single period of hospitalisation.

The Insured Amount will be paid for complete 24-hour days, from the date and time of the Insured's admission to the medical facility, clinic or hospital. Under no circumstances will any Insured Capital be paid for hospitalisations lasting less than 24 hours.

Moreover, if the Insured must be hospitalised in the Intensive Care Unit due to illness or accident during the Indemnity Period established in the Particular Conditions, the Insurer guarantees the payment of an additional Insured Amount for the uninterrupted stay in the ICU/SDU of a medical facility, clinic or hospital, per the scope and limits established

in the policy. The Insured Amount will be paid for complete 24-hour days, from the date and time of the Insured's admission ICU/STU of the medical facility, clinic or hospital.

Whether consecutively or at different times with healthy intervals, no Insured is eligible to receive the Insured Amount for illnesses or accidents stemming from the same process or diagnosis for a period of time longer than the Indemnity Period established in the Particular Conditions.

If the event of multiple concurrent conditions, even if the Insured suffers from several illnesses at the same time or acquires a new illness as a result of the clinical treatment of the initially declared illness, the Indemnity Period and Insured Amount will continue to be as indicated in the Particular Conditions. If the new illness is caused by a process other than the previously declared illness, a new Indemnity Period will begin from the date of the onset of the most recent illness.

For Insureds under the age of 5 or over the age of 65, the coverage under this guarantee is limited to Surgical Hospitalisation due to Illness and/or Accident.

10.7. Dental Assistance

The Insurer guarantees access to the services detailed in the Particular Conditions of the policy as well as in the section titled "**Codified Odontostomatological Medical Services**" of the Dental Guide, which is part of the policy documentation.

The codified odontostomatological medical services apply exclusively to the services published in the Dental Guide. No cash indemnity will be paid under this guarantee in lieu of the provision of the dental service. However, the Insured is free to choose a professional to provide the service from among those listed in the Dental Guide.

The Insured must present the insurance card provided by the Insurer to the professionals on the list, whether in their province where they reside or any other province where the Insurer has a published Dental Guide.

Article 11. Claims Processing

11.1. Use of Premium Medical Directory services

For the purposes of this insurance policy, a claim is understood to have been reported when the services made available by the Insurer to the Insured through the Premium Medical Directory are used.

11.1.1. Territorial Scope. The preferred Premium Medical Directory provided by the Insurer to the Insured is the one for the locality shown in the Particular Conditions. The Insured may also use the services of the Premium Medical Directories for other localities, always within the scope of coverage of the contracted guarantees.

The Insured is aware of and agrees that the Underwriters will be held harmless from any liability and/or obligation for damages, losses, costs or expenses related to this insurance contract if the provision of these services exposes the Underwriter to any type of sanction, prohibition or restriction

based on United Nations resolutions or regulations, laws, economic or trade sanctions imposed by the European Union, the United Kingdom or the United States.

11.1.2. House calls. If the coverage includes house calls, the Insurer will provide this serve at the home address stated in the policy as the Insured's habitual residence, and any change of address must be notified in accordance with the provisions of Article 13 a) of these Conditions.

House calls will only be authorised when the Insured is too ill to travel to the physician's office.

11.1.3. Emergencies. The Insured may go directly to the Permanent Emergency Centre indicated by the Insurer at the address shown in the Premium Medical Directory.

Emergency services at home must be requested by calling the telephone number indicated in the documentation provided to the Insured.

11.1.4. Medical Specialities. Medical specialists are the consultants of general practitioners, advising them in their medical practice upon request. The Insured is free to consult with specialists, although it is recommended they go first to the general practitioner, as he or she is the best person to advise the patient on the action to be taken and which specialist to see based on the Insured's condition.

11.1.5. Healthcare Technicians, Registered Nurses. The services of Healthcare Technicians and Registered Nurses may be requested for treatments if prescribed by a physician.

In emergencies, the medication prescribed by a physician can be administered by the Emergency Services indicated by the Insurer, and whose telephone number appears in the Premium Medical Directory.

11.1.6. Prior authorisation. Special diagnostic tests, hospitalisation, surgical procedures (both for diagnosis and treatment) and the provision of a treatment or therapeutic service (e.g., radiotherapy, chemotherapy, physical therapy and functional rehabilitation, oxygen therapy, haemotherapy, etc.) must be prescribed by a physician, accompanied by a report justifying the need for the service, and the Insured must obtain confirmation form the Insurer's office. Once confirmed, it will be financially binding on the Insurer unless the confirmation explicitly states that it is a service that is not covered under the policy.

In an emergency, the physician's order will suffice but the Insured must obtain confirmation from the Insurer within 72 hours of admission. In this case, the Insurer will be financially liable unless it expresses an objection to the physician's order, should it consider that the action or hospitalisation is not covered under the policy.

For your convenience there is a faster and simpler way to request authorisation by going to the Medical Procedures / Medical Authorisation section of the Generali website.

11.1.7. Documentation. In order to be use the services offered by the policy, provided that they are covered by the policy according to the guarantees purchased, the Insured must always show the insurance identification card provided by the Insurer.

If the card is lost or stolen, the Policyholder and/or Insured must notify the Insurer within forty-eight hours so that the card can be cancelled and a new one issued. Furthermore, the Policyholder and each Insured agree to return the insurance cards to the Insurer once the contractual relationship is cancelled or terminated, regardless of the cause.

11.1.8. Scope of the medical prescriptions. The Insurer will cover the fees and costs of hospitalisation and services prescribed by a physician who appears in Premium Medical Directory, provided that they are covered under the guarantees included in the General, Particular and Special Conditions of the Policy.

11.1.9. Travel Assistance. In order for the services specified in Article 10, section 10.3. -Travel Assistance, to be covered it is essential for the Insured to request the Insurer's intervention as soon as the event occurs by calling the 24-hour telephone numbers listed on the Insured's ID card.

11.2. Reimbursement of Medical Expenses

According to these General Conditions, the Insured may choose a medical professional or facility not included in the Premium Medical Directory, in which case the Insurer will reimburse the expenses incurred by the Insured for medical, surgical and hospital care within the scope of coverage of this policy. The Insurer will reimburse the Insured based on the amount paid by the Insured in accordance with the provisions of the General, Particular and Special Conditions of the policy.

a) Communications.

The Policyholder or Insured must notify the Insurer of the occurrence of a loss within the timeframes indicated below, starting from the date on which the loss becomes known. In the event of non-compliance, the Insurer may claim damages due to the failure to make this declaration, unless it is proven that the Insured learned of the loss by another means.

The deadlines for notifying a loss are:

- 48 hours for emergency hospitalisation
- 3 days before the admission date for scheduled hospitalisation
- 7 days after the occurrence of the loss in all other cases

b) Documentation.

All documentation submitted to the Insurer to request reimbursement of expenses must always reflect the name of the Insured receiving the service.

This documentation is as follows:

- Duly completed Application for Reimbursement of Expenses and Indemnity.

- Original invoices and receipts showing that the Insured has paid for the service for which reimbursement is requested, which must be issued by the physician or facility that provided the service to the Insured. This documentation must contain the following information:
  - General details of the physician or facility such as full name of the individual or company, address, tax ID, the physician's medical licence number and speciality.
  - Nature of the services rendered, date and cost.
- Original medical prescriptions or other original document showing, in addition to the physician's full name and registration number, the patient's full name and insurance ID number, the diagnosis or cause of the diagnostic test or treatment requested by the physician caring for the Insured.
- For hospitalisations, in addition to the above documentation, the Insured must provide the Hospital Discharge Report stating the history, date and time of admission, cause, origin and evolution of the illness or injury, as well as details of the services provided, the dates and the cost.

For your convenience there is a faster and simpler way to request authorisation by going to the Medical Procedures / Expense Reimbursement Request section of the Generali website.

c) Claims payment

Once all required documentation has been received and checked to establish the existence of the claim, the Insurer will proceed to reimburse the expenses in accordance with the provisions of the policy.

Expenses will be reimbursed within 20 days of receiving the required documentation.

If the process lasts more than three months, the Policyholder or Insured must send the Insurer documentation accrediting the payment for the services rendered over the last three months.

If the Insured receives medical treatment in a non-member country of the European Union, the cost of the service to be reimbursed by the Insurer will be estimated in Euros at the official exchange rate on the foreign exchange market on the date when the Policyholder or Insured paid for the service provided.

When the Policyholder or Insured submits documentation in any non-official language in Spain, with the exception of English, the cost of translation will be paid by the Insured.

11.3. Indemnity for Hospitalisation due to Illness and Accident

a) Loss reporting

As a general rule, the Policyholder or Insured must report the occurrence of a loss to the Insurer within seven days at the most, as stipulated in Article 16 of Law 50/1980 on Insurance Contracts.

If the notice is sent by post, it must be sent by registered letter, and the reception date will be the date that appears on the postmark on the envelope. In any event, the start date of the accrual of the Insured Amount can be accredited by the acknowledgement of receipt issued by the Insurer.

The Insurer may make such visits as it deems appropriate to check the Insured's condition and may take such measures as it deems appropriate depending on the results of these visits. If an Insured should oppose or prevent the Insurer from visiting them, the Insurer will be released from providing the service in question, except when it is the physician caring for the Insured who opposes, in which case the physician must explain in writing why this is the case.

The Insured gives their express consent for the Insurer, in the event of a loss, to consult with the physicians who are treating or have treated the Insured about medical or clinical matters concerning the Insured.The Insurer will respect the confidential nature of any data that may be provided.

The Insurer will not be bound by the assessments of professionals from any other public or private organisation.

b) Loss documentation.

In order to collect the Insured Amount, the following documentation must be provided to the Insurer:

Duly completed "Application for Reimbursement of Expenses and Indemnity" signed by the physicians that prescribed admission to the medical facility, clinic or hospital.

In the absence of the "Application for Reimbursement of Expenses and Indemnity", the Insurer may be notified of the loss in writing in a document signed by the attending physician which must include the following details:

- Full name, age, profession and address of the Insured who has been hospitalised.
- Full name, address, medical licence number and speciality of the attending physician.
- Date and time of admission and name of the medical facility, clinic or hospital.
- Medical report stating the reason for admission and the treatment administered to the Insured.
- Probable date of the Insured's discharge from hospital.

Once the Insured has been discharged from hospital, the Insurer must be provided with a supporting document signed by the physician and the administrative management of the facility where the Insured was admitted stating the exact amount of time the Insured was admitted and the date and time of the Insured's discharge.

c) Claims payment.

The Insurer is obliged to pay the Insured Amount upon completion of the investigations and expert opinions necessary to establish the existence of the loss and, where appropriate, the amount of the resulting damages. The Insurer may make partial

payments of the total amount of the claim in cases where the duration exceeds 40 days.

Article 12. Risks not covered by the policy

In addition to the exclusions and limitations established in other articles of these General Conditions, the Particular Conditions and the Special Reimbursement Conditions of the policy, the following are excluded from the coverage under this insurance:

- ***Services derived from care for pre-existing conditions or diseases that pre-date the inclusion of the Insured on the policy, when there are obvious symptoms of their existence and when they have not been declared by the Insured on the Health Questionnaire.***
- ***Prostheses of any kind, anatomical and orthopaedic parts, implantable automatic defibrillator and artificial heart, except for osteosynthesis material and the following prostheses: heart valves, pacemakers, hip prostheses, vascular by-pass, internal traumatological prostheses, abdominal meshes, port-a-cath, intraocular lens in case of cataracts and breast prostheses after radical mastectomy.***
- ***Damages caused by nuclear or radioactive operations which are covered by civil liability insurance for nuclear damage.***
- ***Losses caused directly by any contagious disease that is considered a pandemic in Phase 5 or higher by the World Health Organisation.***
- ***Acts of war, riots, revolutions and terrorism and cataclysmic events (earthquakes, floods and other seismic or meteorological phenomena).***
- ***Non-surgical treatment of obstructive sleep apnoea.***
- ***Psychoanalysis, psychoanalytic therapy, hypnosis, narcolepsy, psychosocial or neuropsychiatric rehabilitation services, group therapy, psychological tests, sleep cures and acupuncture, as well as treatments that are experimental or not sufficiently recognised or endorsed by the relevant scientific community.***
- ***Purely aesthetic treatments (plastic surgery, sclerosis of varicose veins, cosmetic treatments, weight-loss cures, obesity treatment and surgical intervention for myopia, hypermetropia and astigmatism). This does not apply to reconstructive surgery following accidents or burns.***
- ***Transplants of any kind, except for transplants of the following organs: heart, liver, kidney, lung, bone marrow and cornea, which are guaranteed under article 10.5 Reimbursement of Medical Expenses in accordance the terms of the General, Particular and Special Conditions of the policy. However, the reimbursement does not include the cost of the organ itself or the cost of extracting, conserving or transporting the organ to be transplanted. The Insurer accepts no liability whatsoever for sourcing the organ.***

- ***Treatment of any type of drug or substance addiction (e.g., alcoholism).***
- ***Assistance of any kind arising from suicide, attempted suicide or self-injury by the Insured.***
- ***Services derived from AIDS care and/or illnesses caused by HIV.***
- ***Medicines and vaccinations, with the exception of those administered during hospitalisation in accordance with the provisions of Article 10 of these General Conditions.***
- ***Reimbursement of expenses when the service for which reimbursement is requested was provided by a professional or facility in the Medical Guide.***
- ***Reimbursement of health care provided by the spouse or relative of the Insured up to the second degree of consanguinity.***
- ***Genetic mapping for the purpose of determining the predisposition of the Insured or his present or future descendants to acquire certain diseases caused by genetic alterations, and genetic mapping to study the causes of a couple's infertility and sterility.***
- ***Unless otherwise agreed in the Particular Conditions of the policy, medical or surgical procedures and their consequences which the Insured has received voluntarily and that are unrelated to any accident or illness are excluded, except for those indicated in Article 10.4 "Four:Preventive Medicine" of these General Conditions.***
- ***Medical examinations, check-ups and stays at spas, rest homes, nursing homes, geriatric and similar institutions are excluded from the coverage of Guarantee 10.6. "Reimbursement for Hospitalisation due to Illness and Accident".***
- ***Any service not expressly included in the Particular Conditions or in the section of the Dental Guide titled "Codified Odontostomatological Medical Services" is excluded from the coverage under Guarantee 10.7 "Dental Assistance".***
- ***Excluded from the coverage under Guarantee 10.5 Reimbursement of Medical Expenses are the medical acts involved in the treatment of infertility, which are included in Guarantee 10.2 Medical and Surgical Specialities.***

Article 13. Other obligations, duties and powers of the Policyholder or Insured

The Policyholder and, where applicable, the Insured, assumes the following obligations:

a) To notify the Insurer of any change of address by registered letter at least seven days before any service is required. The Insurer will issue the corresponding addendum.

b) To notify the Insurer as soon as possible of any additions and removals of Insureds that may occur during the term of this contract. The Insured's newborn child will be included on the policy automatically (no waiting period longer than any unconsumed portion of the

father's or mother's waiting period), effective as of the date of birth, provided that registration is requested within 15 calendar days following the birth and that the mother is entitled to the childbirth benefit in the policy.

Article 14 Indisputability

If the Insured undergoes a medical examination or is approved for coverage, the policy will be indisputable insofar as the state of health of the Insured or Insureds and the Insurer may not deny benefits on the grounds of the existence of pre-existing conditions, unless there is an express proviso in the Particular Conditions of the policy as a result of the medical examination.

If there is no medical examination and the policy is issued on the basis of the Insurer's Health Questionnaire, and it is later found that there is missing or inaccurate information in the declarations made by the Policyholder or the Insured when answering the Insurer's Questionnaire, the Insurer may cancel the contract within one month of becoming aware of such omission or inaccuracy by sending a letter to that effect to the Policyholder.

The policy will be indisputable one year after signing the contract unless the Policyholder has acted fraudulently.

As the competent authority for the Spanish state, the Ministry of Economy and Competitiveness, through the Directorate General of Insurance and Pension Funds, is responsible for overseeing the insurance sector and for protecting the Insured's freedom to decide on the purchase of insurance and maintaining the contractual equilibrium of existing insurance contracts.

Article 15. Applicable law and jurisdiction

Unless otherwise stated in the Particular Conditions of the Policy, this contract is governed by Spanish law.

Legal actions arising from this insurance contract will be decided by the courts in the Insured's judicial district in Spain. To that end, Insureds who live abroad must provide an address in Spain and any agreement to the contrary will be null and void.

These Terms and Conditions have been written in a simplified manner to make them as comprehensible as possible. Please read them carefully and ask your broker or inquire at any Generali branch office for clarifications of any doubts you may have.

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GENERALI ESPAÑA, S.A. DE SEGUROS Y REASEGUROS. Reg. address: c/ Orense, n 2. 28020 MADRID. N.I.F.: A-28007268.
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