GENERALI TOTAL HEALTH

General Conditions
and Special Conditions

GENERALI

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Expense Reimbursement Insurance with Recommended Medical Directory

60375/02 /GEN

General Conditions and Special Conditions

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What are the General Conditions of the Insurance?

When we consider the possibility of the things that could happen to us or our property, we are exercising foresight, but unfortunately it is not always possible to prevent such damages from occurring. This is true for many people who would likewise be helpless in such situations.

One of the traditional ways of mitigating the consequences of these situations is for several people to share the burden, so that the harmful effects are minimal when shared by many rather than enormous for one person going it alone.

Insurance companies identify the damages that occur and the causes, studies the statistics exhaustively, details the frequency with which the damages occur, quantifies the damages and calculates the price of distributing the risk. On the basis of these calculations, the insurance company offers the public an insurance policy such as the one you have in your hands.

The General Conditions are the result of the operations described above and the means by which Generali describes the risks that it has decided to assume and the form and amount in which it will repair the damages caused. They are called General Conditions because the contents are common to all insurance policies taken out to cover the same causes of damages, in keeping with the technique of equal distribution mentioned above.

What we call **risk** is the possibility that you may require health care (e.g., a doctor's visit or a surgical procedure) as a consequence of a specific cause (an illness or an accident).

The definition of these risks, in addition to being general or common to all insurance of this kind, must be generic, i.e., it must describe the risk in terms of common characteristics rather than a detailed and exhaustive list of possible scenarios. But the brevity and generic nature of the definition does not imply that the risk is indeterminate or that everything is covered. On the one hand, the very definition of the risk delimits its content (e.g., "Other Hospital Expenses" under the Hospitalisation guarantee refers to medicines and materials for patients who are hospitalised, not ambulatory). On the other hand, the risk is further by the situations which the Insurer has decided not to cover or which it simply states are not covered in order to provide more complete information. We **trust that the description of "What is covered?" and "What isn't covered?" under this Insurance** will make things easier to understand.

At the same time, the General Conditions contain other types of Clauses regarding how the amount of the compensation is quantified or how conflicts and other matters that may arise are resolved, all of which are important questions and which, together with the legal provisions, round out the regulatory framework governing the relationship between you and us.

Total Health is **an insurance policy that provides international coverage by reimbursing medical and surgical expenses incurred as a result of illness or accident, as well as for pregnancy and neonatal care,** all in accordance with the provisions of the General and Particular Conditions of the Policy and any Supplements.

Its greatest attraction lies in the freedom to choose the **physician or facility** you wish to use and if you use the professionals and facilities in our **Medical Network,** deductibles neither

the deductibles nor the sub-limits for certain guarantees will apply. In fact, we will pay participating physician or facility directly and you will not be required to pay anything out-of-pocket.

Generali's Total Health Reimbursement Insurance offers three insured capital options with the corresponding sub-limits for each guarantee. You can choose the insured capital that best suits the needs of your family.

For questions, do not hesitate to seek the help and advice of our Agent or your nearest Generali office. There is also a telephone helpline for Insureds.

In any case, please read these General Conditions carefully.

Table of Guarantees

Insured Amount per Insured and Insurance Year or per Single Loss

	OPTION A	OPTION B	OPTION C
Insured Amount	€60,000	€250,000	€500,000

HOSPITALISATION	LIMITS	LIMITS	LIMITS
Hospitalisation per day	€162	€200	€230
ICU	No sub-limit	No sub-limit	No sub-limit
Medical-Surgical Fees:			
Group 1: Minor surgery	€600	€750	No sub-limit
Group 2: Intermediate surgery	€1,500	€2,100	No sub-limit
Group 3: Major surgery	€2,100	€3,600	No sub-limit
Group 4: Major surgery	€3,600	€7,200	No sub-limit
Group 5: Special serious processes	No sub-limit	No sub-limit	No sub-limit
Medical fees per visit:	€60	€60	€60
Prosthesis	€1,500	€2,000	€3,000
Psychiatric Hospitalisation (Max. 60 days)	€3,600	€3,600	€3,600
Other Hospital Costs	No sub-limit	No sub-limit	No sub-limit
Dialysis and Haemodialysis	15 sessions	15 sessions	15 sessions
Hospitalisation not charged to policy	€90	€90	€90
Ambulance	€600	€600	€600

OUTPATIENT CARE	LIMITS	LIMITS	LIMITS
Medical visit:			
Primary Care	€40	€50	€70
Specialist	€70	€95	€100

Diagnostic Tests	No sub-limit	No sub-limit	No sub-limit
Special Treatments	No sub-limit	No sub-limit	No sub-limit
Dental	S.M.R.	S.M.R.	S.M.R.
Psychiatry – Psychology	20 visits/year	20 visits/year	20 visits/year
Podiatry.	6 sessions	6 sessions	6 sessions
Oxygen and Ventilation Therapy	30 day/year	30 day/year	30 day/year
Preventive Medicine	€150	€150	€150

PREGNANCY AND NEONATAL CARE	LIMITS	LIMITS	LIMITS
Pregnancy and Childbirth	€1,500	€2,000	€3,000
Pregnancy and Caesarean section	€1,900	€2,500	€3,600
Neonatal treatment	€7,500	€7,500	€7,500

TRAVEL ASSISTANCE	**Included**
SECOND MEDICAL OPINION	**Included**

Information Clause

The purpose of this Information Clause is to comply 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 the Royal Decree 1060/2015 of 20 November approving the developing regulations for the general duty of information to be provided by Insurers to Policyholders and Insureds.

Name, legal status and registered address of the Insurer

- Name. GENERALI ESPAÑA, S.A. DE SEGUROS Y REASEGUROS
- Registered Address: Calle Orense nº 2, (28020) MADRID-ESPAÑA, NIF A-28007268. Registered with the Madrid Commercial Registry on page M-54,202.

Insurance Regulatory Body

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 to the following e-mail address: 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:

Paseo de la Castellana, 44 28046 MADRID
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.

Definitions

1. You

The Policyholder and/or Insured who assumes the obligations under the contract, except for those which, by their nature, must be assumed by the Insured.

2. Us

Generali, S. A. de Seguros y Reaseguros (hereinafter, Generali), the Insurance Company that assumes the risks agreed in the contract.

3. Insureds

The natural person or persons who meet the requirements established in the Policy and in respect of which the risks covered by the Policy are assumed.

4. Beneficiary

The person named on the Policy or insurance certificate as the Primary Policyholder who is entitled to receive the reimbursement of all medical expenses of the family members covered under this Policy and to receive the compensation payable under the Policy.

5. Policy

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

- The General and Special Conditions
- The Particular Conditions reflecting the individualised risk.
- Riders or Appendices issued to supplement or modify them.
- Application that served as the basis for issuing the Insurance.
- Premium receipts.

6. Premium

This is the price of the Insurance that you pay, plus the corresponding surcharges and taxes. This price is determined taking into account the Policy guarantees with all included and excluded risks and limitations, based on the risk that you have declared to us.

7. Insurance year

The period between the effective date of the Insurance and the expiry date of the Policy, as well as the period between each annual expiry date of successive renewals.

8. Insured amount or Insured capital

The insured amount or insured capital established in the particular conditions of the Policy is the total limit of reimbursable expenses or directly payable to the Recommended Medical Services as a consequence of the application of the guarantees covering each Insured during an annual insurance period. Likewise, the insured amount or insured capital is the total limit of all reimbursable or directly payable expenses over various insurance years for the use of the guarantees as a consequence of the same illness or accident.

9. Deductible

The percentage of the total amount of the costs to be reimbursed under the insurance that must be paid by the you, up to the maximum limits established in the Policy.

10. Waiting periods

The period of time starting when a new Insured is added to the Policy during which some of the coverages under the Policy are not yet in effect.

11. Disease

Any alteration of the state of health, including injuries caused by accidents, which is diagnosed and confirmed by a physician.

All injuries and sequelae resulting from the same accident, as well as all conditions due to the same or related causes are considered to be one and the same disease.

If a condition is due to the same cause that led to a previous illness, or to related causes (including sequelae and complications from the previous illness), it will be considered a continuation of the previous illness rather than a new one.

12. Accident

Bodily injury deriving from a sudden, violent external cause beyond the Insured's control.

13. Pre-existing condition and/or accident

Those that were already diagnosed or treated or for which a physician was consulted or that manifested the first symptoms before the Insured was included on the Policy.

14. Physician

A doctor or graduate in medicine who is legally qualified and authorised in the place where he or she practices to medically or surgically treat disease.

15. Outpatient care

Medical care provided in a medical office, in the patient's home or in a hospital or clinic without an overnight stay.

16. Hospitalisation

Hospitalisation occurs when a patient is admitted to hospital for a minimum of 24 hours, or is to a day hospital for a surgical procedure.

For the purposes of the maximum limit of 180 days in the Hospitalisation Guarantee, hospitalisation for the same cause that led to a previous hospitalisation is considered for the purposes of this Policy a continuation of the previous one, unless 90 days have elapsed since the previous discharge.

17. Hospital

Any public or private establishment legally authorised for the medical treatment of disease or bodily injury, equipped with adequate material and human resources to perform diagnoses and surgical procedures, staffed by physicians and other medical staff 24 hours a day. For the purposes of this Policy, asylums, nursing homes, rest homes, spas and neuro-psychiatric clinics are not considered hospitals.

Similarly, facilities dedicated to the rest, internment or treatment of the elderly, disabled, chronically ill, mentally ill, drug addicts or alcoholics are not considered hospitals.

18. Day hospital

A facility equipped with the appropriate structure and resources for the surgical treatment of patients on an outpatient basis.

19. Surgical procedure

Any operation that uses an incision or other method to reach into the patient's body for purposes other than diagnosis, performed in a hospital by a surgeon, and normally requiring the use of an operating theatre.

20. Loss

Any assistance provided under the cover of and in accordance with any of the Policy guarantees.

21. Necessary medical and surgical care

That which is medically prescribed and is necessary and appropriate for the diagnosis or treatment of a disease or accident based on generally accepted medical practice.

22. Reasonable and customer expenses

The fees for medical and surgical 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.

23. Pregnancy

The period of time between fertilisation of the ovum and delivery or caesarean section. This includes medical conditions that may signal a "difficult pregnancy" such as occasional spotting, morning sickness, hyperemesis and similar conditions.

24. Complications of pregnancy

Conditions that require hospitalisation before the end of the pregnancy which are different than the pregnancy itself but adversely affected or directly caused by the pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, miscarriage, and medical or surgical conditions of comparable severity. Includes ectopic pregnancy, spontaneous termination of pregnancy when a viable delivery is not possible, puerperal infection, eclampsia and toxaemia.

25. Emergency

A situation which, in the opinion of a physician, could pose a serious danger to the life or physical integrity of the person and which must therefore be treated within 24 hours.

26. Prosthesis

A medical device or product that partially or fully replaces a limb, organ or tissue or its function, provided that it is permanent and made of artificial material.

27. Osteosynthesis material

Anatomical parts or elements made of metal or other materials used to join the ends of a fractured bone or to weld the ends of a joint.

Article 1. Object of the Insurance

Within the limits and in the situations established in the Particular and General Conditions of the Policy, we offer these guarantees:

- The reimbursement of reasonable and usual expenses for medical and surgical care you may require, both inpatient and outpatient, during the term of the Policy due to or as a consequence of disease, accident, pregnancy and **childbirth or caesarean section**, occurring during the same period of time.
- The benefits of the **Travel Assistance** coverage, in the terms set out in **Annex II** of these General Conditions.
- The benefits of a **Second Medical Opinion** in accordance with the terms of **Annex III** of these General Conditions.
- The payment of the **indemnities** provided for in the Policy according to the terms of each Guarantee.

The Insured is free to select the physician or centre of his choice to provide the required care.

Article 2. Guarantees

Total Health Insurance offers you the following **Guarantees**:

1. Hospitalisation.
2. Outpatient care.
3. Pregnancy and Neonatal care.
4. Travel Assistance.
5. Second Medical Opinion.
6. Dental Assistance.

1. Hospitalisation

What is covered?

The expenses incurred due to hospitalisation of the Insured up to a maximum of 180 days for each hospitalisation and Insurance year due to:

1.1. **Hospital admission:** The Insured's hospital room and board plus a bed for the companion, **up to the daily sub-limit in the Particular Conditions**.

1.2. **Time** spent in Intensive Care Units, Critical Care Units and Coronary Care Units with no daily sub-limit.

1.3. **Medical fees:** Of surgeon, assistants, anaesthetists and for specialists, subject to the **sub-limits for each procedure shown in the Particular Conditions**, according to the classification of groups of medical acts described in **Annex I of these General Conditions; and for specialist consultations up to the quantitative limit established in the Particular Conditions.**

1.4. **Other hospital expenses** such as operating theatre fees, medicines, devices, treatments, rehabilitation and other services required during hospitalisation.

1.5. **Hospitalisation in a psychiatric centre up to a maximum of 60 days per Insured and Insurance year or for the same illness**, including the cost of the Insured's room and board whilst admitted, medical fees for treatment, medicines and other services required during hospitalisation, **up to the sub-limit established in the Particular Conditions.**

1.6. **Hospitalisation not charged to the Policy:** If the hospital expenses are covered but were not charged to the Policy, we pay for each full day of hospitalisation **the amount stipulated in the Particular Conditions.**

1.7. **Prostheses:** We will pay the cost of purchasing an internal bone prosthesis, osteosynthesis material, cardiac (excluding artificial heart), vascular or ophthalmological prosthesis, abdominal mesh, port-a-cath, and breast prosthesis following radical mastectomy, **up to the annual sub-limit stipulated in the Particular Conditions for this item.**

1.8. **Ambulance**: We will pay the cost of transfer by ambulance, **up to the sub-limit in the Particular Conditions.**

1.9. **Haemodialysis**: only in acute and reversible cases, as well as in exacerbations of chronic processes, **with a maximum of 15 sessions per process.**

For the purposes of the maximum limit of 180 days for this Guarantee, hospitalisation for the same cause that led to a previous hospitalisation is considered for the purposes of this Policy a continuation of the previous one, unless 90 days have elapsed since the previous discharge.

What is not covered?

a) Plastic or cosmetic surgery, except for the cost of restorative surgery as a consequence of an accident covered by the Policy and breast reconstruction after radical mastectomy.

b) Rest cures and diseases and treatments stemming from alcohol, drug and gambling addictions.

c) Hospitalisation and operations due to pre-existing physical defects or deformities, refraction defects and/or congenital or hereditary anomalies or defects, except for "Neonatal Care" as provided for in the third Guarantee under Article 2.

d) Any prosthesis other than the ones listed in section 1.7 above.

What is the deductible?

Unless expressly agreed otherwise in the Particular Conditions, **you will be responsible for the following percentages of each covered loss:**

In Spain 10%.

Outside Spain 20%.

Is there a waiting period?

This guarantee will take effect **after three months for any surgical procedure or hospitalisation**, except for accidents covered under the Policy or emergency care due to diseases diagnosed after the Insured has been added to the Policy.

2. Outpatient Care

What is covered?

Expenses incurred for the following outpatient care:

2.1. Office visits:

a) Primary care: General practitioners and paediatricians, and the professional services of healthcare technicians, registered nurses, nursing assistants and physical therapists, either in the doctor's surgery or at the Insured's home, if necessary.

b) Specialised care: Specialist physicians.

All subject to the **sub-limits for office visit fees established in the Particular Conditions of the Policy.**

2.2. Diagnostic tests: Clinical analyses, diagnostic imaging, endoscopy and electrophysiology studies.

2.3. Special treatments, including:

a) Functional rehabilitation treatments with a maximum of **60 sessions per Insured and Insurance year**.

b) Outpatient surgery, subject to the **sub-limits for medical fees established in the Particular Conditions** for surgical procedures (Article Two, section 1.3.).

c) Chemotherapy, cobalt therapy, radiotherapy and lithotripsy.

2.4. Preventive medicine: Covers the cost of check-ups described below under the heading "What does Preventive Medicine cover?," **up to the sub-limit established in the**

Particular Conditions. This sub-limit does not apply for check-ups that are done in-network.

2.5. Podiatry. Limited to six sessions per year, except for foot pathologies.

2.6. 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.**

2.7. Oxygen and Ventilation Therapy. At home only in acute and reversible cases, as well as exacerbations of chronic processes with prescription.

Aerosol Therapy: At home only in acute and reversible cases, as well as exacerbations of chronic processes, with a maximum of 30 days. With medical prescription. The Insured pays for all medication.

2.8. Stomatology. Includes stomatological treatments and extractions in Medical Directory. Excludes fillings, endodontics, prostheses and orthodontic and periodontic treatments.

What is not covered?

Dietary treatments, slimming cures, treatment of capillary processes (e.g., alopecia), and aesthetic medical treatments.

What does preventive medicine cover?

1. General check-ups for men and women from the age of 45:

   A standard check-up at one of our recommended facilities or reimbursement of the amount paid, up to the **sub-limit established in the Particular Conditions**, every two years from the second year of the Insurance, up to the age of 59 and from then on once a year up to the age of 70.

   In-network medical check-ups include:

   - Complete medical examination by systems and apparatus.
   - Blood work to determine the following parameters: Blood count, formula, sedimentation rate, glucose, total cholesterol, uric acid and transaminases (GOT and GPT).
   - Urinalysis with determination of density, sediment and abnormal elements.
   - Basic resting electrocardiography.
   - By prescription of the examining physician and depending on the patient's clinical characteristics: two-view chest X-ray.
   - A colonoscopy may be performed every two years by prescription.

2. Gynaecological check-up for women from the age of 20:

A standard gynaecological check-up at our recommended facilities or by a recommended gynaecological specialist, or reimbursement of the amount paid, **subject to the sub-limit established in the Particular Conditions**, every year from the second year of the insurance, from 20 to 70 years of age.

In-network medical check-ups include:

- Complete gynaecological examination, including breast exploration.
- Cytology (Pap smear).
- Bilateral mammography starting at age 40, by prescription of the examining physician.

What is the deductible?

Unless expressly agreed otherwise in the Particular Conditions, for this outpatient care you will pay the 20% deductible for each justified and covered expense:

Is there a waiting period?

With the exception of preventive medicine, outpatient coverage takes effect **three months after the date on which the Insured is added to the policy for the tests and treatments indicated below:**

- **High technology diagnostic tests: Such as catheterisation and other invasive tests such as arthroscopy, laparoscopy and amniocentesis.**
- **The following special treatments: Lithotripsy, Radiation therapy, Cobalt Therapy and Chemotherapy.**
- **Outpatient surgery.**

3. Pregnancy and Neonatal Care

What is covered?

Covers expenses arising from:

3.1. **Pregnancy and childbirth**, as well as the processes described in the definition of pregnancy in the Introductory Article. When your child is born, this Pregnancy coverage entitles you to Neonatal Care for your Newborn.

3.2. **Pregnancy and caesarean section**, as well as the procedures described in the definition of pregnancy in the Preliminary Article. When your child is born, this Pregnancy coverage entitles you to Neonatal Care for your Newborn.

3.3. **Neonatal care:** If a child is born while the Insurance is in force, we will pay for the newborn's medical and hospital expenses, including neonatal deafness screening, **provided that you request the inclusion of the newborn on the policy within 15 days of birth:**

- If the application for inclusion is **accepted** and it is discovered in the first year of life that the newborn has a congenital disease, the newborn will be eligible for additional coverage above and beyond the normal coverage under the Policy during the first

year of life, **subject to the sub-limit established in the Particular Conditions for Neonatal care.**

- If the application for membership is **rejected** by the company due to problems due to developmental defects, deformities or congenital disease, you will be eligible for additional coverage for your newborn under the Policy during the first year of life, **subject to the sub-limit established in the Particular Conditions for Neonatal care.** Before your child turns one, you may submit updated reports on the congenital problem for re-examination of the application to join the Policy.

3.4. Childbirth preparation is included up to a limit of €120 per pregnancy.

How do the pregnancy sub-limits apply?

- **If you choose from among the Recommended Medical Services (physicians, tests and hospitals) for all pregnancy and childbirth or pregnancy and caesarean section care, there are no deductibles or reimbursement sub-limits.**
- **If you choose to be reimbursed for any of your pregnancy and childbirth or pregnancy and caesarean section care, mixing reimbursement with the Recommended Medical Services, the sub-limits stipulated in the Particular Conditions will apply.**

What is not covered?

Abortion and sterilisation, infertility diagnosis and treatment, and contraception.

What is the deductible?

For Pregnancy and Neonatal care, you will pay a deductible of 20% for each justified and covered expense.

Is there a waiting period?

This coverage **takes effect eight months** after the Insured is added to the Policy with coverage for pregnancy and childbirth or pregnancy and caesarean section and complications of pregnancy.

In order to be eligible for **Neonatal care, the child must be born eight months after the mother has been added to the Policy.**

4. Travel Assistance

Guarantee detailed in Annex II. The coverage under this guarantee is valid:

a) nation-wide in 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. In order to be eligible for the guaranteed benefits, the Insured must have his or her 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.**

5. Second Medical Opinion

Under this guarantee, the Insured can request a second opinion in relation to the diagnosis of a serious disease.

This service is provided by reputable medical societies with experience in Second Medical Opinions.

All Insureds under the policy are eligible for this coverage which is described in Annex III of these General Conditions.

6. 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 and is also available on the website.

The only codified odontostomatological services available are the ones 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 3. Use of Guarantees

For the Hospitalisation, Ambulatory Care, Pregnancy and Neonatal Care guarantees, in keeping with the freedom of choice of medical professionals and facilities established in the of the Insurance (Article One), the Insured is free to choose:

- The services of a physician and/or facilities of his or her choice in Spain or abroad, in which case we will reimburse the expenses incurred, after the deductible is met and subject to the sub-limits, up to the limit of the insured capital.
- Physicians and/or facilities in the Medical Directory, in which case there are no deductibles or sub-limits, **up to the limit of the insured capital and according to the terms discussed below.** In this case, the expenses are paid directly by us.

1. Expense reimbursement option

Should the Insured decide to choose their own physician or facility, the company will reimburse the covered **expenses, once the deductible is met, up to the applicable sub-limit in each case.**

Under no circumstances will the Insured have to pay more the €1,500 per insurance year in deductibles. Once you exceed this amount, we will reimburse 100% of the health care costs incurred, **up to the applicable sub-limit in each case.**

2. Use of the Medical Directory

The Insurer will provide the Policyholder with an identification card for each Insured. The Medical Directory which lists the participating hospitals and clinics and the addresses and opening hours of participating physicians, and telephone numbers for emergency house calls can be found on the Insurer's website.

For hospitalisation:

- You must choose from among the hospitals or clinics in any province that appear in the Medical Directory and in order for us to pay the cost you request authorisation at least 72 hours in advance by calling the Insured's helpline.
- In the event of emergency hospitalisation, the physician's orders or the admission report from the hospital will suffice. In this case, you must inform us of the situation as soon as possible, even by telephone.

For outpatient treatment:

- You may contact the providers listed in the Medical Directory, identifying yourself as an Insured and presenting your insurance card or other form of ID. You only need to request prior authorisation for invasive diagnostic tests carried out in a hospital, special treatments (except rehabilitation) and the preventive medicine described in Guarantees 2.2, 2.3 and 2.4 of Article Two.

For pregnancy:

For pregnancy coverage you must apply for authorisation in the manner described above.

3. Advantages of using providers in the Medical Directory

- If you use the providers in the Medical Directory exclusively, the sub-limits in the Particular Conditions do not apply, except as indicated for Outpatient Care in Article 2.1 of these General Conditions relative to **number of sessions per Insured and per Insurance year for Occupational Therapy treatments,** and the maximum number of periodic check-ups covered under Preventive Medicine.
- If you use the providers in the Medical Directory as per the Insurance conditions we will pay them directly and you will not have to pay anything out-of-pocket or any deductible, as long as you identify yourself and/or obtain prior authorisation from us.

  Otherwise, you will be reimbursement for your expenses, subject to the applicable limits and deductibles.

4. Insured amount or Insured capital

The insured amount or insured capital established in the particular conditions of the Policy is the total limit of expenses that will be reimbursed or paid directly to providers listed in the Medical Directory as a consequence of the application of the guarantees covering each Insured during an annual insurance period. Likewise, the insured amount or insured capital is the total limit of all reimbursa-

ble or directly payable expenses over various insurance years for the use of the guarantees as a consequence of the same illness or accident.

Article 4. Transformation of the Insurance.

On the first expiry date of the Policy after the date on which an Insured turns 74 years of age, the coverage under the Policy will be providers in the Medical Directory, excluding any type of reimbursement.

Article 5. Territorial Scope

The guarantees under this Insurance apply to health care both in Spain and abroad.

If the Insured resides abroad for more than 90 days of an Insurance year, the coverage under the Policy is limited to medical expenses incurred in Spain.

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.

Article 6. General Exclusions

The following risks, illnesses and treatments are excluded from the Insurance coverage:

1. ***All kinds of pre-existing conditions when the Insured is added to the Policy, and any associated illnesses or treatments.***

   Medical and health associated with occurring that occurred before you were added to the Policy.

   This exclusion does not apply to pre-existing conditions declared in the "Declaration of State of Health", which is the basis of the Policy, in the following cases:

   - **If a pre-existing condition was declared and two years have gone by since the date on which the Insured was added to the Policy without showing symptoms or without having to consult a physician or without requiring treatment or medication for the condition or its consequences, it will be covered under the Policy unless we established specific conditions regarding that condition to enable the Insured to be added.**

- If we expressly agreed to cover the condition by means of a clause in the Particular Conditions when the Insured was added to the Policy.

2. *Pre-existing physical defects or deformities, refractive defects and congenital or hereditary anomalies, except as provided for in Article Two, Guarantee 3.3: "Neonatal care."*
3. *Any type of test or treatment not recognised by medical science on the effective date of the Policy, as well as surgeries or therapies considered experimental at the same time, unless expressly approved by us. Acupuncture, Homeopathy and Organometry.*
4. *Preventive medicine not covered under Article Two, Guarantee 2.4, any type of preventive treatment, vaccination or medication, with the exception of those administered in the event of hospitalisation.*
5. *Psychoanalysis, psychoanalytic therapy, hypnosis, narcolepsy, psychosocial or neuropsychiatric rehabilitation services, group therapy, psychological tests, sleep cures, as well as treatments that are experimental or not sufficiently recognised or endorsed by the relevant scientific community. Also excluded are illnesses or accidents resulting from alcohol, drug and gambling additions.*
6. *All illnesses caused by or derived from the human immunodeficiency virus (HIV) or possible mutations: Acquired Immunodeficiency Syndrome (AIDS) and its varieties.*
7. *Any type of treatment of processes involving teeth and gums, except as established in point 2.8 of Article 2 "Guarantees", and except for those defined in the Particular Conditions or those which are necessary as a result of an accident covered by the Policy that affects organs other than the oral cavity. Under no circumstances are dental prostheses covered.*
8. *The cost of purchasing, renting, maintaining and repairing all kind s of prosthetics, and orthopaedic and therapeutic devices, or the cost of purchasing any prosthesis other than the ones described in Guarantee 1.7 of Article 2 "Guarantees". Non-surgical treatment of obstructive sleep apnoea.*
9. *Non-artificial organs or tissues, although the surgical procedure for transplanting them may be covered.*
10. *Losses caused directly by any contagious disease that is considered a pandemic in Phase 5 or higher by the World Health Organisation.*
11. *Self-harm, attempted suicide and accidents or illnesses resulting from civil or international war, acts of terrorism, insurrection, popular uprising, seismic movement, flood or volcanic eruption, as well as the consequences of nuclear damage as defined in the Nuclear Energy Act, and contamination of a catastrophic nature.*
12. *Occupational illnesses as defined under current law and illnesses or accidents stemming from the Insured's participation in extremely dangerous profession-*

al, sporting or recreational activities such as: underground or underwater activities, mountaineering, climbing, parachuting, jumping from bridges or high places, hang-gliding, bullfighting, boxing and organised races with vehicles, boats or skis and the professional practice of sports.

13. *The cost of health care provided by the spouse, siblings, parents or children of an Insured.*
14. *The fees of physicians or facilities in respect of whom the Insurer is considering suspending reimbursement, after giving prior notice of the suspension to the Insured. In the case of treatment in progress, the suspension will not take place sooner than two months from the date of the notice.*
15. *The reimbursement of expenses when the service in question was provided by a professional or facility included in the Medical Directory.*
16. *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.*
17. *Any medical procedure for the treatment of infertility is excluded.*
18. *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 include restorative surgery following accidents or burns.*

Article 7. Conditions for inclusion on the Insurance

Individuals who meet the following conditions and who are named as such in the Particular Conditions of the Insurance or any subsequent Rider are eligible to be Insureds under the Policy:

- **Age: The age limit for joining the Insurance is 64 or such other age as we may establish in the eligibility Rules.**
- **Newborn babies:** Newborns can be included on the Insurance from the time of birth **as long as the mother has been an Insured for at least eight months before the birth.** Otherwise, the newborn will be added to the Policy at the time of discharge from the hospital where he or she was born, once the application is submitted and accepted.
- **Residence: The Insured must reside in Spain for at least 270 days of each Insurance year.**

  If the Insured resides abroad for more than 90 days of an Insurance year, the coverage under the Policy is limited to medical expenses incurred in Spain.

- Relationship with the Primary Policyholder: Any person of legal age or emancipated minor, their spouse and unmarried children who live with and are financially dependent on the Primary Policyholder may be an Insured on the Policy.

  Unless otherwise expressly agreed, all the aforementioned insurable persons must be jointly insured.

- Application for Insurance and Acceptance: In order for an applicant to be insured, the application form must be completed and signed together with the Declaration of State of Health. We reserve the right to accept or reject the application in each case or, if necessary, to propose a modification of the coverage or special insurance conditions.

Article 8. How to Proceed in the Event of Loss

1. Notice and documentation

In the event of a loss that affects any of the coverage that provides expense reimbursement, you must notify us as soon as possible and always within seven days of receiving medical assistance using the following documentation:

- A duly completed "Indemnity Claim" form accompanied by a medical report at our request.

  A separate form must be completed for each medical act or claim, except in the case of repeated medical acts for the same condition, which case it will be sufficient to refer to the first form submitted.

- For hospitalisation, the "Indemnity Claim" must be accompanied by report from the attending physician explaining the process of the illness including diagnosis, history, date of onset, cause and evolution, as well as medical discharge.

- Original invoices must be detailed and must necessarily contain the name of the individual or company, tax identification number and licence number of the service provider, type of medical service, the person to whom it was provided and the date, as well as a breakdown of the charges, if any.

Any documentation you submit to use that does not include the information mentioned above will not be considered a valid claim. We will notify you of any additional information we require.

You, your relatives or assignees must allow our physicians to visit and examine you, as well as other enquiries or checks that we deem necessary. To that end, you must release the professionals who have treated you and the facilities where the services were provided from professional confidentiality and cooperate in obtaining the requested information.

You must carefully follow the instructions of the physician in charge of your treatment and provide us with any information on the circumstances or consequences of the claim.

Failure to fulfil these obligations will entitle us to claim damages from you for the damages sustained due to delay, unless the delay was due to fraud or gross negligence on your part, in which case you will forfeit the right to reimbursement of costs.

For your convenience and for faster service, you can fill out the forms on the website at www.generali.es, under "Insurance Procedures"/"Reimbursement Request."

2. Indemnity payment procedure

We will pay the guaranteed amounts once we receive the documentation indicated in paragraph 1 of Article Eight and have determined whether the claim is covered. To that end, we may obtain any information relating to the claim that we deem necessary from any other Insurer, entity or person and you agree to cooperate with us in doing so.

Expenses incurred and paid by you in foreign currency and cash advances will be paid by us in Spain, in euros, at the exchange rate on the date of the reimbursement or advance.

We will only pay for the cost of translating reports, invoices or receipts for medical fees if they are written in English, French or Portuguese; for any other language, you will pay the cost.

In any event, we reserve the right to settle hospital bills and medical fees directly with the medical facilities and professionals.

If we do not make use of this option, you may request and we will grant you advances on account of the duly justified invoices or bills when the amount exceeds €600. These advances may never exceed the amounts and limitations established in the Policy.

3. Conflict resolution

- In the event of disagreement as to the origin or nature of the illness or care provided, each party will appoint an Expert, whose acceptance must be confirmed in writing. If one of the parties fails to appoint an Expert and is asked to do so by the other party, it must do so within eight days of such a request. If the party fails to do so within this period of time, it will be understood that the party agrees to accept and be bound by the report issued by the other party's Expert.
- If the Experts reach an agreement, this will be reflected in a joint report indicating the causes of the loss and the other circumstances considered in determining the Reimbursement of Expenses under the Policy.
- When there is no agreement between the Experts, the two parties will appoint a third Expert by mutual agreement. If there is no such agreement, a case may be initiated in the manner set forth in the Voluntary Jurisdiction Act (article 80) or the notarial legislation. In such cases, the expert's report will be issued by the deadline specified by the parties or, failing this, within thirty days of the acceptance of the appointment by the third party expert.
- The parties will be notified immediately and unequivocally of the Experts' report containing the unanimous or majority opinion, which will be binding on them unless it is challenged either by us within thirty days or by you within 180 days, both calculated

from the notification date. If it is not challenged by the deadlines stated above, the expert's report will be rendered unassailable.

- If the Experts' report is not contested, we will pay the Reimbursement indicated by the Experts within five days.

Article 9. Premiums

The premiums established in accordance with our current rate schedule will be modified:

- When there is a change in the family unit or an individual modification of the risk which you must report to us.
- When there are changes in age, based on our current rate schedule.
- When we modify our rates, which we will inform you of in writing. If you do not agree, you may choose to cancel the contract at the end of the current year by notifying us in writing at any time prior to the expiry date.
- When the automatic adjustment discussed in Article Ten of these General Conditions takes place.

Article 10. Automatic Adjustment of Insured Amounts

For Guarantees 1, 2 and 3 of Article Two, the insured amounts, sub-limits, and Policy premiums will be adjusted every year to reflect the changes in the National of Consumer Price Index under the sub-heading of Medical and Similar Services published by the National Institute of Statistics, or any other index or institution that may replace them.

The adjusted insured amounts will not apply to treatments that had already begun, and the adjustment of sub-limits for Pregnancy and Neonatal Care will not apply to pregnancies and births that have already taken place.

Article 11. Clauses Regarding the Relationship Derived from the Insurance Contract

1. Basis for the contract

- The Insurance Policy is written on the basis of the declarations made by you on the Insurance application and on the Declaration of State of Health, which are the basis for our acceptance of the risk, our assumption of the consequences of a claim up to the agreed limits and the determination of the premium.
- Should the contents of the Policy differ from your application, you may ask us to correct any differences within one month of receiving the Policy. After that, the provisions of the policy will apply.

- The Policy consists of these General Conditions, the Special Conditions, the Particular Conditions which personalise our contract with you, the Insurance Application and any riders and premium invoices issued. The policy may be amended in the future by agreement with the Policyholder as often as necessary through consecutively numbered and duly signed appendices.

  In the event of any error, inaccuracy or concealment of data on the Insurance Application completed by you and known to you, we may cancel the contract within one month of becoming aware of such inaccuracy. If a loss occurs without our knowledge of such an inaccuracy, the benefit will be reduced in proportion to the difference between the premium agreed in the Policy and the premium that should have been charged, unless the inaccuracy is the result of fraud or gross negligence on your part, in which case we will be released from covering the loss. 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.

2. Effective date and term of the contract

Notwithstanding the waiting periods established for each guarantee, the agreed coverage and any modifications or additions will take effect as of the date and time indicated in the Particular Conditions, provided that the premium has been paid, unless otherwise agreed in the Particular Conditions.

Either party may oppose the renewal of the contract by notifying the other party in writing: in the case of the Policyholder at least one month before the end of the current insurance period and in the case of the Insurer at least two months in advance.

Unless otherwise agreed, contracts with an initial duration of less than one year will not be renewed.

The insurance coverage will automatically cease on the expiry date of the Policy. As of that date you will no longer be entitled to expense reimbursement for any subsequent health care, even for care originating from illnesses or accidents prior to the termination date of the Policy.

However, when it is our decision not to renew the Policy and if you were under medical treatment known to us on the termination date of Policy you will be entitled to the payment of expenses or the daily compensation for as long as such treatment continues, up to the limit of the unused portion of the insured amount and without the covered treatment exceeding 180 days beyond the termination of the Policy. Our obligations will cease com-

pletely at the end of this period. This extension is not applicable to the Travel Assistance guarantee.

3. Changes in risk

You must inform us as soon as possible of any circumstances that aggravate the risk such as professional or athletic activities, among others, and are of such consequence that had they been known to us when the contract was signed we would not have signed it or would have done so under more burdensome conditions.

No later than two months after you inform us of the aggravation of the risk, we may propose a modification of the Policy conditions and you will have fifteen days after receiving the proposal to accept or reject it.

Likewise, we may terminate the contract by notifying you in writing within one month of the date on which we became aware of the aggravation.

If a loss occurs without you having notified us of the aggravation, we will be released from our obligation if you acted in bad faith. Otherwise, the benefit will be reduced in proportion to the difference between the agreed premium and the premium that would have been charged if the true extent of the risk had been known.

During the course of the contract you may report any circumstances that reduce the risk and are of such consequence that if they had been known to us when the contract was concluded, it would have been concluded under more favourable conditions.

In this case, at the end of the insurance period in progress the Insurer will reduce the amount of future premiums proportionally; otherwise, you 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 you informed us of the reduction of the risk.

4. Premium payment

The insurance premium must be paid in advance for the first and successive insurance years and the contract will remain in abeyance and will not take effect until payment has been made. The above notwithstanding, losses that occur during the first month of the second insurance year or any successive years will be covered, provided that the premium is paid during that month, even after the claim has occurred.

In the event of non-payment of any successive premium, our coverage will be suspended one month after the due date.

If we do not demand payment within six months of the due date of the premium payment, the contract will be terminated.

5. Communications and notifications between the parties

5.1. 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.

5.2. 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 mobile 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.

5.3. 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 mobile phone number, regardless of whether or when the recipient opens the emails and/or SMS messages.

5.4. 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.

5.5. Applicable law

This insurance contract is subject to and governed by Spanish law.

5.6. Jurisdiction

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.

5.7. Subrogation

Once the medical costs have been paid, we may take actions or exercise rights on your behalf in connection with the loss due to illness or accident against the persons responsible for the loss, up to the limit of the amount paid.

This subrogation right cannot be exercised against your spouse or other relatives up to the third degree of consanguinity, adoptive parents or adopted children who live with you. However, this rule does not apply if the responsibility is the result of fraud or if it is covered under an insurance contract. In the latter case, the scope of the subrogation will be limited by the terms of the insurance contract.

In both the Insured and the Insurer take action against the responsible third party, the settlement obtained will be shared between us in proportion to our respective interests.

You agree to cooperate fully to this end.

Annex I. Groups of classified medical acts and surgical procedures

The following classification of groups of medical acts and surgical procedures is established in accordance with the "Terminological Classification of medical acts and techniques of the Spanish Medical Colleges Organization of January 1992".

Group 1: Includes Groups O and I, as well as Group III of Nephrology and Intensive Care Medicine of the aforementioned classification and procedures such as: Sclerosis of varicose veins, tonsillectomy, simple fractures, chalazions and all similar medical acts or procedures in terms of technique and importance.

Group 2: Includes Groups II and III, encompassing processes such as: Haemorrhoids, inguinal and crural hernias, maxillary sinusitis, dislocations and all similar medical acts or procedures in terms of technique and importance.

Group 3: Includes Groups IV and V, encompassing processes such as: Safenectomy (removal of varicose veins), ovarian cysts, cataracts, appendectomy, meniscectomy, prostatectomy, herniated disc (except cervical) and all similar medical acts or procedures in terms of technique and importance.

Group 4: Includes Groups VI, VII and VIII, barring the exceptions in Group 5 below, encompassing processes such as: Gastrectomy, closed valvular stenosis, cervical disc herniation, vitrectomy and all similar medical acts or procedures in terms of technique and importance.

Group 5: Includes the Special Groups and Group VIII of Vascular Surgery, Neurosurgery, Angiology and Vascular Surgery, as well as Renal and Hepatic Transplants for specialties, encompassing processes such as: Thoracoabdominal aneurysms, surgery for acute myocardial infarction, surgery for cerebral ischaemia, polytraumatised and complex multiple injuries, and all similar medical acts or procedures in terms of technique and importance.

The Group classification will depend on the specialty of the medical provider who renders the service.

If there are operations with different approach routes but the same surgical time, the partial limit will be the one for the highest classification Group and 60% of the other Group, with a maximum of two groups.

Annex II. Travel Assistance

The coverage 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 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 physician, 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 will,

as soon as it is notified, organise the necessary contacts between its medical service and the physicians 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 be 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 there 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 a physician'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 are 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 to appear 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 an 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.***
4. ***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.***
5. ***The participation of the Insured in bets, challenges or fights.***
6. ***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.*

7. *Suicide, attempted suicide or self-harm by the Insured.*
8. *Rescue missions in mountains, chasms, oceans or deserts.*
9. *Illness or accidents caused by the consumption of alcoholic beverages, narcotics, drugs or medicines, except when prescribed by a physician.*
10. *Fraudulent acts of the Policyholder, the Insured or their assignee.*
11. *Sudden onset epidemics and/or infectious diseases that spread rapidly among the population, as well as those caused by pollution and/or atmospheric contamination.*
12. *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 eruption 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.*
13. *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, 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.***

Annex III. Second Medical Opinion

1. This service is provided by reputable medical societies with experience in Second Medical Opinions (hereinafter, Provider).

2. **Beneficiaries**

   Anyone who is named in the policy as an Insured and purchased this guarantee may request these services.

3. **Object of the Guarantee**

   To offer named Insureds the opportunity to request medical information from the Provider in relation to second opinions on the diagnosis of a serious disease.

   Serious diseases are understood to include but are not limited to cancer, cardiovascular disease, organ transplants, neurological and neurosurgical diseases, including cerebrovascular accidents, chronic renal insufficiency, idiopathic Parkinson's disease (paralysis agitans), Alzheimer's disease and multiple sclerosis.

4. **Territorial Scope**

   Insureds may access these services from anywhere in the world.

5. **Benefits Included**

   — Access to the opinions of the most renowned medical experts worldwide.

   — Forwarding of diagnostic documentation to the specialist to issue a report.

   — Forwarding the response to the Insured (and/or their medical team) in the form of a report summarising the case, the reason for the consultation, the medical expert's opinion and their curriculum vitae.

   — Request for further medical information on the case, if necessary.

   — Selection of experts and hospitals for treatment.

   — Assistance if the Insured is transferred to a facility suggested by the Provider to receive care: making doctors' appointments, arranging for hospital admission and coordinating transfers.

— Obtaining budgets and estimated cost of hospitalisation and treatment, as well as reviewing and tracking invoices issued for treatment.

These General Conditions are written in simplified format to make them as easy as possible to understand. Please read them carefully and ask for any clarifications you may need from your broker or any Generali branch office.

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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