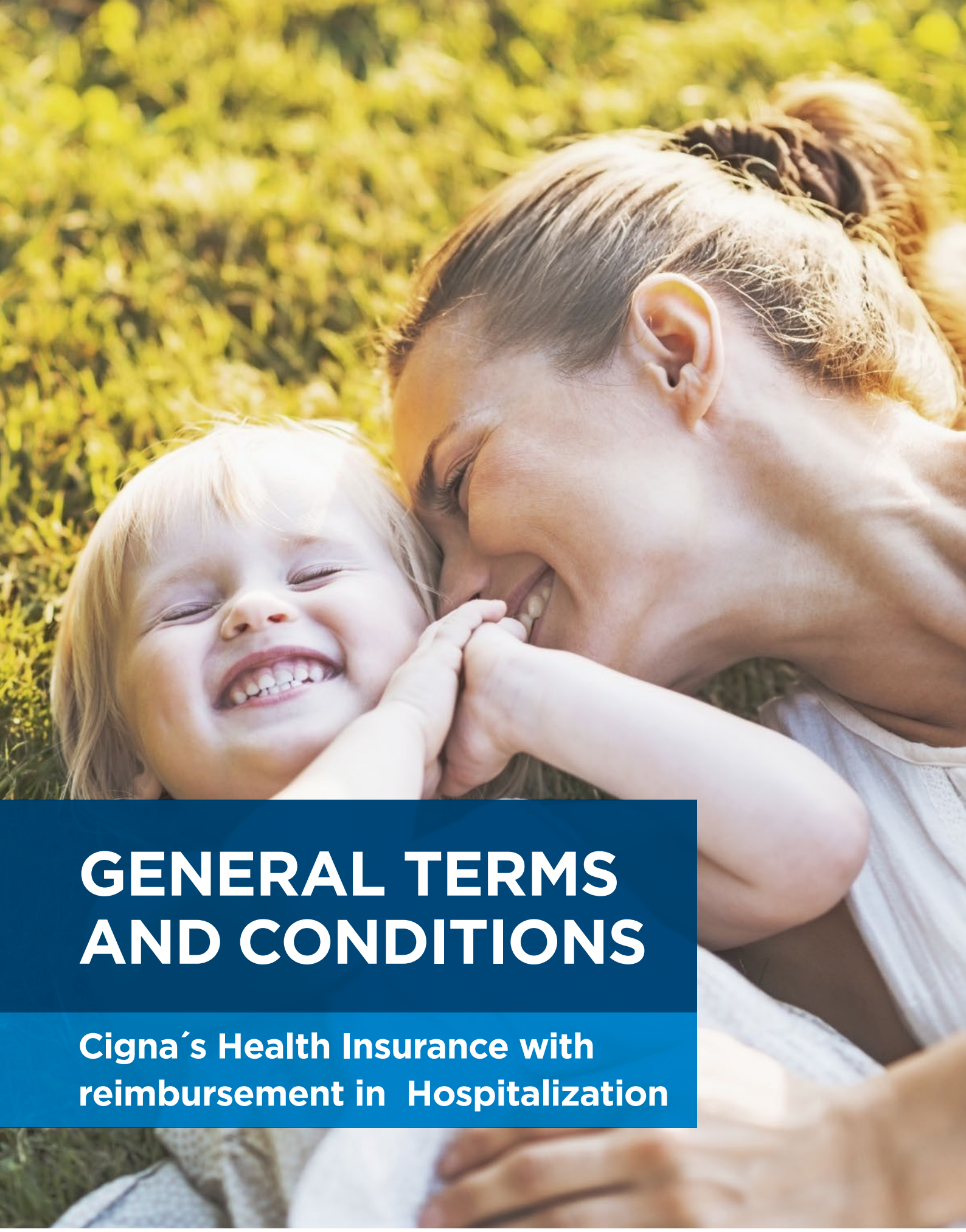

GENERAL TERMS AND CONDITIONS

Cigna´s Health Insurance with reimbursement in Hospitalization

Cigna®

Together, all the way.℠

Cigna®

Together, all the way.℠

INDEX

GENERAL TERMS AND CONDITIONS

LEGAL INFORMATION ABOUT THE INSURER

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Cigna Life Insurance Company of Europe, SA/NV, Sucursal en España, with its registered office in Pozuelo de Alarcón (28223 Madrid) at Parque Empresarial La Finca, Paseo del Club Deportivo 1, Edificio 14, Planta Primera (hereinafter Cigna).

Entered on the Madrid Companies Registry in Volume 809, Sheet 205, Section 8, Page M 11184; Tax ID No. N-0021205J.

Registered with the Directorate-General for Insurance and Pension Funds under number E0133. Cigna Life Insurance Company of Europe, SA/NV, Sucursal en España is the Spanish branch of Cigna Life Insurance Company of Europe, SA/NV, a privately-held limited liability company incorporated under Belgian law with its registered office in Belgium at Plantin en Moretuslei 309, 2140 Amberes. This entity is subject to the oversight of the National Bank of Belgium and it is also subject to the said regulator, as an insurance entity operating in Spain under the regime for the right to establishment, for matters relating to liquidation.

The oversight authority over the insurance activity in Spain is vested in the Directorate-General for Insurance and Pension Funds pertaining to the Ministry of Economic Affairs and Digital Transformation.

The present General Conditions shall be applicable to all Health Insurance contracts, without prejudice to the applicable Particular Conditions and Special Conditions, if any. In the event of any discrepancy between the General, Particular and Special Conditions, the applicable Special Conditions shall prevail over the Particular Conditions, and the latter over the General Conditions.

DEFINITIONS

For the purposes of the present Mixed Health Insurance contract, the following definitions shall apply:

- **Accident.** Bodily injury suffered during the validity of the Policy as a consequence of a violent, sudden, external cause outside the control or intention of the Insured.

  Cardiovascular diseases and the lesions related with such conditions will not be considered as Accidents.

- **Medical act.** Service rendered by a healthcare specialist or professional legally licensed for the purpose, in the exercise of their profession, at a Healthcare Centre or hospital or at the patient's home.

- **Anti-neoplastic (or cytostatic) drug.** Substances preventing the development, growth, or proliferation of malignant tumour cells catalogued as such in the Vademecum.

- **Insured.** The natural person resident in Spain to whom the rights deriving out of the contract correspond and who, in the absence of the Policyholder, personally assumes the obligations arising out of the present contract.

- **Dependent Insured.** Spouse or Life Partner of the Main Insured, and/or the children of the Main Insured or of the Spouse or Life Partner.

- **Main Insured.** The Insured party personally assuming the obligations of the policy in the absence of the Policyholder.

- **Ambulatory assistance.** This is the diagnostic and/or therapeutic medical assistance provided under an out-patient regime at the Healthcare Centre, at the patient's home, and/or at a hospital without any overnight stay, and generating a stay lasting less than 24 hours. Major out-patient surgery is not included in this concept.

- **Hospital assistance.** That provided at a Hospital under an admission regime for the Insured's medical or surgical treatment.

- **Healthcare Assistance.** The medical acts included in the benefits of the Policy.

  Healthcare Assistance may be provided at a Hospital (with or without admission) or else at Healthcare Centres or at the Insured's home.

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- **Assistance and/or Hospitalization for social reasons.** Assistance and/or hospitalization for reasons not related to objective medical pathologies but rather due to issues of a social and/or family nature.
- **Waiting period.** Period of time counted from the date that cover under the Policy begins during which certain items of cover are not effective.
- **Psychiatric Day-care Centre.** Any health establishment, whether public or private, legally authorized and staffed with at least one psychiatrist and one psychologist. For the purpose of this policy, **the following establishments shall not be considered as Psychiatric Day-care Centres: convalescent homes, spas, clubs or associations of patients, centres mainly providing treatment for chronic diseases or behaviour therapy, and addiction treatment centres.**

  The Psychiatric Day-care Centre must hold the mandatory administrative authorization in force and must be entered on the register of Healthcare Centres, Services and Establishments of the corresponding regional government.
- **Healthcare Centre or Medical Centre.** Facility equipped with technical resources at which qualified healthcare specialists and professionals holding an official qualification or professional licence conduct healthcare activities. Healthcare Centres may comprise one or more healthcare services making up their healthcare offering.

  The Healthcare Centre must hold the mandatory administrative authorization in force and must be entered on the register of Healthcare Centres, Services and Establishments of the corresponding regional government.
- **Check-up.** Organized set of medical tests or visits carried out to check the individuals' general state of health which are not supported by any symptoms or pathologies.
- **Complex orthopaedic surgery.** Surgery referring to disorders in the locomotive apparatus, their muscular, bone or joint parts and the acute, chronic, traumatic, and recurrent lesions in the same requiring advanced technology and specialized surgeons trained in the most advanced surgical techniques.
- **Scientific community.** Group of experts (public or private health institutions, professional societies, panels of experts and even professional groups, whether national, regional or local) in certain pathologies which aim is to review, assess and reach a consensus on the most relevant and current aspects regarding diagnosis, monitoring and treatment of such pathology, in order to make decisions in clinical practice.
- **Consultation.** Assistance provided in person at a Healthcare Centre or Hospital Centre by the healthcare specialist or professional legally qualified for the purpose to the Insured for the purposes of diagnosing and/or treating an Illness or Lesion.
- **Co-payment.** Predetermined amount for each medical act assumed by the Policyholder and/or Insured as a contribution to the cost of the service, depending on the type of insurance contracted and in accordance with the terms and conditions agreed in the Policy and not subject to reimbursement by the Insurer.
- **Health Questionnaire.** A form with questions provided by Cigna to the Policyholder and/or Insured for the purposes of determining their health status and understanding the circumstances that might influence the assessment of the risk and the contracting of the insurance.
- **Illness or lesion.** All involuntary alterations in health status diagnosed and confirmed by a Physician and requiring Healthcare Assistance.
- **Congenital Illness.** Any illness existing at the moment of birth as a consequence of hereditary factors or conditions acquired during pregnancy up to the very moment of birth.

  These conditions may be manifested and recognized immediately after birth or may be discovered later during any period of the Insured's life.
- **Serious Illnesses.** For the purposes of this policy, those described in paragraph two of Article 2.9.7.
- **Pre-existing Illness or Lesion.** That beginning prior to the moment of the initial inclusion on the Mixed Health Insurance, where the symptoms and/or signs are known by the Insured or a legal representative, if appropriate, and not declared, regardless of the existence of a medical diagnosis, when completing the Health Questionnaire prior to the acceptance and contracting of the Policy.
- **Specialist.** Practising physician who has received specific training as a specialist in a branch of medicine or surgery recognized by the Healthcare Authorities of the country where the activity is practised, allowing the exercise of that branch of medicine or surgery, and having a medical office connected with that discipline.
- **Deductible.** Fixed amount or a percentage of the medical and/or hospital expenses established in the policy and paid by the Insured to the healthcare provider, and not subject to reimbursement by the Insurer.
- **Standard Room.** Hospital Room with a single space. Suites or rooms with an anteroom are not considered to be Standard.
- **Medical fees.** Amount corresponding to the professional

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services provided by healthcare specialists and professionals.

For the purposes of this policy, medical and surgical fees include those of the surgeon, the assistants, anaesthetists, and medical personnel required in the medical procedure or assistance provided. Therefore, the sum insured established for the medical and surgical fees covers all those of the aforementioned professionals.

- **Hospital.** All public or private establishment legally authorized for the treatment of illnesses or lesions, equipped with round-the-clock medical presence and the necessary resources to reach diagnoses and perform surgical procedures and with the possibility of admission for more than 24 hours.

  For the purposes of this Policy, **hotels, old people's homes, rest homes, spas, facilities devoted mainly to the treatment of chronic illnesses or behavioural therapy centres are not considered to be Hospitals, nor are establishments for the treatment of alcoholism or drug addiction.**

- **Hospitalization.** Admission (voluntary or involuntary) of the Insured into a Hospital for a minimum of 24 hours as a consequence of an Illness or Accident, under the care and attention of a Physician.

- **Day Care.** This implies registration as a patient at those healthcare units of a Hospital specifically denominated as such for a period of less than 24 hours, with the patient spending the night at his or her own home.

- **Implant.** Medical device designed to be inserted in full or in part into the human body through a surgical procedure or a special technique, for diagnostic, therapeutic and/or aesthetic purposes, and intended to remain there after the said procedure.

- **Inter-consultation.** Consultation made during the hospital admission to a specialist other than the one responsible for admission.

- **Surgical procedure / Surgery.** All operations for diagnostic or therapeutic purposes performed by means of an incision or other internal approach route, carried out by a surgeon or surgical team and normally requiring the use of an operating room in an authorized Hospital or Healthcare Centre. All surgical operations must be included within one of the Groups established or in the equivalent in the Classification of the Spanish Organization of Regional Medical Associations ("Organización Médico Colegial", OMC).

- **Orthopaedic material.** Medical devices for external use applied to correct or avoid alterations in the human body.

- **Aesthetic Medicine.** Medicine which purpose is the restoration, maintenance and promotion of aesthetic appearance and beauty, aimed at solving defects that have no clinical impact on the individual's health or derive from physiological ageing.

- **Complementary diagnostic resources.** Tests necessary for the achievement of a clinical diagnosis and classified as such within the Nomenclature of the OMC.

- **Physician.** Doctor, graduate or holder of a master's diploma in medicine legally qualified and authorized to treat Illnesses or Lesions medically or surgically in the place where he or she is practising.

- **Acute Pathology.** That appearing suddenly, limited in time (6 months) and requiring prompt treatment.

- **Chronic Pathology.** A long-term illness or ailment (more than 6 months). In rehabilitation treatment, a chronic pathology is considered to be that in which there is no expectation of any absolute recovery in a limited period of time or that in which the rehabilitation treatment turns into a maintenance therapy.

- **Exacerbated Chronic Pathology.** Chronic pathology presenting acute exacerbation, likely to require immediate treatment limited in time.

- **Pelvic Floor Pathology.** A pathology derived from the organs kept by the pelvic floor (vagina-uterus and bladder) to the extent that the weakness or dysfunction of the pelvic floor muscles causes a bad position of the aforementioned organs, causing prolapse, and alters urinary continence.

- **Policy.** This is the insurance contract. It is a document containing the conditions regulating the insurance contract and comprises the General Conditions, the Particular Conditions and the Special Conditions, the insurance application form and the Health Questionnaire, as well as the supplements, appendices or riders issued.

- **Premium.** Price of the insurance. It will include the taxes and surcharges that are legally applicable. The insurance premium is annual, even when their payment is split into instalments.

- **Surgical process.** Process established after a clinical diagnosis within a surgical treatment plan, which starts on the date of admission to receive such treatment and terminates on the date of hospital discharge. It includes: hospital stays, whether in a room or an Intensive Monitoring Unit, day hospital, sitting room, operating room, recovery room, material, medication, instrumentation, prosthesis and implants, diagnosis tests, therapeutic acts and fees of all healthcare professionals and specialists involved in the process during the hospital stay.

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- **Healthcare professional.** A licensed professional with skills and knowledge specific for the care of people's health, organized by means of official professional associations and holding the corresponding official qualification expressly empowering them to do so.
- **Prosthesis.** Artificial replacement that, when implemented temporarily or permanently by means of a special operating procedure, replaces an organ or bodily tissue or complements its physiological function.
- **Genetic Test.** This is a type of medical test that analyses genetic material and is intended for the diagnosis and the prescription or modification of an effective treatment of illnesses in affected symptomatic patients.
- **Psychotherapy.** Treatment method applied to a person suffering a mental conflict on the indications or prescription of a psychiatrist, neurologist, paediatrician or oncologist.
- **Radiopharmaceutical.** Medical product with at least one radioactive component, which must have the previous authorization from the Spanish Agency of Medicines and Medical Devices (AEMPS) and which details are listed in the technical information sheet of the AEMPS. They are used as contrast media and they enable the molecular study of the organism or a certain pathology.
- **Radiation Therapy.** Treatment based on the application of ionizing radiation, which includes gamma ray, alpha particles, electrons and photons.
- **Contracted Medical Services (or Cigna Medical Staff).** Group of health specialists, healthcare professionals, Healthcare Centres and Hospitals contracted by Cigna in Spain, as reflected on the web site and in force at the moment the service is provided.
- **Claim.** Any event that has consequences requiring the provision of medical assistance, which costs are covered, in whole or in part, by the Policy.
- **Sum insured.** The maximum limit of the compensation to be paid by the Insurer in each case. The amount of the Sum Insured for each guarantee contracted will be reflected in the Special Conditions (Plan) of the policy.
- **Gene therapy.** Treatment or service aiming at modifying or manipulating the expression of a gene or altering the biological properties of living cells for therapeutic purposes. The genetic therapy is a technique that modifies a person's genes in order to treat or cure an illness.

  The genetic therapies can use different mechanisms:

  - replacing a gene that causes an illness with a healthy copy of that gene;
  - inactivate a gene that causes an illness because it is not functioning properly;
  - introducing a new or modified gene in the body to help treat an illness.
- **Maintenance therapy.** Treatment aimed at avoiding any relapse in a pathology after the maximum degree of functional recovery has been achieved.
- **Policyholder.** The natural or legal person contracting the insurance on their own account or on behalf of others and who is responsible for the obligations and duties arising therefrom, except for those that, by their nature, must be fulfilled by the Insured. If the Policyholder is also the Insured, he or she will be considered to be the Main Insured.
- **Emergency.** Situation of the Insured requiring the immediate provision of medical assistance. This assistance may be rendered either at the Insured's home or in a Hospital or Healthcare Centre equipped with an emergency service.
- **Life-threatening Emergency.** Urgent and immediate need to receive Healthcare Assistance without which the life of the Insured would be endangered or irreparable harm would result for his or her physical integrity.

ARTICLE 1. PURPOSE

Within the limits and conditions established in the policy and the term for its duration, Cigna assumes the undertaking to provide the Insured with Healthcare Assistance in all kinds of illnesses or lesions included in the specialities in the descriptions of the cover offered under the Policy, following collection of the premium and with the waivers applicable in each case

Cigna will not provide any cover that has not been expressly contracted and that is therefore not listed in and/or specified in the Policy.

In no case shall Cigna reimburse fees for professionals and other Contracted Medical Services paid directly by the Insured, nor the Fees and/or other medical expenses derived from the Healthcare Assistance provided by Professionals and Hospitals not included in the Contracted Medical Services. In no case shall Cigna reimburse fees for professionals and other Contracted Medical Services paid directly by the Insured.

The cover provided under the Policy is valid and rendered solely and exclusively in Spain, except where the type of cover in question foresees otherwise, and save for the provisions regarding the reimbursement of expenses incurred abroad.

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Only residents in Spain may be Insured. For the purposes of this contract, a resident in Spain is considered to be that person remaining in Spanish territory for more than 183 consecutive days.

ARTICLE 2. INSURANCE COVER

2.1 Ambulatory Emergencies and Hospital Emergencies.

2.2 Primary medical assistance.

This covers general medicine and paediatrics for patients up to 16 years of age, at both Healthcare Centres and at home, when it is not possible to travel to the centre for medical reasons.

2.3 Nursing or Nursing Services.

The assistance provided by qualified nursing personnel, at the office / medical centre or at the patient's home is guaranteed **when prescribed by a physician**.

2.4 Specialities.

The consultations, diagnostic tests and treatments performed under the cover contracted, whether at a medical centre or a hospital, are covered in the following specialities.

2.4.1 Allergology.

Vaccines and food intolerance tests are not included.

2.4.2 Anaesthesiology and Resuscitation.

2.4.3 Angiology and Vascular Surgery.

Techniques using surgical laser for peripheral vascular surgery are included.

Treatments for aesthetic purposes are excluded.

2.4.4 Digestive Apparatus.

FibroScan for the assessment of hepatic fibrosis and diagnostic or therapeutic digestive endoscopies (including sedation if required) is included.

Mucosectomy, Endoscopic Sub-Mucosal Dissection as well as Echoendoscopy are included.

Capsular and virtual endoscopy are excluded.

2.4.5 Cardiology.

Echocardiograms, conventional Holter, cardiac stress tests, electrophysiological and haemodynamic studies are included.

2.4.6 Cardiovascular Surgery.

2.4.7 General Surgery and Surgery of the Digestive Apparatus.

Laser techniques are included in proctology and for warts removal.

The use of radiofrequency in liver surgery is included.

Bariatric surgery is included in accordance with the criteria of the Spanish Society for Surgery of Obesity (SECO) and **exclusively with definitive surgical procedures and at the Contracted Medical Services designated for the purpose by Cigna.**

Lipoedema surgery is excluded.

2.4.8 Oral and Maxillofacial Surgery.

Procedures derived from a dental pathology are excluded, except for the extraction of impacted or not erupted wisdom teeth**, as are pre-prosthetic operations and treatments in the speciality of odontology, aesthetic treatments, as well as prior and subsequent medical assistance required in connection with any of these procedures or treatments.**

For the purposes of this Policy, orthognathic surgery shall be considered to be a dental pathology.

2.4.9 Orthopaedic and Traumatological Surgery.

Neuronavigation is included **solely and exclusively in cases of surgery for intramedullary tumours and scoliosis greater than 20 degrees**, with the limits and conditions set out in the Policy.

Endoscopic spinal surgery for the surgical treatment of extruded lumbar hernia not requiring stabilisation is included.

2.4.10 Paediatric Surgery.

2.4.11 Plastic and Restorative Surgery necessary to eliminate the sequelae of an Illness or Lesion covered by the Policy or derived from a surgical procedure also guaranteed under the Policy and that occurred during its validity.

Surgery for aesthetic purposes and lipoedema surgery are excluded.

Breast reconstruction and nipple-areola complex reconstruction surgery are included in malignant oncological processes.

Symmetrisation of contralateral breast through mastopexy without implants is included for oncological processes diagnosed as from January 1st, 2022, when mastectomy has been performed.

Breast reconstruction and symmetrisation must be performed at the same surgical operation and within a period of time not exceeding 1 year after the surgery to remove the malignant neoplasm was performed.

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Breast reconstruction following bilateral or contralateral prophylactic mastectomy covered by the policy is included, **at the same surgical operation and using the same technique.**

Prostheses and implants are covered under the terms of Article 2.9.4.

Lipofilling technique is excluded.

2.4.12 Chest surgery.

2.4.13 Dermatology and Venereal Diseases.

Laser surgery for warts removal is included.

Photodynamic therapy is included for basal cell and nodular carcinomas and Bowen's disease. **Medication excluded.**

One digital dermatoscopy (epiluminiscence) per insured and year, solely and exclusively at Contracted Medical Services designated for the purpose by Cigna, is included for the early diagnosis of melanoma, **when justified by at least one of the following indications:**

- Multiple atypical nevi (> 50).
- Familial dysplastic nevus syndrome.
- Personal or family history (**in the first and second degree**) of diagnosed melanoma.
- Carriers of genetic mutations associated with the development of melanoma.

The treatment of actinic lesions on the skin and dermatocosmetic treatments are excluded.

2.4.14 Endocrinology and Nutrition.

Dietary treatments are excluded, unless they have been prescribed in connection with an illness covered by the Policy.

2.4.15 Geriatrics.

2.4.16 Gynaecology and Obstetrics.

Gynaecological laser is included for the treatment of lesions in the uterine cervix and for genital warts **solely and exclusively at the Contracted Medical Services designated for the purpose by Cigna.**

The diagnosis of infertility and sterility is included. **Genetic studies are not considered to be diagnostic for infertility and sterility**, except for peripheral blood karyotype. The determination of Factor II Prothrombin and Factor V Leiden is included for patients who have suffered medically justified repeated abortions. **Treatments intended to resolve sterility problems and tests related to these treatments are excluded.**

Gynaecological laser is excluded in cases of urinary incontinence, genital rejuvenation and in any other aesthetic pathology.

Family planning. Tubal ligation, vasectomy and the implantation of an IUD contraceptive method is covered, **but not the cost of the device, which is for the expense of the Insured.**

ONCOTECT for the early diagnosis of human papilloma virus (HPV) is included.

The following prenatal diagnostic tests are included

› Amnisure Test for the detection of premature bursting of membranes.

› One (1) 3D or 4D ultrasound scan per pregnancy.

› **Amniocentesis is only covered in the following cases:**

1. Risk of foetal chromosomal anomaly:

a) Advanced age of the mother (35 years old and above).

b) Foetal chromosomopathy in a prior pregnancy.

c) Structural chromosomal anomaly or mosaicism in a parent.

d) Ultrasound foetal anomaly or data suggesting aneuploidy.

e) Aneuploidy markers in maternal serum.

2. Risk of gender-related genetic disorder.

3. Risk of congenital metabolic disorder.

4. Risk of defect in the neural tube:

a) Alpha-fetoprotein..

b) Acetylcholinesterase.

5. Risk of foetal infection.

› Non-invasive prenatal diagnostic test (NEOBONA), **with prior authorization from the Company, at the Contracted Medical Services designated for the purpose by Cigna in pregnant women accrediting at least one of the following conditions:**

a) Foetal ultrasound findings indicating an increase in the risk of aneuploidy.

b) Prior history of a pregnancy with trisomy.

c) Positive result (high risk with figures over 1/270) in any of the following tests for aneuploidy: First-trimester screening, sequential screening or integrated screening (quadruple test)

2.4.17 Haematology and Haemotherapy.

2.4.18. Internal Medicine.

2.4.19. Nephrology.

The treatment of reversible acute renal insufficiencies

with dialysis and artificial kidney is included, as well as any exacerbation of chronic processes.

2.4.20 Neonatology.

2.4.21. Pneumology.

Spirometries, Endoscopies and Echobronchoscopies are included.

2.4.22. Neurosurgery.

Neuronavigation is included **solely and exclusively in cases of intracranial surgery, surgery for intramedullary tumours and scoliosis greater than 20 degrees**, with the limits established in the Policy.

2.4.23. Neurology.

2.4.24. Ophthalmology.

Photocoagulation, campimetry, fluorescein angiographic and retinographic techniques, as well as endothelial counting are included for studies prior to cataract surgery..

Refractive surgery is excluded for the correction of short-sightedness, long-sightedness, astigmatism and any other refractive ocular pathology.

2.4.25 Medical Oncology.

Therapeutic targets are included.

Predictive genomics platforms are included in recently operated cases of breast cancer without lymph node involvement, with a tumour size larger than 1 cm and less than 5 cm, positive for oestrogen receptor (OR) and negative for human epidermal growth factor receptor 2 (HER2), provided that there are no contraindications for receiving systemic chemotherapy.

BRCA 1 and 2 tests **at the Contracted Medical Services designated for the purpose by Cigna are included, with prior authorization from the Company, in the following cases:**

a) Insured with a diagnosis of breast, ovarian or prostate cancer after January 1st, 2017.

b) Insured without a personal history of breast, ovarian or prostate cancer when any of the following conditions is met:

- 2 or more 1st or 2nd degree family members:
  - less than 50 years old, affected by breast cancer;
  - at any age, affected by ovarian or prostate cancer.

Cigna will request such medical documentation as may be considered essential to accredit the fulfilment of the previous conditions, as well as to be able to authorize BRCA 1 and 2 tests, with the power to decline cover if the documentation required is not provided..

The Tumoral DNA Diagnostic Test is included for malignant solid tumours classified as Carcinoma of Unknown Primary Origin, when its aetiological diagnosis has not been possible through habitual tests, and for advanced lung carcinoma where no liquid biopsy has been performed. **Subject to prescription by a qualified professional and limited to one test per Insured and year. Following authorization, tests must be carried out through the Service Provider chosen by Cigna at the Contracted Centres designated by the Company for the purpose.**

Parenteral anti-neoplastic chemotherapy medication is included and so are those palliative medicinal products without any anti-tumoral effect administered simultaneously in the same treatment session to prevent adverse side effects and/or control symptoms. Treatment will be dispensed either through a hospitalization regime or at a day hospital and always in accordance with the technical information sheet corresponding to each medicinal product and the international protocols established.

Growth factors, EPO and modulators are excluded.

Genetic testing for the risk of hereditary gastrointestinal cancer is included **in the following cases, with prior authorization from the Company, and at the Contracted Medical Services designated for the purpose by Cigna:**

- Gastrointestinal cancer before 50 years of age.
- Multiple cancers in an individual.
- ≥ 3 members of a family with gastrointestinal cancer and other related tumours (uterine and ovarian cancer).
- ≥ 10 gastrointestinal polyps over a lifetime.
- Family history of hereditary colorectal cancer syndromes.

2.4.26 Radiation Oncology.

Radiotherapy, **except for combined radiotherapy, which is excluded**, cobalt therapy, intra-operative radiotherapy, and radiosurgery are included for the treatment of intracranial tumours and metastases (stereotaxic radiosurgery).

2.4.27 Otorhinolaryngology.

The following surgical techniques are included:

- Surgical laser used in ENT surgery for the reduction of tonsils, turbine surgery, SAS surgery and laryngeal microsurgery, **solely and exclusively at the Contracted Medical Services designated for the purpose by Cigna.**
- Radiofrequency.

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Fibroscopy and vestibular testing are included.

2.4.28 Psychiatry.

Admission to psychiatric hospital is included due to acute psychiatric conditions, according to the limits and conditions set out in the Policy.

Psychotherapeutic treatment, **under psychiatric day-care centre regime**, is included in patients with eating disorders, should any other previous treatment have failed, with disorder being understood as anorexia and bulimia nervosa. **Prior prescription by a Psychiatrist is required** and treatment may be provided through the medical services of the company, in accordance with the limits and conditions established in the policy.

Psychiatric day-care centre cover does not include eating disorders presenting any of the following conditions or disorders: be underage, personality disorder or drug consumption.

Psychoanalysis, hypnosis, individual or group psychotherapy, psychological tests, treatments for narcolepsy and/or similar therapies, as well as educational therapy or special education in patients with mental problems are excluded.

2.4.29 Rheumatology.

2.4.30 Pain treatment.

Implantable pumps for the perfusion of medicinal substances and medullary stimulation electrodes are excluded.

2.4.31 Urology.

Vasectomy, urodynamic studies, flowmetering, and cystoscopies are included, as is extra-corporeal shock-wave lithotripsy **solely and exclusively for the treatment of kidney stones.**

Laser surgery for warts removal is included.

Prostatic vaporization using laser is included in cases of benign prostatic hyperplasia, **solely and exclusively at the Medical Contracted Services designated for the purpose by Cigna.**

The use of laser techniques is included for the treatment of reno-uretero-vesical lithiasis.

Robotic prostatic surgery (Da Vinci) is included as surgical process for radical prostatectomy with partial lymphadenectomy and no evidence of metastasis, in the event of a prostate cancer diagnosis. This treatment may be carried out by the Contracted Medical Services designated for the purpose by Cigna, **following payment by the Insured to the Hospital of the deductible established for the purpose in the Special Conditions of the Policy.**

Fusion-guided prostatic biopsy is included in patients with a high level of suspected prostatic carcinoma with persistently elevated PSA (more than six months) and negative prior ultrasound-guided biopsies. It is necessary to obtain **a prescription from a professional and the prior authorization from the Company and the procedure will be carried out by the Contracted Medical Services designated for the purpose by Cigna, in accordance with the limits and conditions set out in the Policy.**

The study and treatment of sexual impotence and treatments intended for or related to sterility problems, as well as healthcare assistance in connection with these treatments, are excluded.

2.5. Complementary diagnostic resources.

Diagnostic resources are covered **when prescribed by a Physician** and the use of contrast media is included.

2.5.1 Clinical Analyses.

Analyses at home are included with prescription and medical report in case of patients with functional dependence in basic activities of daily living (ADL), **subject to prior authorization from the Company.**

Food intolerance tests are excluded.

2.5.2 Pathological Anatomy.

Immunohistochemical studies are included as is **one Liquid Biopsy per Insured and year, following authorization, and at the Contracted Medical Services designated for the purpose by Cigna**, in patients with a diagnosis of advanced lung cancer **(excluding small-cell lung cancer)**, where it is not possible to obtain a sample for biopsy or the amount of the tumour is insufficient for analysis, and no Tumoral DNA Molecular Test has been performed.

2.5.3 Clinical Neurophysiology.

Polysomnograms and polygraphic studies and monitoring at the Insured's home are included **up to a maximum of one study per Insured and year with a duration of not more than 24 hours.**

2.5.4 Nuclear Medicine.

The performance of PET-CAT (positron emission tomography) and PET-NMR studies with the radiopharmaceutical 18-FDG are included **solely and exclusively for the following oncological pathologies:**

a) Characterization of a solitary pulmonary nodule.

b) Detection of tumours of unknown origin.

c) Characterization of pancreatic mass.

d) Head and neck tumours. For staging, monitoring of

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response to treatment or detection in the event of a suspected relapse.

e) **Primary lung cancer.** In the event of staging or detection of a suspected relapse.

f) **Breast cancer.** For staging and detection of a suspected relapse.

g) **Cancer of the oesophagus.** Solely and exclusively for staging.

h) **Carcinoma of the pancreas.** For staging and detection of a suspected relapse.

i) **Colorectal cancer.** For staging and detection of a suspected relapse.

j) **Malignant lymphoma.** For staging, monitoring of response to treatment and detection of a suspected relapse.

k) **Malignant melanoma.** For detection due to suspected relapse and for staging with Breslow > 1.5 mm or metastasis in lymph gland nodules in the initial diagnosis.

l) **Gliomas with a high degree of malignancy (III or IV).** In the event of detection of a suspected relapse.

m) **Non-medullary thyroid cancer.** Only for patients with increased serum levels of thyroglobulin and negative for radioactive iodine in a full body scan, in the event of a reasonable suspicion of relapse.

n) **Ovarian cancer.** For detection in the event of a reasonable suspicion of relapse.

o) **Cancer of the uterine cervix.** For initial staging, monitoring of response to treatment and detection in the event of a suspected relapse.

p) **Tumours of the biliary trees.** For initial staging

It includes the performance of PET-CAT studies with the Choline radiopharmaceutical **exclusively for the re-staging of prostate cancer in patients suffering a biochemical relapse.**

It includes the performance of PET-CAT studies with the Gallium 68 radiopharmaceutical **exclusively for the staging of neuroendocrine tumours.**

It includes the performance of PET-CAT studies with the Dopa radiopharmaceutical **exclusively for medullary thyroid cancer.**

It includes the performance of PET-CAT studies with the Methionine radiopharmaceutical **exclusively for recurrent brain tumour.**

Furthermore, the performance of a PET-CAT scan with the radiopharmaceutical 18-FDG **in epilepsy resisting medical treatment** is covered. In accordance with the criteria of the Spanish Neurology Society, epilepsy is considered to be resistant when it has not been possible to control crises following appropriate treatment with two well-tolerated anti-epileptic drugs, suitably chosen and prescribed (either as monotherapy or in combination), with lack of control being understood as the emergence of crises in the course of a year or crises suffered over a period of time less than three times the interval between crises presented prior to starting treatment.

2.5.5 Radiodiagnosis.

Habitual techniques are covered, such as:

a) General radiology.

b) Ultrasound scans.

c) CAT (Computerized axial tomography).

d) NMR (Nuclear magnetic resonance imaging, 3 Tesla NMR, MR Enterography): including sedation in paediatric patients and/or adults with a psychiatric and/or neurological pathology.

e) Angiography.

f) Digital arteriography.

g) Bone densitometry.

h) Mammography.

i) Vascular and interventionist radiology. Radiofrequency is included in percutaneous bone surgery and percutaneous liver surgery.

j) Coronary CAT angiography for monitoring coronaropathies and to rule out, **solely and exclusively, occlusions of aorto-coronary stents and bypasses, in response to one of the following indications:**

1. Atypical chest pain in patients without known coronary disease and with:
   - Doubtful or non-conclusive functional tests (electrocardiography, conventional Holter, cardiac stress test and echocardiography).
   - Normal functional tests (electrocardiography, conventional Holter, cardiac stress test and echocardiography) with persistence of symptoms without a clear diagnosis.
2. Screening for coronary disease in dilatated myocardiopathy or prior to non-coronary heart surgery.
3. Assessment of patency of the coronary bypass.
4. Assessment of patency of stents greater than 3 mm.

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5. Assessment of pulmonary veins prior to atrial fibrillation ablation.

k) Functional magnetic resonance image of the brain for the planning of brain tumour surgery.

2.6 Special treatments. The following treatments are covered:

a) The following treatments are covered **only through the Contracted Medical Services**, in the event of chronic or acute pathology, at a Hospital, Medical Centre, or at home

- **Aerosol therapy.**
- **Oxygen therapy.** Both the medical act for oxygenation and the oxygen required are included.
- **Ventilation therapy.** Treatment with continuous positive airway pressure (CPAP) or bi-level positive airway pressure (BPAP) is specifically included.

b) **Physiotherapy and Rehabilitation.** This covers treatments using combined techniques for the rehabilitation of the musculoskeletal system and respiratory rehabilitation, whether under in-patient or out-patient regime, for patients with acute and/or exacerbated chronic pathologies, at a Hospital or Medical Centre, performed by a physiotherapist and/or a rehabilitation physician, resulting from an Illness or Accident covered by the Policy, and **when prescribed by a healthcare professional**, with the limits and conditions established in the Policy.

Admissions to hospital which main purpose is rehabilitation are excluded.

Shock-wave lithotripsy of the muscle and bone structure is included, with a maximum of three (3) sessions per process, when prescribed by an orthopaedic surgeon or qualified rehabilitation practitioner, with prior authorization from the Company, solely and exclusively at the Contracted Medical Services designated for the purpose by Cigna, for the treatment of the following pathologies: calcific/non-calcific tendinitis, heel spur, plantar fasciitis, and pseudoarthrosis.

Lymphatic drainage after lymphadenectomy is included in a malignant oncological process, by applying the following combined techniques: manual lymphatic drainage and press therapy.

Cardiac rehabilitation after an acute myocardial infarction or after coronary heart surgery is included.

Pelvic floor rehabilitation is included when prescribed by a urologist, gynaecologist or general surgeon (as appropriate), in accordance with the limits and conditions set out in the Policy, using combined techniques in the following cases:

- pathological urinary incontinence (1st and 2nd degree);
- pathological faecal and anal incontinence (2nd degree);
- postpartum rehabilitation.

Hypopressive therapy is excluded.

Devices using laser in rehabilitation of the musculoskeletal system are included in accordance with the limits set out in the Policy.

Treatments for learning, acquisition of skills or early stimulation and maintenance therapies are excluded.

c) **Phoniatry and Speech Therapy.** . Sessions given by a legally qualified phoniatrist and/or speech therapist are covered in accordance with the limits established in the Policy.

Speech therapy treatment is excluded if it is not to re-establish speech capacity or if:

- **It is used to improve speech abilities that have not been completely developed.**
- **It can be considered as a tutorial or educational.**
- **It is carried out to maintain the communicative capacity of speech.**

2.7 Medical-Surgical Hospitalization.

The expenses detailed below are covered in the event of hospitalization **prescribed by a legally qualified Physician or Specialist**:

a) **Expenses caused due to staying in hospital.** Use of a Standard Room and/or Day Hospital and maintenance of the Insured admitted to hospital as well as a bed for the person accompanying the same (if any), up to the daily quantitative limit established for the purpose in the Policy.

Hospital expenses for the use of telephones, television, maintenance of the person accompanying the Insured and other services not directly related to the treatment of the Illness or Accident are excluded, as well as those derived from admissions that are not medically necessary.

b) **Hospital medical services.** use of operating room, material, medicinal substances (both in the operating room and those supplied during Hospitalization), anaesthesia, resuscitation and/or any other medical services providing during Hospitalization up to the daily quantitative limit established for the purpose in the Policy.

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c) **Expenses for medical fees.** Fees of specialists, assistants and anaesthetists involved and pertaining to the Contracted Medical Services designated for the purpose by Cigna, with the limits set out in the Special Conditions of the Policy.

d) **Psychiatric Hospitalization Expenses: on prescription**, up to the maximum number of days per Insured and year established in the Policy.

e) **Hospitalization expenses in an Intensive Monitoring Unit or Intensive Care Unit (ICU),** with the limits established in the Policy.

f) **Day Hospital expenses.** These expenses are included on the same conditions and with identical exclusions as the expenses foreseen **in letters a), b) and c) of this article 2.7. The limits established for hospital stays and hospital medical expenses shall apply.**

g) **Intra-operative electrophysiological monitoring**. In intra-cranial procedures, in surgery of the parotid and thyroid glands and in surgery of the spine with involvement of the medulla or nerve roots, all confirmed using imaging techniques or electromyogram, solely and exclusively at Contracted Medical Services designated by Cigna.

2.8 Cover for maternity and new-born infants.

2.8.1 Obstetrics.

2.8.2 Vaginal or Caesarean delivery.

2.8.3 Preparation for childbirth.

Pre-delivery preparatory courses in accordance with the limits and conditions set out in the Policy.

2.8.4 New-born infants.

Provided delivery is covered, the hospital and medical expenses caused in connection with new-born infants are covered while they remain without interruption in the Hospital where the birth took place, with the limits and exclusions established in the Policy **and up to a maximum of seven (7) days of Hospitalization.**

Medical assistance and the expenses derived from childbirth outside a Hospital are excluded.

2.9 Other Healthcare Services.

2.9.1 Ambulance.

Land-based ambulance services are covered for transportation from the Insured's home to a private Hospital and from a Hospital to the Insured's home, or between private hospitals, provided that admission is covered by the Company.

It must be prescribed by the Physician that is responsible for the patient (on clinical grounds and provided that it cannot be done by any other means), in accordance with the limits and conditions set out in the Policy. These limits shall not apply when transportation by ambulance is necessary and if the failure to provide it immediately endangers the life of the Insured or leads to irreparable harm for his or her physical integrity or health.

This service may be provided by the Contracted Medical Services designated for the purpose by Cigna, in accordance with the limits and conditions set out in the Policy.

It must be arranged through the Emergency Service of the Company.

Transportation services related to rehabilitation treatments and the performance of diagnostic tests or consultations under an out-patient regime are excluded.

2.9.2 Podiatry.

Consultations and therapeutic procedures **(no surgery)** carried out at the office (chiropody, podiatric treatment of ingrowing toenails and podiatric treatment of papilloma) are included with the limits and conditions set out in the Policy.

2.9.3 Cigna 24H Medical Guidance hotline.

It is offered on the telephone number indicated for this purpose by the Insurer.

2.9.4 Prostheses and Implants.

The following prostheses are covered in accordance with the limits established in the Policy:

1. Heart valves.
2. Pacemakers (with the exclusion of any kind of defibrillator).
3. Percutaneous occluder device, according to cover established in Article 2.4.5. Cardiology.
4. Vascular prosthesis
   - Bypass;
   - Stent;
   - Coils: **only in case of intracranial embolization, pelvic varicose veins and varicoceles.**
5. Internal orthopaedic prostheses and osteosynthesis material.
6. In surgery for cataracts, monofocal intraocular lenses are covered.
7. Breast prostheses following radical mastectomy for

an oncological process and following prophylactic mastectomy in accordance with the provisions contained in articles 2.4.10 and 2.9.10.

8. Surgical meshes for the repair of defects in the abdominal wall, urological meshes, and synthetic meshes for breast coverage after surgery of malignant neoplasm.

9. Implantable Port-a-cath reservoirs in oncological treatments.

10. Digestive prostheses: oesophageal, hepatobiliary and colorectal, **solely and exclusively in oncological processes.**

11. Biological dura mater meshes for the replacement of the dura mater in intracranial or spinal surgery for tumours, and replacement of the pericardium in cardiac surgery.

12. Testicular prostheses.

13. Hydrocephalus valve in shunts of Cerebrospinal Fluid (CSF).

14. Biological ligaments. Cover for biological ligaments from bone banks **solely and exclusively in knee ligament surgeries.**

15. Teflon tympanum drainages

Orthopaedic material is excluded, i.e. orthopaedic apparatuses in general (wheelchairs, orthopaedic beds, corsets, neck braces and supporting canes), as well as any other material not explicitly reflected in the present General Conditions.

Surgical operations and hospital expenses are excluded if intended for the implantation or replacement of a prosthesis that is not covered.

2.9.5 Transplants.

Hospital and medical expenses derived from the performance of transplants for organs, tissues, cells or cellular components are covered in accordance with the limits per Insured and year established in the Policy.

The organs, tissues, cells or cellular components used in the transplant and their transportation are excluded.

Donor testing is excluded.

2.9.6 AIDS.

This benefit covers the expenses derived from the treatment of the Illnesses or Lesions arising as a result of the Insured suffering Acquired Immunodeficiency Syndrome (AIDS), with the limits and conditions established in the Policy.

2.9.7 Second Medical Opinion.

In the case of Serious Illnesses indicated in the following paragraph, the assessment by renowned Specialists, contacted through a Provider chosen by the Company, of the diagnosis and/or medical treatment of the Insured in connection with said Illnesses is covered. For this benefit to be provided, the Insured must complete the forms provided and, where appropriate, deliver such medical information and/or documentation as may be required. The Insured will obtain a report, through the said service provider, containing a second medical opinion from one or more Specialists with no ties whatsoever to the Insurer.

The illnesses with respect to which a second medical opinion may be requested are as follows: oncology, cardiac diseases (including cardiac surgery and angioplasty), organ transplant, neurological and neurosurgical diseases (including cerebrovascular accidents), complex orthopaedic surgery, degenerative diseases and demyelinising diseases of the nervous system and illnesses and suffering derived from renal insufficiency.

In those cases where, after receiving the Second Medical Opinion, the Insured wishes to travel abroad to receive treatment, information about support services can be obtained by calling the insurance company, **although this does not mean that medical assistance will be guaranteed while abroad; this will only be covered when so specifically stated in the Policy and always on the terms and conditions agreed.**

2.9.8 Psychological Guidance Service.

The **Psychological Guidance Service** offered is included via the telephone number and with the timetable indicated for the purpose by the Insurer and via on-line consultations.

2.9.9 Preventive Medicine.

Medical consultations, physical examinations and specific diagnostic tests necessary for the early detection of Illnesses related to the specialities indicated below are covered:

a) **Digestive Apparatus.** This includes a programme for the prevention of colorectal cancer for Insured parties at the age at risk, determined according to accepted medical standards.

b) **Cardiology.** This includes a programme for the prevention of coronary risk for Insured parties at the age at risk, determined according to accepted medical standards. This programme includes: electrocardiography, conventional Holter, cardiac stress test and echocardiography.

c) **Gynaecology.** An annual gynaecological revision is covered for the early diagnosis of Illnesses in the breast and the neck of the womb.

Prophylactic contralateral mastectomy is included for those

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Insured parties **diagnosed as having breast cancer and with a positive result in the BRCA 1 and/or BRCA 2 tests**, and who decided to submit to bilateral mastectomy. The reconstruction of both breasts is also included, **provided that this is performed as part of the same operation and with the same reconstructive technique.**

Lipofilling technique is excluded.

Where the reconstruction of the healthy breast cannot be performed, for medical reasons, during the initial operation and has to be deferred, the Insured will have a **maximum term of 12 months following the mastectomy to undergo this reconstruction.**

The procedure will be covered in accordance with the limits and conditions set out in the Policy and must be carried out, with the prior authorization from the Company, at the Contracted Medical Services designated for the purpose by Cigna, in accordance with the limits and conditions set out in the Policy.

Prophylactic bilateral mastectomy is included for those asymptomatic **Insured parties who have obtained a positive result after completing a BRCA 1 and/or BRCA 2 test** in accordance with the conditions established in the Policy for these tests and who freely and voluntarily decide to undergo a bilateral mastectomy with reconstruction of both breasts through the placement of breast prostheses, **provided that this is performed as part of the same surgical operation.**

Any other reconstructive technique is excluded.

The procedure will be covered at the Contracted Medical Services designated for the purpose by Cigna, with the prior authorization from the Company, in accordance with the limits and conditions set out in the Policy.

Prophylactic oophorectomy is included for those asymptomatic Insured parties who have obtained a positive result after completing a BRCA 1 and/or BRCA 2 test in accordance with the conditions established in the Policy for these tests and who freely and voluntarily decide on the preventive removal of their ovaries, in accordance with the limits and conditions set out in the Policy.

d) Paediatrics. Regular consultations and examination of the child's development are included, as well as health checks for the New-born Infant, including otoacoustic emission testing, audiometry, visual acuity testing, metabolic diseases, both in the cases established in Article 2.8.4 of the General Conditions and also after the child is registered on the Policy.

e) Urology. This includes a programme for the prevention of prostatic cancer for Insured parties at the age at risk, determined according to accepted medical standards.

2.9.10 Odontology.

Visits, simple extractions, peri-apical X rays (to view the innermost part of the tooth), orthopantomography **and one session of dental hygiene per annum are included.**

For the purposes of delimiting this benefit, a simple extraction is understood to be the removal of a tooth that, in terms of technical difficulty, does not require any kind of special instrumentation in order to be performed, as opposed to a complex extraction requiring some type of special instrumentation either due to the tooth's anatomy or the destructive condition of the tooth.

2.10 Cover for serious or complex cases (Case Management / Clinical Follow-Up Unit)..

Individualized monitoring by a nursing professional, following prior authorization from the Insurer, is included for Insured parties presenting serious pathologies such as those indicated below by way of example and without limitation:

- Oncological processes
- ICU
- Long-term Hospitalization
- High-risk pregnancies
- Premature deliveries
- Multiple trauma

The levels of cover offered, subject to the clinical criterion of the Cigna Nurse managing the case, include, among others:

2.10.1 Assistance and follow-up related to the cover for a second medical opinion.

2.10.2 Guidance about Medical Staff.

2.10.3 Hospital visits.

2.10.4 Detailed cover management.

2.10.5 International coordination.

2.10.6 Individualized follow-up by a designated nurse who will act as the link to the Company during this process.

Inclusion in the programme for the Clinical Follow-Up Unit will not hinder the management of any clinical process.

In no case will Cigna offer recommendations about the medical indications the Insured may have received, whether from a personal physician or from the doctors providing the second medical opinion, and the patient will retain, at all times, full autonomy to make a decision.

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ARTICLE 3. WAITING PERIODS

During the waiting periods established for cover as indicated in the Policy, the Insured is not entitled to receive the benefit, unless the said Waiting periods are not applicable and this is expressly indicated in the Particular Conditions. Similarly, Cigna assumes any necessary Healthcare Assistance in the event of a Life-Threatening Emergency and for so long as this emergency situation may last, in accordance with the indications given in the Policy.

The following types of cover referred to in the present contract have the Waiting Periods indicated below:

3.1 Vaginal or Caesarean delivery.

The provision of vaginal or Caesarean delivery has a **Waiting Period of eight (8) months** counted from the date the cover begins, except in cases of a Life-Threatening Emergency for the mother or the foetus, or in births diagnosed as premature, provided that the pregnancy has begun after the date of registration of the Insured.

Similarly the **Waiting Period of eight (8) months** will apply to Caesarean sections prescribed for the Insured in advance (i.e. scheduled Caesareans, regardless of the reason) and not a consequence of a Life-Threatening Emergency for the mother or the foetus.

3.2 Hospitalization and/or Surgery.

All of the benefits included in Article 2.7 of the General Conditions have a **Waiting Period of six (6) months**, counted from the date the cover begins, except in cases of a Life-Threatening Emergency for the Insured.

3.3 Access to the Cigna Hospital Network in the USA.

This has a Waiting Period of twelve (12) months counted from the date the cover begins for the Insured under the Policy.

3.4 Transplants.

These have a **Waiting Period of twelve (12) months** counted from the date the cover begins for the Insured under the Policy.

ARTICLE 4. EXCLUSIONS

Apart from the exclusions indicated in each of the articles, cover under this insurance is EXCLUDED in all the following cases:

a. **Damage or Claims that, in view of their magnitude and severity, are classified as catastrophic or a national calamity.**

b. **Events caused violently as a consequence of terrorism, rebellion, sedition, mutiny or popular uprising and events or actions of the Armed Forces and the Security Forces and those caused by armed conflicts.**

c. **Natural phenomena such as flooding, earthquakes, volcanic eruptions, atypical cyclonic storms, falling sidereal bodies and meteorites.**

d. **Those derived from nuclear energy.**

e. **Epidemics officially declared as such.**

f. **Pre-existing Illnesses or Lesions. The present exclusion shall not apply when the Health Questionnaire was not required nor when, although required, Cigna has expressly agreed in writing to cover such pre-existing state.**

g. **Claims relating to all kinds of Congenital Illnesses, except those of:**

› The children of the Insured who have been born during the currency of the policy and whose deliveries (vaginal or Caesarean) were covered by this Policy, provided that:

- **Their inclusion on the Policy has been notified within the term of one month from their birth and they have been registered on the insurance retrospectively to the date of birth.**

› The children of the Insured who were born or adopted during the currency of the Policy and whose deliveries (vaginal or Caesarean) were not covered, provided that:

- **The Insured has notified the Insurer, at least one month prior to the date of birth or adoption, of the intention to insure the said children and they have been registered on the insurance retrospectively to the date of birth.**

h. **General medical examinations, check-ups and any visit, treatment or test classified as Preventive Medicine** (except those mentioned in Article 2.9.11).

i. **Any admission to hospital, surgical operation, diagnostic test or medical treatment that has not been prescribed and approved by a Physician.**

j. **Those derived from alcoholism, drug addictions and intoxication due to the abuse of alcohol or the use of psychotropic, narcotic or hallucinogenic drugs. Accidents suffered while in a state of drunkenness or under the effects of drugs or narcotics, or as a consequence of criminal actions by the person in question, recklessness or gross negligence as declared in a court of law.**

k. **Plastic or restorative surgery** (except as mentioned in Article 2.4.10).

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l. **Treatments with a purely aesthetic purpose, rejuvenation, detoxification and/or sleep cures, thermal and climatic cures, hair implants, treatments at spas and gymnasiums and maintenance therapies.**

m. **Prostheses and implants of any kind, as well as orthopaedic anatomical parts,** except those specifically covered by the Policy under Article 2.9.4.

n. **Genetic tests other than those expressly mentioned in the specialities**, except for those intended for the diagnosis of illnesses in affected symptomatic patients. **The determination of genetic maps for predictive or preventive purposes is expressly excluded. Pharmacogenetic studies are excluded,** except those expressly mentioned, **as well as gene therapy treatments.**

o. **Pharmaceutical products outside the Hospitalization regime, including those administered on an out-patient basis,** except for those specifically covered by the Policy with a maximum reimbursement limit equivalent to their retail price published by the Ministry of Health or other competent authority. **Vaccines of all kinds. Admissions to Day Hospitals for the sole purpose of administering medicines or pharmaceuticals are excluded.**

p. **Surgical techniques and/or therapeutic treatments using laser or HIFU and robotic surgery,** except those expressly included in the different specialties.

q. **All those diagnostic and therapeutic procedures not habitually used (in a majority of the Spanish Regions) and not in widespread use at Public Health Centres (a majority of such Centres in each of the Regions) and diagnostic tests and treatments whose clinical efficacy and safety have not been sufficiently proved or for which there is no consensus among the Scientific Community in Spain.**

r. **Attempted suicide or voluntary mutilation, and Accidents deliberately caused by the Insured.**

s. **Sex reassignment operations or any treatment necessary for the preparation of or recovery from such operations (for example, psychological advice), including the complications resulting from such treatment.**

t. **Hospitalization for social problems.**

u. **For those Insured parties covered by the benefits of the Social Security regime, Healthcare Assistance provided at Social Security centres o centres included in the National Health System, including the Spanish Regions, that do not have agreements in place with the Insurer.**

v. **Illnesses or Accidents derived from participation as an amateur in any dangerous activity or sport. The following activities are considered to be dangerous activities or sports, albeit without limitation: motor sports, airborne sports or activities, racing competitions, off-piste skiing, scuba diving, undersea fishing without breathing equipment, potholing, mountain climbing, bungee-jumping, rafting, parachuting, hang-gliding, whitewater canoeing, bobsleigh, boxing or martial arts, any kind of race, rally or competition not conducted on foot, rugby, weightlifting, fencing and shooting. Accidents suffered during professional participation in races or competitions and their corresponding events and training sessions.**

w. **Assisted reproductive treatments, as well as any other similar treatment and the diagnostic study and treatment of sexual impotence; treatment intended to solve problems of sterility; reversal of vasectomies or any other surgical treatment intended to re-establish the Insured's fertility.**

x. **Any assistance related to or derived from a medical procedure, or the complications thereof, that is not covered by the Policy.**

y. **Foetal intervention.**

In addition to the preceding exclusions, the exclusions established in the corresponding Section are applicable in all cases to the cover for Healthcare Assistance While Travelling Abroad.

REFERENCES TO THE INSURANCE CONTRACT ACT

ARTICLE 5. THE INSURANCE CONTRACT

5.1 Documentation and Formalization of the Insurance Contract and Duty to provide information.

Prior to the conclusion of the contract, the Policyholder is under the OBLIGATION to declare to the Insurer, in accordance with the questionnaire submitted by the latter, all of the circumstances known to the Insured that might have an influence on the Insurer's assessment of the risk.

Bearing the foregoing obligation in mind, the present Policy has been arranged on the basis of the declarations made by the Policyholder and/or by the Insured on the Subscription Document or Insurance Application Form, on the Health Questionnaire, and on any other means for the transmission of information admitted by Cigna and accepted by the Insured, expressly including electronic and telephonic contracting. The said declarations constitute the fundamental obligation of the Policyholder and/or the Insured regarding the declaration of the risk, especially the Health Questionnaire, and they therefore

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constitute an essential element of the contract and the basis for its formalization.

The Policyholder has the duty and the obligation to sign each and every one of the documents making up the Policy and to deliver a signed copy thereof to the Insurer.

The insurance shall become effective after the Policy is signed and the corresponding Premium paid.

Should the contents of the Policy differ from the insurance proposal or from the clauses agreed, the Policyholder may require the Insurer to remedy the divergence identified within the term of one month counted from the delivery of the Policy. Once this term has elapsed without any complaint having been made, the parties shall abide by the provisions contained in the Policy.

Once the contract has been formalized and during the course of the same, the Policyholder and/or the Insured must notify the Insurer, as promptly as possible, of any alteration in the factors and circumstances declared at the moment the Policy was contracted that might aggravate the risk and are of such a nature that, had they been known to the latter at the moment the contract was concluded, it would not have entered into it or would have done so on more onerous conditions.

In no case shall any variation in the circumstances regarding the state of the Insured's health be considered an aggravation of the risk and therefore need not be notified to the Insurer.

5.2 Conditions for Inclusion in the insurance.

It will not be possible for persons aged 64 or over to subscribe this insurance, or such other age, if any, specified in the Particular or Special Conditions.

The Insurer and the Policyholder may agree on inclusion conditions in addition to those appearing in the Particular Conditions.

The Insurer reserves the right to reject the inclusion in the insurance or to limit or exclude any of the cover therein on the basis of the declarations made in the Health Questionnaire or any other document furnished for the purpose and of the medical examination, if any.

5.3 Duration of the Contract.

The insurance cover is stipulated for the period of time foreseen in the Particular Conditions and, on its expiry, it will be deemed to have been automatically extended for the term of one year and so on thereafter on the expiry of the annual period under way.

Both the Policyholder and the Insurer may oppose the extension of the contract by means of written notification sent to the other party at least one month in advance of the conclusion of the cover in the initial period or the annual extension when the party opposing the extension is the Policyholder, and two months when it is the Insurer.

5.4 Subrogation.

The Insurer, once the Healthcare Assistance referred to in the present contract has been provided, shall be able to exercise any and all rights and actions that, in connection with the Illness or Accident, might correspond to the Insured against the persons responsible for the same or the public bodies or other entities that may have a legal or regulatory obligation to cover the same pursuant to any compulsory or voluntary insurance up to the limit of the cost for the Healthcare Assistance provided.

This subrogation right shall not be exercised against the spouse of the Insured nor against any other relatives to the third degree of consanguinity, any adoptive parent or adopted child living with the Insured in question. This exception shall have no effect if the liability stems from criminal intent, or if the responsibility is covered under an insurance contract. In this latter case, the subrogation shall be limited in scope in accordance with the terms of the said contract.

In the event where the Insurer and the Insured act jointly against the third party with liability, any collection obtained will be distributed among them in proportion to their respective interest.

5.5 Limitation of legal action.

Any lawsuits arising out of the present contract shall be time-barred after five years have elapsed from the moment when they could have been exercised.

5.6 Communications.

All communications will be addressed by the Policyholder/Insured to the Insurer at its registered office, or at any of its offices or another remote electronic address expressly designated by the Insurer for certain communications, provided that this is expressly stated.

Communications of the Insurer to the Policyholder and, if any, to the Insured, shall be made at the address of the latter indicated in the policy and/or email address or other remote electronic means, whenever this is compatible with the content and format of the communication.

Communications effected by an insurance broker or brokerage office to the Insurer on behalf of the Policyholder or the Insured shall have the same effects as if they had been made by the Policyholder in person, except as otherwise indicated by the same. In all cases, the express consent of the Policyholder will be required for the subscription of a new contract or to amend or rescind the insurance contract in force.

Nonetheless, communications made by the Policyholder or

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the Insured to the insurance broker or brokerage office are not deemed to have been made to the Insurer until they have been received by the latter.

Communications made by the Policyholder or Insured to an insurance agent of the Insurer shall have the same effects as if they had been made directly to the latter.

The Insurer shall obtain the Policyholder's and/or Insured's consent to record the telephone conversations held in connection with the present Policy and to use the same in its quality assurance processes, and, when pertinent, as evidence for any dispute that may arise between the parties, at all events preserving the confidentiality of the conversations.

Those communications made in writing that have been refused, those sent by registered mail and not collected from the Post Office, and those that do not reach their destination because of a change of address that has not been indisputably notified to the Insurer shall have identical effects as those communications received. This also applies in case of change of the place or means of communication established in the Policy that has not been notified to the Insurer.

ARTICLE 6. DUTIES AND OBLIGATIONS OF THE INSURED

6.1 Premiums.

The Policyholder shall pay the Insurer the Premium in the manner and on the dates specified in the Particular Conditions to this Policy. If payment by instalments is arranged for the annual Premium, the Policyholder shall be obliged to pay the first instalment at the moment the contract is concluded. Subsequent Premiums must be paid on their corresponding maturities. Payment by instalments of the Premium shall not release the Policyholder from the obligation to pay the full amount of the Premium.

If the first Premium is not paid due to the fault of the Policyholder, or if the Sole Premium is not paid on its maturity, the Insurer is entitled to resolve the contract or to demand payment of the Premium due through forced recovery on the basis of the Policy. If the Premium has not been paid before the Claim arises, the Insurer will be released from its obligation.

In the event of any non-payment of one of the subsequent Premiums, or of any of the instalments if payment of the Premium by instalments has been arranged, then cover by the Insurer shall be suspended one month after the date of maturity. If the Insurer has not claimed payment within the six months following the maturity of the Premium, the contract will be understood to have been extinguished. In any case, when the contract is suspended, the Insurer may only demand payment of the Premium for the ongoing period and it shall be entitled to the fraction of premium for the time during which the cover was suspended.

If the contract has not been resolved or extinguished pursuant to the preceding paragraphs, the cover shall once more be effective from midnight on the date the Policyholder paid the Premium (or the pending instalment(s)).

The Insurer, giving two months' notice to the Policyholder prior to the termination of the ongoing period, may alter the Premiums annually on the basis of the technical and actuarial calculations necessary to determine the impact of the following concepts on the financial and actuarial scheme of the insurance: the increase in the cost of the healthcare services, the increased frequency of the benefits covered by the Policy, the increase in the loss rate, the incorporation into the cover guaranteed of technological innovations emerging or being used after the execution of the contract, or other events with similar consequences.

The Policyholder may opt between the extension of the insurance contract with the new Premiums established by the Insurer for the following annual period, or its extinction on the maturity of the annual period under way. In this case, the Policyholder must notify the Insurer of the decision not to extend the contract giving at least one month's notice prior to the date of the Policy's maturity.

6.2 Collaboration in processing.

In the event of a Claim covered by this insurance contract, the Policyholder and/or the Insured will be obliged to cooperate with the Insurer to reduce all the consequences of the same, as well as to communicate immediately to the Insurer the occurrence, circumstances and possible consequences of the Claim.

The Insured, any relatives or successors in title musts allow the visit of the Insurer's Physicians, as well as any verification or confirmation that the Insurer may consider necessary for the verification of the Claim, authorizing the delivery to the Insurer of any and all documents related to the cover under the Policy that may be requested.

All complementary information requested by the Insurer to verify the Claim must be sent by the Policyholder or the Insured within the maximum term of sixty (60) days from the occurrence of the Claim.

Together with notification of the Claim, the Policyholder or the Insured must send the Insurer the medical report specifying the diagnosis and nature of the Illness when so required by the Insurer. Documents will be submitted in the manner and with the contents requested by the Insurer.

In addition, the Insured must faithfully observe all the prescriptions of the Physician in charge of curing the

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condition and must give the Insurer all kinds of information about the circumstances or consequences of the Claim.

Any failure to comply with these obligations will give rise to the possibility for the Insurer to claim back any damages suffered. Should any criminal intent or serious blame attach to the Policyholder and/or Insured, the Insurer shall be released from its obligation to provide compensation.

6.3 Taxes and Surcharges.

All taxes and surcharges that may legally be passed on and must be paid in connection with this contract, whether at present or in future, shall be for the account of the Policyholder or the Insured.

ARTICLE 7. OBLIGATIONS OF THE INSURER

7.1 Provision of Cover.

The healthcare assistance covered by the policy is provided through healthcare professionals and Hospitals in Spain included in the Contracted Medical Services.

The Insured will be required to present identification in advance as the person covered by the insurance. For this purpose, the Policyholder will be provided, at the start of the cover, with the corresponding to cards accrediting the status of an insured party and the Insured must present this card to the professional together with a National ID card or legally equivalent document. The information about the Contracted Medical Services will be updated from time to time on the Cigna web page. The Policyholder will be jointly and severally responsible for any expenses incurred by the Insured for services rendered by the Contracted Medical Services through the use of a Cigna card corresponding to an extinguished insurance arrangement. All this is without prejudice to the liabilities that the Insured might incur in the event of fraudulent use of the card.

The Insurer will not reimburse the fees of professionals and other Contracted Medical Services paid directly by the Insured, nor the medical expenses and fees arising out of the Healthcare Assistance provided by professionals and Hospitals not included in the Contracted Medical Services, except in the cases expressly reflected in the policy.

For the purposes of the insurance, the Claim will be deemed to have been notified when the Insured goes to the Contracted Medical Services or requests a service.

The Insured may freely choose and use the services of the healthcare professional and/or Medical Centre or Hospital considered to be most appropriate among the Medical Staff of Cigna, in accordance with the levels of cover contracted in the Policy. The right of freedom of choice of the professional and Medical Centre and/or Hospital, the lack of any organizational hierarchy on the part of the Insurer and the independence of criterion, as well as the existence of professional secrecy, are all circumstances that, each one individually, necessarily presuppose the absence of any kind of liability on the part of the Insurer for the acts performed by the same.

7.2 Information to the Policyholder.

Pursuant to the provisions contained in the Insurance and Reinsurance Entities (Organization, Oversight and Solvency) Act (Act 20/2015) and the Royal Decree 1060/2015, dated November 20th, 2015, on the Organization, Oversight and Solvency of Insurance and Reinsurance Entities, the Insurer provides the following information, in addition to that already contained in the rest of the Policy:

a) **The law applicable to this insurance contract** is the Insurance Contract Act 50/1980, dated October 8th, 1980, and the Insurance and Reinsurance Entities (Organization, Oversight and Solvency) Act 20/2015, dated July 14th, 2015, as well as the regulations developing the same.

b) **When the contract has been entered into using any remote contracting technique,** and, in accordance with the provisions contained in Act 22/2007, dated July 11th, 2007, on the remote marketing of financial services targeting consumers, the Policyholders shall be able to cancel the present insurance unilaterally, without needing to indicate the reasons and without any penalty whatsoever, within the term of thirty (30) days from the date the insurance was entered into or the receipt by the Policyholder of the contractual terms and conditions and the compulsory prior information foreseen in the aforesaid Act, if this is received after the conclusion of the insurance.

   In order to exercise this right, Policyholders shall send the corresponding notification addressed to the Insurer, using any lasting medium accessible to the Insurer. Policyholders may submit the said notification using electronic means, provided that measures are in place to guarantee the integrity, authenticity and absence of tampering of the notification and enabling the date of the sending and receipt of the same to be confirmed. Coverage of the risk shall cease from the date of issue by the Policyholder of the cancellation notification.

c) **In the event of any complaint or dispute regarding the insurance,** the Policyholder, Beneficiary, Insured or successors in right of any of the same may address the following instances for its resolution:

   i. In writing, to the Incidents Department of Cigna Life Insurance Company of Europe, SA-NV Sucursal en España, Parque Empresarial La Finca, Paseo del Club Deportivo 1, Edificio 14, Planta Primera. 28223 Pozuelo de Alarcón - Madrid, or at the following email address: servicio.incidencias@cigna.com.

ii. The Cigna Client Ombudsman, at C/ Velázquez, 80, 1º Dcha., 28001 Madrid, or at the following email address: reclamaciones@da-defensor.org.

The processing of complaints and disputes by the above instances shall never exceed the term legally established and the procedure is regulated in the Regulations for the Defence of Clients at Cigna Life Insurance Company of Europe, available at the Entity's offices.

iii. Once the internal route of the Insurer referred to in the preceding section has been exhausted, it will be possible to initiate the administrative procedure for complaints before the Complaints Service of the Directorate-General for Insurance and Pension Funds located at Paseo de la Castellana, 44, 28046 Madrid, (www.dgsfp.mineco.es). For this purpose, claimants must demonstrate that the term of one month has elapsed since the date the complaint was submitted to the Insurer's Incident Department, without the same having been resolved or the consideration of the complaint refused or the request denied.

7.3 Personal Data Protection.

Cigna Life Insurance Company of Europe, SA/NV, Sucursal en España shall process data related to the applicant/policyholder (in the case of individual insurance policies), insured and beneficiary (jointly, the "Data Subject) as data controller, for the following legitimate purposes and grounds: (a) handle the application and/or insurance contract; (b) comply with all legal obligations; and (c) prevent and investigate fraud, based on legitimate interest. Data Subject's data (including health information) shall be collected directly from the Data Subject or through other sources (insurance broker, employer, in the case of collective insurance policies, or medical professionals, among others). Cigna shall share the Data Subject's personal data with third parties, including recipients located in countries that do not ensure an adequate level of protection (United States of America). The Data Subject may exercise, at any time, its rights of access, rectification, objection, erasure, portability and restriction of processing and withdrawal of consent by sending notification via email to CGHB-EU-Privacy@cigna.com.

For more information on the processing of the Data Subject's personal data, please, refer to the Personal Data Protection Annex of the Policy.

ARTICLE 8. COMPLAINTS

8.1 Arbitration.

If both parties agree, they may submit their differences to the consideration of arbitrators pursuant to current legislation.

8.2 Competent Jurisdiction.

The competent Judge for hearing any lawsuits arising out of the insurance contract will be that corresponding to the Insured's domicile in Spain and any agreement to the contrary will be void.

ARTICLE 9. EXPRESS ACCEPTANCE ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

The Policyholder expressly acknowledges the receipt of the General, Special and Particular Conditions making up this Policy and states his or her awareness of and agreement with the same.

Similarly, in accordance with the provisions contained in Section 3 of the Insurance Contract Act, and as an additional agreement over and above the Particular Conditions, the Policyholder states that he or she has read, examined and understood the contents and scope of all the clauses in the present contract and, in particular, those that, duly highlighted in bold print, might limit his or her rights.

Lastly, the Policyholder expressly acknowledges having received from the Insurer, in writing, the corresponding information relating to the legislation applicable to the insurance contract, the various instances for dealing with complaints, the Member State of the Insurer's domicile and its oversight authority, the company name, registered office and legal form of the Insurer, as well as, where appropriate, the minimum information foreseen in Act 22/2007, dated July 11th, 2007, on the remote marketing of financial services targeting consumers.

In the case of collective insurance policies, the Policyholder states that he or she has provided the Insured parties, and will provide any future Insured parties, with the aforesaid information, as well as any other information that may affect the rights and obligations of the Insured parties pursuant to the General, Particular and Special Conditions of this Policy, particularly the information relating to their personal details and the consent to process personal information, prior to their inclusion in the insurance

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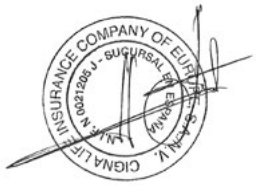

Juan José Montes Escriba
Managing Director Cigna Life Insurance
Company of Europe, SA/NV, Sucursal en España.

ADDENDUM: CIGNA MEDICAL STAFF WITH REIMBURSEMENT IN HOSPITALIZATION

PLANS C01, C06, C09, C10, C12, C31, C32, C33, HM1 Y HM5

The article 7. OBLIGATIONS OF THE INSURER is amended in the following terms.

ARTICLE 7. OBLIGATIONS OF THE INSURER

7.1 Provision of the Cover. The levels of cover referred to in this insurance will be provided in the following formats, in accordance with the provisions established for each one:

a) **Contracted Medical Services.** In this cover provision format, the Insured has direct access to the cover contracted in the Policy through the healthcare professionals and Hospitals in Spain included in the Contracted Medical Services.

The Insured will be required to present identification in advance as the person covered by the insurance. For this purpose, the Policyholder will be provided, at the start of the cover, with the corresponding cards accrediting the status of an insured party and the Insured must present this card to the professional together with a National ID card or legally equivalent document. The information about the Contracted Medical Services will be updated from time to time on the Cigna web page. The Policyholder will be jointly and severally responsible for any expenses incurred by the Insured for services rendered by the Contracted Medical Services through the use of a Cigna card corresponding to an extinguished insurance arrangement. All this is without prejudice to the liabilities that the Insured might incur in the event of fraudulent use of the card.

n this cover provision format, the Insurer will not in any case reimburse the fees of professionals and other Contracted Medical Services paid directly by the Insured, nor the medical expenses and fees arising out of the Healthcare Assistance provided by professionals and Hospitals not included in the Contracted Medical Services.

For the purposes of the insurance, the Claim will be deemed to have been notified when the Insured goes to the Contracted Medical Services or requests a service.

b) **Reimbursement of Expenses.** In this cover provision,format, the Insured will be able to request the healthcare benefits covered under the Policy from Specialists or Hospitals of his or her choice, **except in those cases expressly specified in Article 2 of the General Conditions where the cover is provided solely and exclusively through the Contracted Medical Services format.** The Insurer will reimburse the Insured for the invoices paid by the latter, with the percentages and up to the limits established in the General Conditions, the Particular Conditions and the Special Conditions, the appendices, supplements and riders to this Policy.

The Insured must necessarily send the Insurer the original invoice for the fees paid in order to determine the amount of the reimbursement, complete the reimbursement request form prepared for the purpose by the Insurer and, where applicable, provide such additional information as may be requested to verify the Claim and/or the Healthcare Assistance rendered.

In this scenario, the Policyholder or the Insured must notify the Insurer of the Claim within the maximum term of seven (7) days counted from the initial Healthcare Assistance.

The notification of the Claim must be completed and signed by the Physician attending the Insured. In the event of any failure to comply with this obligation, the Insurer may claim back the damages caused through this lack of notification.

This effect shall not rise if it is shown that the Insurer was aware of the circumstances through another means.

In this cover provision format, the Insurer will not reimburse the Insured for the amounts of any invoices issued for Healthcare Assistance provided by the professionals and Hospitals included in the Contracted Medical Services.

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c) **Mixed format or simultaneous use of both formats.** This implies the use of the two formats described above (Cigna Medical Staff and Expense Reimbursement). In this format, the Insurer will assume directly the costs of the Healthcare Assistance received by the Insured in the Contracted Medical Services format and will reimburse the said expenses of the professionals and centres not included on Cigna's Medical Staff, in accordance with the Reimbursement terms and conditions agreed.

In any case, this mixed format will be possible if the agreements between the Insurer and the professionals, centres and establishments so allow.

Otherwise, the entire amount of the expenses for the simultaneous use will be limited to the amount established in the Particular Conditions for the Expense Reimbursement benefit. For the purposes of the said limit, the Insurer will first pay the expenses corresponding to the Contracted Medical Services.

In consequence, the maximum amount of the reimbursement will be the difference between the said limit and the cost of the Contracted Medical Services.

In all of the cover provision formats, the Insured may freely choose and use the services of the healthcare professional and/or Medical Centre or Hospital considered to be most appropriate, in accordance with the levels of cover and the provision format contracted in the Policy. The right of freedom of choice of the professional and centre, the lack of any organizational hierarchy on the part of the Insurer, and the independence of criterion,
as well as the existence of professional secrecy, are all circumstances that, each one individually, necessarily presuppose the absence of any kind of liability on the part of the Insurer for the acts performed by the same.

The rest of the articles in the General Conditions for the Medical Staff Product contracted remain unaltered.

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RIDER 1

ASSISTANCE WHEN TRAVELLING ABROAD

The following additional covers and guarantees shall be provided by the insurance company IRIS GLOBAL Soluciones de Protección de Seguros y Reaseguros, S.A., with its registered office at Ribera del Loira 4-6, 28042 Madrid, and Tax ID No. A-78562246, and registered with the Directorate-General for Insurance and Pension Funds under number C0627.

DEFINITIONS

For the purposes of the present Rider on Assistance While Travelling Abroad, the following definitions shall apply:

- **Insured's family home.** Place of residence in Spain. For the purposes of the benefits established in each cover and the limits of compensation described therein, the Insured's home is his or her habitual residence in Spain, so every reference to Spain shall be deemed to be a reference to the country of origin of the Insured and the word "abroad" shall refer to any other country.
- **Luggage.** Objects for personal use that the Insured carries during the trip, as well as those sent by any means of transport.
- **Relatives.** Only spouses, partners, children, parents, grandchildren, grandparents, siblings, parents-in-law, sons-in-law, daughters-in-law, brothers-in-law and sisters-in-law of the Insured shall be considered to be relatives, except as otherwise specified in each Cover. Likewise, the Insured's legal guardian shall be considered to be a relative.
- **Partner.** Spouse or life partner registered as such in an official Register, whether local, regional or national, as well as any other similar domestic situation duly accredited.
- **Habitual residence.** Place where the Insured's main home is located. In case of doubt, it shall be the habitual residence recorded in the Municipal Register.
- **Trip abroad.** Any trip and consequent stay by the Insured parties outside the country where they have their habitual residence and/or domicile.

CONDITIONS

Healthcare Assistance is covered during temporary travel outside Spanish territory **for periods of less than 90 consecutive days** , on the terms and conditions detailed in the regulation of the Travel Assistance Guarantee. In order to receive this Assistance, a telephone call must first be made to the telephone number indicated for the purpose by the Insurer.

The terms and conditions covered under the guarantee for "Assistance While Travelling Abroad" during temporary trips abroad for periods of less than 90 consecutive days are as follows:

STIPULATION ONE: GUARANTEES COVERED

- **Guarantee one: medical, pharmaceutical or hospital expenses abroad**

The Insurer assumes the expenses and medical fees for Consultations or treatment of the Insured, including surgical and pharmaceutical expenses, in the event of Illness or Accident covered by the Policy, provided that the Company's agreement has been requested in advance in accordance with the provisions contained in the steps to be followed in the event of a Claim (Stipulation FIVE).

Should the Physician of the Insurer, or of the Reinsurer, if any, covering this benefit, by agreement with the Physician attending the Insured, determine the need for the Insured to be hospitalized, the Insurer will take charge of the expenses for the Insured's transportation to the Hospital, the stay thereat and the healthcare services necessary to cure the Insured, including pharmaceutical expenses **up to the limit of 20,000 euros per Claim and Insured.**

- **Guarantee two: emergency dental expenses while abroad**

In the case of a trip abroad, the Insurer will take charge of treatment expenses as a consequence of the onset of acute dental problems such as infections, toothache, broken teeth, filling falling out, etc. **requiring emergency treatment, up to the limit of 300 euros per Claim and Insured.**

- **Guarantee three: transport by ambulance or medical repatriation**

The Insurer will proceed with transport to a Hospital in Spain, providing medical or healthcare attention where necessary, for any Insured who has suffered an Accident or Serious Illness requiring life-saving care, and provided that this is so decided by the Insurer's medical services in collaboration with the Physician treating the Insured, when the Insured is unable to continue the journey by his or her own unaided efforts.

Transportation by ambulance will be effected in the most suitable means having regard for the state of the patient or accident victim, as well as for the other considerations of a healthcare nature and the availability of resources. **In any case, an air ambulance will only be used in Europe and countries bordering the Mediterranean.**

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In the event of benign conditions or minor injuries that do not require medical repatriation, the Insurer will take charge of the Insured's transportation in a vehicle or ambulance to the place at which the necessary healthcare can be provided.

› **Guarantee four: sending a specialist**

If the severity of the Insured's condition does not allow for transportation by ambulance to Spain as provided for in the preceding cover, and if the Healthcare Assistance that can be provided locally is considered not to be sufficiently suitable in the opinion of the Insurer's medical services, the Insurer will send a Specialist to the place where the Insured is located to provide healthcare attention until such time as medical repatriation can proceed.

› **Guarantee five: sending of medicinal substances**

The Insurer will send medicinal substances of vital interest for the treatment of the Lesions or Serious Illness occurring during the trip abroad where these cannot be obtained at the place where the Insured, patient or accident victim is located. Where the Insurer assumes the medical expenses in accordance with and applying Guarantee One, these expenses shall extend to the cost of the medicinal substances; otherwise, the Insured will only be liable for the price paid by the Insurer for the acquisition of the medicinal substance in question.

› **Guarantee six: remote medical consultation or advice**

Should the Insured require medical information during the journey and this cannot be obtained locally, it may be requested from the Insurer by telephone. The Insurer will provide the information requested through its assistance call centres, without assuming any liability for the said information, in view of the impossibility of giving a diagnosis telephonically.

› **Guarantee seven: administrative steps for hospitalization**

The Insurer will collaborate in the handling of any and all administrative steps needed to be taken to formalize the Insured's admission to the Hospital, following a request to the assistance call centre.

› **Guarantee eight: expenses for the return of persons accompanying the insured**

Where the Insured is hospitalized or transported, because of an Accident or Serious Illness covered by the Policy, and had been travelling with his spouse or Life Partner or direct relatives in the first degree who are unable to continue their trip using the means of transport they had been using, the Insurer will organize and assume the cost of their transportation to the place of origin or their destination, at the choice of the persons accompanying the Insured, using a public means of collective transport, **provided that the cost of transporting them to their destination does not exceed the cost of returning home.**

› **Guarantee nine: return of minors**

If the Insured were travelling in the company of children under 18 years of age and these are left without Healthcare Assistance due to an Accident, Illness or the transportation of the person covered by the Policy, making it impossible for them to continue their journey, the Insurer will organize and assume the cost of their return to the family home in Spain, paying the travel expenses of a relative or friend designated by the Insured to accompany them on their return, if necessary.

If the Insured is unable to designate anyone, the Insurer will provide a travelling companion.

In any case, the transportation of the minors and their travel companion will take place in the most suitable public means of collective transport having regard for the circumstances of the case.

› **Guarantee ten: early return**

If the Insured has to interrupt the planned trip due to the death of a spouse or life partner, parents or offspring in the first degree of consanguinity or affinity of any of the Insured parties, the Insurer will provide a return ticket by rail (first class), air (tourist class) or in the most suitable public means of collective transport in order to reach the place of the deceased relative's place of burial in Spain.

This guarantee extends exceptionally to cases of serious material damage to the family home in Spain.

› **Guarantee eleven: transportation or repatriation of mortal remains**

If the death of the Insured occurs during a trip covered by the Policy, the Insurer will take charge of the necessary steps and expenses for the transportation of his or her mortal remains to the place of their burial in Spain.

› **Guarantee twelve: person accompanying mortal remains**

If there is no-one to accompany the mortal remains of the deceased Insured during their transportation, the Insurer will provide the person domiciled in Spain designated by the relatives with a return ticket by rail (first class), air (tourist class) or in the most suitable public means of collective transport in order to accompany the corpse.

› **Guarantee thirteen: expenses of the person accompanying the mortal remains**

If the preceding cover comes into effect, and if the person accompanying the remains must stay at the place where the demise occurred due to steps related to the transportation of the Insured's mortal remains, the Insurer will take charge of the board and lodgings expenses **up to 60.10 euros per day with a maximum of three (3) days.**

› **Guarantee fourteen: return of the persons accompanying the deceased**

If the deceased Insured had been travelling in the company of his or her partner or relatives, the Insurer will organize and

assume the cost of their return travel in the most suitable public means of collective transport to the family home, provided that they could not continue their journey in the means of locomotion they had been using.

› **Guarantee fifteen: procedural bonds and expenses**

The Insurer will advance to the Insured, following receipt of a formal guarantee to proceed with the refund of the amounts loaned within the term of sixty (60) days, the amount corresponding to expenses for the legal defence of the Insured, 601.01 euros, as well as the amount of any criminal bonds the Insured may be obliged to establish as a consequence of judicial proceedings followed on account of an traffic accident occurring outside the country of habitual residence and/or domicile of the Insured, **up to a maximum of 6,010.12 euros.**

› **Guarantee sixteen: travel information service**

The Insurer will furnish the Insured with basic information by telephone about the issue of passports, visas required, recommended or obligatory vaccinations, currency exchange rates, Spanish consulates and embassies around the world and, in general, useful information for travellers, both prior to the start of a journey or after it has begun.

› **Guarantee seventeen: healthcare information service**

With the prior authorization from the Insured, the Insurer will make available to the Insured's relatives its network of assistance call centres to facilitate any and all information that may be necessary regarding all the Healthcare Assistance operations and help provided.

› **Guarantee eighteen: transmission of urgent messages**

The Insurer will make available to the Insured its network of assistance call centres to transmit any and all urgent messages as may be necessary as a result of the application of the cover and cannot be sent by the Insured in any other way.

› **Guarantee nineteen: sending items forgotten during the trip**

Should the Insured have forgotten any item of luggage or personal objects during the trip, the Insurer will organize and assume the sending of the same to the Insured's domicile in Spain, **up to a maximum of 120.20 euros.**

This guarantee shall also extend to those objects that may have been stolen during the trip and are later recovered.

› **Guarantee twenty: return expenses on hospital discharge**

The Insurer will take charge of the Insured's return expenses when, as a consequence of an accident or illness covered by the policy, he or she has been hospitalized and discharged but, in consequence, has been unable to use the return ticket to Spain due to the impossibility of arriving at the corresponding means of transport at the time and date indicated on the return ticket. **The limit for this guarantee is set at 900 euros.**

› **Guarantee twenty-one: cash delivery while abroad**

If the Insured is deprived of cash as a result of an illness or accident during a trip abroad, the Insurer, upon receipt of pertinent evidence, **will only take charge of the arrangement and costs of sending cash up to a limit of €3000, provided that it is operationally viable.**

The amount sent to the Insured must be repaid to the Insurer within a maximum period of thirty (30) days.

› **Guarantee twenty-two: transportation expenses of the person accompanying the insured**

In case the hospitalization of the Insured, caused by an accident or illness covered by the policy, is expected to last for more than three nights, the Insurer will provide the person designated by the Insured with a return ticket by rail (first class), air (tourist class) or in the public means of collective transport the Insurer deems most suitable in order to accompany the Insured while in hospital.

› **Guarantee twenty-three : board and lodging expenses of the person accompanying the insured while in hospital.**

In case the hospitalization of the Insured, caused by an accident or illness covered by the policy, is expected to last for more than three nights, the Insurer shall bear the board and lodging expenses for the person designated by the Insured at the city where the latter is hospitalized, **up to a limit of €100 per day with a maximum of 10 days.**

This cover also applies even when such person was travelling with the Insured.

› **Guarantee twenty-four: extended stay.**

If the Insured falls ill or suffers an accident while travelling abroad and he or she cannot return on the planned date, the Reinsurer, upon the decision of its medical staff based on their contact with the physician attending the Insured, shall bear those expenses that were not foreseen initially by the Insured and incurred due to the extension of the hotel stay, board and lodging u**p to a limit of €100 per day with a maximum of 10 days.**

STIPULATION TWO: EXCLUSIONS

A) EXCLUSIONS APPLICABLE TO GUARANTEES IN THE EVENT OF LESION OR ILLNESS

The following are excluded from the Policy:

a) **Pre-existing and/or Congenital Illnesses, chronic conditions or those under medical treatment prior to the start of the trip abroad.**

b) **General medical examinations, check-ups and any visit or treatment classified as Preventive Medicine, in accordance with generally accepted medical criteria.**

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c) **Trips intended for the purpose of receiving medical treatment.**

d) **The diagnosis, monitoring and treatment of pregnancy, its voluntary interruption, and deliveries.**

e) **Suicide, attempted suicide or self-inflicted wounds of the Insured.**

f) **The consumption of alcoholic beverages, drugs or medicinal substances, unless the latter have been prescribed by a Physician.**

g) **The treatment, diagnosis and rehabilitation of mental illnesses or nervous disorders.**

h) **Sexually transmitted diseases and subsequent illnesses.**

i) **The acquisition, implantation, replacement, extraction and/or repair of prostheses of all kinds, such as pacemakers, anatomical, orthopaedic or odonatological parts, spectacles, lenses, apparatus for the hard of hearing, crutches, etc.**

j) **Dental, ophthalmological or otorhinolaryngological treatments, except in emergency scenarios.**

k) **Special treatments, experimental surgery, plastic or restorative surgery and other forms of surgery not recognized by Western medical science.**

l) **Any medical expense incurred in Spain, even though it may correspond to a treatment prescribed or begun abroad.**

B) EXCLUSIONS APPLICABLE TO GUARANTEES IN THE EVENT OF DEATH

The following are excluded from the Policy:

a) **Claims occurring as a consequence of the Insured's suicide.**

b) **Burial and ceremonial expenses, as well as the cost of the coffin in the guarantee for transportation or repatriation of mortal remains.**

C) EXCLUSIONS GENERALLY APPLICABLE TO ALL GUARANTEES

The following are excluded from the Policy:

a) **Benefits not notified to the Insurer in advance and those for which the latter's agreement has not been obtained,** except in duly accredited scenarios of material impossibility.

b) **The professional practice of any sport, and the practice as an amateur of winter sports, competitive sports and flagrantly dangerous or high-risk activities.**

c) **Journeys lasting for 90 consecutive days or more.**

d) **The involvement of any official emergency rescue institution or the cost of its services.**

e) **The rescue of persons in mountains, chasms, seas, jungles or deserts.**

f) **Fraudulent acts on the part of the Policyholder, the Insured, the Beneficiary or their relatives.**

g) **Risks derived from the use of nuclear energy.**

h) **Extraordinary risks such as war, terrorism, popular uprisings, strikes, natural phenomena and any other catastrophic phenomenon or events that, in view of their magnitude and severity, are classified as a catastrophe or national calamity.**

STIPULATION THREE: LIMITS OF THE GUARANTEES

The maximum limits of the guarantees in the cover of Assistance While Travelling Abroad shall be those specified for each guarantee. For those guarantees indicated as included and for which no quantitative limit is shown, the maximum limit of the same will be the effective cost of the provision of the service covered by the Insurer. In any case, all limits in this Rider are per Claim and Insured.

STIPULATION FOUR: TERRITORIAL SCOPE

Cover shall be applicable in any country in the world, excluding Spain.

STIPULATION FIVE: PROCESSING OF CLAIMS (TRAVEL ASSISTANCE)

To request any of the Contracted Medical Services under this Rider, it will suffice to place a telephone call to the following telephone number: +34 91 572 44 06. This alert service operates 24 hours a day.

STIPULATION SIX: DATA PROCESSING AND PROTECTION

IRIS GLOBAL Soluciones de Protección Seguros y Reaseguros, S.A., shall process data related to the Insured as data controller, that has been provided as a result of requesting assistance by reason of a Claim. These data may be processed for the purpose of arranging the assistance requested, as well as determining the payment of expenses incurred and assumed by the data subject or, where appropriate, the payment of compensations.

For more information on the processing of personal data

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and to exercise your right to access to your personal data, its rectification or erasure, restriction of processing and to object to processing, as well as the right to data portability and withdrawal of consent you can sent a notification to the following address:

DATA CONTROLLER

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

Calle Ribera del Loira, 4 - 6

28042 MADRID (SPAIN)

proteccion.datos@mail.irisglobal.es

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Parque Empresarial La Finca
Paseo del Club Deportivo 1, Edificio 14. Planta Primera
28223 Pozuelo de Alarcón (Madrid)

www.cigna.es