

ASISA HEALTH STUDENTS

# General Terms and Conditions





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# **ASISA HEALTH STUDENTS GENERAL TERMS AND CONDITIONS**

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## **PRELIMINARY CLAUSE**

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This Insurance Policy is governed by the following regulations: Law 50/1980 of 8 October on Insurance contracts; Law 20/2015 of 14 July on the Regulation, supervision and solvency of insurance and underwriter entities; Royal Decree 1060/2015 of 20 November on the Regulation, supervision and solvency of insurance and underwriter entities and Law 22/2007 of 11 July on Distance marketing of financial services for consumers, and other applicable Spanish legislation.

The following documents form an integral part of the Insurance Policy: Insurance Application, Health Questionnaire, General Terms and Conditions, Particular Terms and Conditions, Special Terms and Conditions (where appropriate), as well as their schedules, appendices and supplements. The clauses limiting the entitlements of the Insured Parties that have been expressly accepted by the Policyholder will apply. Simple transcriptions or references to mandatory legal provisions do not require such acceptance.

The General Directorate of Insurance and Pensions, attached to the Spanish Ministry of Economy, Trade and Enterprise, is responsible for the control and supervision of the insurance activity of ASISA, ASISTENCIA SANITARIA INTERPROVINCIAL DE SEGUROS, S.A.U.

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## **DEFINITIONS**

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For the purposes of this Insurance Policy, the following definitions will apply:

**Accident:** means a bodily injury resulting from a violent, sudden and external cause that is beyond the control of the Insured Party.

**Oral Accident:** means a bodily injury resulting from a violent, sudden and external cause that is beyond the control of the Insured Party, which causes damage to the Insured party's Oral Cavity.

**Insured Party/Parties:** means the natural person named in the Particular Terms and Conditions for whom the insurance is taken out and who, in the absence of a Policyholder, takes on the obligations arising from the Insurance Policy.

**Insurance Company:** means ASISA, ASISTENCIA SANITARIA INTERPROVINCIAL DE SEGUROS, S.A.U., which takes on the contractually agreed risk in exchange for the collection of the Premium. In addition, the Insurance Company may be referred to in this document as the Insurer or ASISA.

**Beneficiary(ies):** means the person(s) entitled to receive, in the event of a Claim, the Insured Sum under this Insurance Policy, in accordance with the Optional Accident Death Benefit and/or Hospitalisation Benefit Cover that has been contracted.

**Oral Cavity:** means the anatomical space consisting of the teeth, their supporting structures, including the palatal and mandibular alveolar ridge, and the overlying gingiva.

**The following are excluded under this definition: facial skin, lips, disorders of the muscles and temporomandibular joint, floor of the mouth and hard and soft palate (except the alveolar part of the hard palate and jaw).**

**Insurance Policy:** means the document containing the terms and conditions governing the insurance. The follow-

ing comprise an integral part of the Insurance Policy: Insurance Application; Health Questionnaire; General Terms and Conditions; Particular Terms and Conditions, which individualise or specify the risk that is insured; Special Terms and Conditions (where appropriate); supplements, schedules or appendices that are issued to complement or modify it during the insurance term.

**Table of Coverage and Excesses:** means the list of benefits and the Excesses that apply to them that are included under the Optional Dental Insurance Cover, whenever contracted. This is provided in the pre-contractual documentation and is attached as Schedule VII to these General Terms and Conditions.

**Medical Directory/Directory of Doctors and Services:** means the list of healthcare professionals and establishments approved for the insurance product under contract, organised by province, which the Insurance Company makes available to the Insured Party through the offices of its provincial branches, at [www.asisa.es](http://www.asisa.es) and on the ASISA App.

The information in the Medical Directory/Directory of Doctors and Services may undergo changes. Accordingly, it is recommended that prior to requesting and receiving any service, you first confirm that the healthcare professional or health centre is indeed approved by ASISA to provide the service in question. In the event of any contingency, consult with the Insurance Company through the available information channels.

The Policyholder and the Insured Party are hereby informed and accept that the healthcare professionals and health centres indicated in the Medical Directory/Directory of Doctors and Services are acting with full independence of criteria, autonomy and exclusive liability within the scope of the health services they provide.

**Medical Directory/Directory of Dentists and Dental Services:** means the list of healthcare professionals and establishments approved for the Optional Dental Insurance Cover, organised by province, which the Insurance Company makes available to the Insured Party through its branch offices, at [www.asisa.es](http://www.asisa.es) and on the ASISA App.

The information in the Medical Directory/Directory of Dentists and Dental Services may undergo changes. Accordingly, it is recommended that prior to requesting and receiving any service, you first confirm that the healthcare professional or dentist's consulting room is indeed approved by ASISA to provide the service in question. In the event of any contingency, consult with the Insurance Company through the available information channels.

The Policyholder and the Insured Party are hereby informed and accept that the healthcare professionals and health centres indicated in the Medical Directory/Directory of Dentists and Dental Services are acting with full independence of criteria, autonomy and exclusive liability within the scope of the health services they provide.

**Health Questionnaire:** means the declaration that must be made truthfully and completely by the Policyholder/Insured Party prior to signing the Insurance Policy and which enables the Insurance Company to assess the risk to be insured.

**Previous or Pre-existing Ailment/Illness:** means an alteration to the state or condition of health of the Insured Party that exists prior to taking out or being added to the Insurance Policy and that would normally have been perceived by signs or symptoms, regardless of the existence of a medical diagnosis.

**Wilful Misconduct:** means an act or omission committed by fraud, deceit or concealment in relation to matters

relevant to the conclusion and performance of the Insurance Policy or to the determination of the corresponding benefits or compensations, with the intention of causing damage or obtaining a benefit.

**Address of the Policyholder and/or the Insured Party:** means the one stated in the Particular Terms and Conditions.

**Illness:** means any alteration to the Insured Party's health not caused by an Accident, diagnosed by a doctor and which requires the provision of medical care or, where appropriate, the payment of compensation.

**Start Date:** means the date and time of entry into force of the Insurance Policy and/or any of the Optional Cover taken out at a later time. It is indicated in the Particular Terms and Conditions and, if applicable, in the supplement for which at least one Optional Cover is contracted.

**Initially Planned Therapeutic Objective:** for the purposes of the Optional Dental Insurance Cover, it means the medical-dental objective pursuant to the initial diagnosis regarding the Insured Party that led to commencement of the Initial Dental Treatment.

**Excess:** for the purposes of the Optional Dental Insurance Cover, it means the amount that the Insured Party must pay to the health professional or healthcare centre approved by the Insurance Company for the covered dental services provided. This amount, which may vary depending on the dental service in question, will be determined in the Table of Coverage and Excesses.

**Mandatory Healthcare Cover:** means the basic healthcare cover that is taken out in all cases under this Insurance Policy. It comprises the healthcare Benefits established in the Second Clause to the General Terms and Conditions

and is regulated by the rest of the applicable clauses therein and by the Particular Terms and Conditions.

**Optional Cover:** means the cover regulated by the Fifth Clause to the General Terms and Conditions (Accidental Death Benefit, Hospitalisation Benefit and Dental Insurance) and refers to the cover stated in the pre-contractual documentation. This cover can be taken out voluntarily by the Policyholder at the time of signing the Insurance Policy or at a later time. Its specific terms and conditions are set out in the Particular Terms and Conditions or applicable supplement.

**Hospital:** means an establishment intended for the continuous care and assistance of the sick and injured by means of medical and nursing staff, 24 hours a day, and which has the appropriate material resources for this purpose.

**Day Hospital:** means a hospital unit for medical and surgical procedures, with or without anaesthesia, involving a registered stay of the patient of less than 24 hours.

**Hospitalisation:** means the stay of an Insured Party in a Hospital for a minimum of 24 hours.

**Implantology:** for the purposes of the Optional Dental Insurance Cover, it means the prosthodontic rehabilitation of the totally or partially edentulous patient using intraosseous dental implants placed by means of a surgical procedure.

**Discharge Report:** for the purposes of the Optional Dental Insurance Cover, it means a document issued by the dentist who coordinates the Initial Dental Treatment and the Restorative Dental Treatment, once the said dentist considers that the treatments have been completed after having accomplished the Initially Planned Therapeutic Objective.

**Orthodontics:** for the purposes of the Optional Dental Insurance Cover, it means the dental speciality that studies, prevents and corrects alterations in development

and shapes of the dental arches and the position of the jaws with a view to re-establishing the morphological and functional balance of the mouth and face, improving, or potentially also improving, facial appearance.

**Medical Problems or Situations Unrelated to the Treatment:** for the purposes of the Optional Dental Insurance Cover, these are understood to be those pathological contingencies occurring that are unrelated to the treatment which, once the treatment has been completed and the Initially Planned Therapeutic Objective has been accomplished, may appear and which directly and negatively affect the planned evolution subsequent to the Discharge Report, provided that they require the medical-dental attention covered by the Optional Cover for recovery from the Initially Planned Therapeutic Objective.

**Waiting Period:** means a period of time during which some of the benefits established in the Insurance Policy are not covered. The Waiting Periods established in each case are calculated from the Insurance Policy start date or the effective date of the Optional Cover if it was not taken out at the same time as the Mandatory Cover or, where appropriate, from the date of registration of a new Insured Party. There are no Waiting Periods under this Insurance Policy.

**Insurance Term:** means the period of time between the Start Date of the Insurance Policy/registering of a new Insured Party, or of the entry into force of Optional Cover, if it was not taken out at the same time as the Mandatory Cover, and that of its termination (expiry).

**Benefit:** means the coverage for the assistance provided due to a Claim under these General Terms and Conditions.

**Premium:** means the price of the insurance. The Premium receipt will also contain the legally applicable surcharges and taxes.

**Claim:** means an event envisaged in the Insurance Policy which, once it has occurred, gives rise to the Insurance Company's obligation to provide the Insured Party with assistance within the scope established therein or to the payment of compensation in accordance with the Insured Sum established in each case in the Particular Terms and Conditions for the Optional Cover taken out. In the case of compensatory cover, all the damages arising from the same event constitute a single Claim.

**Insurance Application:** means a form supplied by the Insurance Company in which the Policyholder asks to take out the Insurance Policy.

**Insured Sum:** means the amount of compensation to be paid by the Insurance Company in the event of a Claim. The Particular Terms and Conditions of the policy indicate the Insured Sum for each event covered, depending on the Optional Cover taken out.

**Health Card:** means the document owned by ASISA, ASISTENCIA SANITARIA INTERPROVINCIAL DE SEGUROS, S.A.U., which is given to each Insured Party, the use of which is personal and non-transferable and required to receive the services covered by the Insurance Policy.

**Policyholder (Contracting Party):** means the natural or legal person who, together with the Insurance Company, enters into this Insurance Policy, and to whom the obligations and duties arising thereof respond, except for those which by their nature correspond to the Insured Party and/or Beneficiary(ies).

**Initial Dental Treatment:** means a dental treatment initially undergone by the Insured Party, the subsequent contingencies of which are covered by the Optional Dental Insurance Cover.

**Restorative Dental Treatment:** for the purposes of the Optional Dental Insurance Cover, it means the dental treatment that the Insured Party has undergone in order to recover the Initially Planned Therapeutic Objective.

**Emergency:** means a situation which, due to the problem or symptoms, requires immediate medical attention.

**Life-threatening Emergency:** means a situation in which a problem has suddenly or abruptly occurred the nature and symptoms of which make it likely that there is an imminent or very high risk to the life of the Insured Party, or irreparable damage to the Insured Party's physical integrity unless immediate therapeutic action is taken.

## CLAUSES

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### **ONE: SUBJECT MATTER AND COVERAGE LIMIT**

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This is a health Insurance Policy that includes Mandatory Healthcare Cover through a specific Medical Directory/ Directory of Doctors and Services that apply to the product and which has been approved by the Insurance Company.

Accordingly, within the limits and conditions stipulated in the Insurance Policy, and after signing it and paying the Premium for the Mandatory Healthcare Cover, the Insurance Company will place at the disposal of the Insured Party, within the national territory, a wide range of duly authorised health professionals, centres and services, from which the Insured Party may request healthcare in those specialities and disciplines included in this Mandatory Healthcare Cover, **provided that these are resources or techniques recognised by standard medical practice at the time of taking out this Insurance Policy.**

As long as the provisions of this Insurance Policy are

met, the Insurance Company will directly cover the cost of the care provided to the Insured Party by the aforementioned health professionals, centres and services, with the Insured Party being obliged to use the means of identification/payment indicated by the Insurance Company. **Under no circumstances whatsoever may optional compensation be given in lieu of the healthcare services covered by this Mandatory Healthcare Cover.**

Whatever the case, in accordance with the provisions of Article 103 of the Law on insurance contracts, the Insurance Company undertakes to provide the necessary urgent care, for the time required, in accordance with the terms and conditions of the Insurance Policy, which in any case will be provided through the means approved by the Insurance Company in accordance with the Medical Directory/Directory of Doctors and Services that applies to this Mandatory Healthcare Cover.

Furthermore, the Policyholder may voluntarily request, at the time of taking out the Insurance Policy or at a later date, to take out all or some of the Optional Cover detailed in the Fifth Clause to these General Terms and Conditions (Accidental Death Benefit, Hospitalisation Benefit and Dental Insurance), subject to the requirements established by the Insurance Company. The specific terms and conditions of the said Optional Cover are set out in the Particular Terms and Conditions or applicable supplement.

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## **TWO: MANDATORY HEALTHCARE COVER. DESCRIPTION OF THE INSURED BENEFITS**

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In order to access the benefits insured under this Mandatory Healthcare Cover, the Insurance Company provides the Insured Party with a Medical Directory/Directory of

Doctors and Services which includes the Emergency Services, the list of doctors for the different specialities, nursing professionals, other healthcare professionals and health centres approved in the respective province.

## **1.- Emergency Service**

The Insurance Company has an Emergency and Urgent Care Coordination Centre for the whole of Spain that operates 24/7 every day of the year via the free telephone number 900 900 118. This centre offers a comprehensive service for emergency care through which urgent assistance and information on emergencies can be requested nationwide (medical consultation by telephone; medical, paediatric and nursing visits at home in provincial capitals and large towns; emergency ambulances and information on approved emergency services and hospitals).

Moreover, in each provincial capital and in other large towns, the Insurance Company provides the Insured Party with a 24/7 home emergency service, as well as a permanent hospital emergency service at approved centres.

The Medical Directory/Directory of Doctors and Services made available to the Insured Party via various media (provincial offices, ASISA website—[www.asisa.es](http://www.asisa.es)—, mobile phone app, and other available information channels) lists the telephone numbers where any service should be requested and the centres to be contacted in the event of an emergency.

## **2.- Primary medicine: general or family medicine, paediatrics, nursing.**

### **2.1.- General or family medicine.**

This includes medical care in consulting rooms, on request and as scheduled, as well as the indication or pre-

scription of basic diagnostic and therapeutic procedures (analytical tests and general radiology).

The care will be provided in the doctor's consulting room and, **when the circumstances require it, in the opinion of the doctor in the Insurance Company's Medical Directory/Directory of Doctors and Services, it may be provided at the Insured Party's home, whenever possible, for those patients who due to their problem are unable to visit a centre.**

## **2.2.- Paediatrics**

This includes on-demand and scheduled medical care in consulting rooms for children **up to and including 14 years of age**, as well as the indication of basic diagnostic and therapeutic procedures (analysis and general radiology).

The care will be provided in the doctor's consulting room and, **when the circumstances require it, in the opinion of the doctor in the Insurance Company's Medical Directory/Directory of Doctors and Services, it may be provided at the Insured Party's home, whenever possible, for those patients who due to their problem are unable to visit a centre.**

Newborns will be entitled to this medical care, at the doctor's consulting room or at home, **under the insured mother's Insurance Policy and for a maximum term of the first thirty (30) days of life.** For the care to continue, the newborns must be registered as insured with the Insurance Company within the aforementioned period through this insurance product (or another healthcare insurance with identical or enhanced coverage), within the aforementioned period as stipulated in Ninth Clause (b).

## **2.3.- Nursing**

This service may be provided in a consulting room or at

the Insured Party's own home, **whenever possible and when the Insured Party needs to be tended to at home as a result of being unable to travel due to their condition.**

**Whatever the case, a prior prescription from a doctor in the Insurance Company's Medical Directory/Directory of Doctors and Service treating the patient is required, duly indicating the treatment and its duration.**

### **3.- Specialised medicine**

Consultation of medical specialities: the Insured Party may freely choose the specialist doctor from the Medical Directory/Directory of Doctors and Services for the following specialities:

- Allergology
- Anaesthesiology and resuscitation
- Angiology and vascular surgery unit
- Digestive system
- Cardiology
- Cardiovascular surgery
- General and digestive surgery Proctology
- Oral and maxillofacial surgery
- Orthopaedics and traumatology surgery
- Paediatric surgery
- Plastic and reconstructive surgery
- Thoracic surgery
- Medical-surgical dermatology and venereology
- Endochrynology and nutrition
- Stomatology and dentistry
- Geriatrics

- Haematology and haemotherapy
- Physical medicine and rehabilitation
- Internal medicine
- Nuclear medicine
- Nephrology
- Pneumology
- Neurosurgery
- Clinical neurophysiology
- Neurology
- Obstetrics and gynaecology
- Ophthalmology
- Medical oncology
- Radiation oncology
- Otolaryngology
- Psychiatry
- Rheumatology
- Urology

Whenever the Insurance Company does not have professionals of a particular speciality in a certain province, the Insured Party can make use of this service through the Insurance Company's Medical Directory/Directory of Doctors and Services in any other province in which the said speciality exists. **Under no circumstances whatsoever will any travel expenses involved be covered by the Insurance Company.**

#### **4.- Means of diagnosis**

**All means of diagnosis require a prior written prescription from a doctor specialising in the subject from the Insurance Company's Medical Directory/Directory of**

**Doctors and Services. Likewise, diagnoses must in all cases be carried out by a doctor or centre approved by the Insurance Company for the specific case.**

**For those services in this section marked with an asterisk (\*), prior express authorisation from the Insurance Company is also required.**

For instance, the following means of diagnosis are considered to be covered:

Clinical analyses: haematology, biochemistry, bacteriology and immunology, cytology and karyotypes (\*).

Genetic testing (\*): **exclusively when the purpose is to diagnose a specific disease, in accordance with the corresponding protocols and clinical guidelines in patients affected and showing signs or symptoms of it.**

Genetic testing to identify therapeutic targets in neoplastic processes (\*) are also included, **the determination of which is required in the technical file of the anti-tumour medicinal product drawn up by the corresponding health authority.**

The Oncotype® and MammaPrint® genomic platforms for breast cancer are also covered (\*) **as long as they comply with the recommendations established for each of them. A prescription and report by a medical oncology specialist from the Insurance Company's Medical Directory/Directory of Doctors and Services is required, stating the platform requested (only Oncotype® or MammaPrint®).**

Prenatal foetal DNA screening in maternal blood is also included (\*) **exclusively to detect the foetal aneuploidy of chromosomes 13, 18 and 21 and of sex chromosome anomalies, when so indicated according to the risk indexes established at any given time by the Spanish**

**Society of Gynaecology and Obstetrics (Sociedad Española de Ginecología y Obstetricia).**

**Genetic testing to identify carriers, pre-symptomatic studies or testing for genetic counselling; family, genealogical testing or parentage identification studies are not covered; neither is testing for prenatal genetic diagnosis (except foetal DNA in maternal blood under the conditions indicated above) nor for preimplantation genetic diagnosis.**

**Genetic studies that are covered always require a prescription and report by a doctor specialising in the subject from the Insurance Company's Medical Directory/Directory of Doctors and Services, in addition to prior and express authorisation by the Insurance Company.**

Anatomical pathology: includes general anatomopathological studies (biopsies, cytology and immunohistochemical studies), as well as molecular genetic studies (\*) that are essential to diagnose certain diseases in affected and symptomatic patients and to identify therapeutic targets **under the conditions and subject to the limits and exclusions detailed in the section on genetic studies.**

**Neither necropsies nor autopsies are covered.**

Diagnostic imaging and nuclear medicine: conventional radiology, vascular or diagnostic interventional radiology (\*), Doppler ultrasonography, hepatic elastography, mammography, digital mammography, Computerized Axial Tomography Scan (CT) (\*) **(excludes a spectral CT)**, Magnetic Resonance Imaging (MRI) (includes cardiac MRI, MR enterography and prostrate multiparametric MRI)(\*), bone densitometry, gammagraphic studies (\*), Single Photon Emission Computed Tomography (SPECT)(\*) and SPECT-CT (\*), Positron Emission Tomography (PET) and PET CT (\*) **(exclusively for those oncological, cardiac and neurological problems for**

which the FDG marker is approved by the Spanish Agency of Medicines and Medical Devices in accordance with its technical data sheet), included in Schedule I to these General Terms and Conditions (\*). PET-MRI is not covered.

Circulatory system: electrocardiogram and phonocardiogram. Echocardiogram, Doppler, catheterisation (\*), Holter monitor (ECG and BP; **implantable Holter monitors or ILR are not covered**), ergometry and cardiac electrophysiological studies (\*).

Digestive system: endoscopy, virtual colonoscopy (\*), capsule endoscopy test (\*) (**only for the diagnosis of gastrointestinal bleeding or intestinal bleeding of unknown or hidden origin**).

Clinical neurophysiology: electroencephalogram, echoencephalogram, electronystagmography, electromyography, electroretinography and nerve conduction velocity measurement. Polysomnographic study **only for sleep apnoea/hypopnoea syndrome (SAHS), respiratory problems and neuromuscular diseases, narcolepsy and other hypersomnias and seizures or epilepsy** (\*).

Obstetrics and gynaecology: diagnostic laparoscopy (\*), diagnostic hysteroscopy (\*), ultrasound, foetal monitoring, amniocentesis (\*), karyotyping (\*). Pregnancy control including triple screening, as well as non-invasive prenatal screening by studying the foetal DNA in maternal blood (\*), **exclusively to detect the foetal aneuploidy of chromosomes 13, 18 and 21 and of sex chromosome anomalies, when so indicated according to the risk indexes established by the Spanish Society of Gynaecology and Obstetrics (Sociedad Española de Ginecología y Obstetricia)**.

Surgery: fundus photography, fluorescein angiography, Optical Coherence Tomography (OCT), visual field test, ultrasound.

Otolaryngology: direct and indirect laryngoscopy, diagnostic tests for vestibular pathology (electronystagmography, videonystagmography) (\*) auditory evoked potentials and otoacoustic emissions.

Urology: urethrocystoscopy, cystoscopy, ureteroscopy, flowmetry and urodynamic testing.

Fusion prostate biopsy is covered (\*) **only when there is a high clinical suspicion of prostate cancer accredited by a medical report based on PSA values and the rate of PSA increase, and as long as a previous conventional or ultrasound-guided biopsy has been performed within the last year with a negative result.**

## 5.- Special treatment techniques.

**All special treatment techniques always require prior written prescription from a doctor specialising in the subject from the Insurance Company's Medical Directory/Directory of Doctors and Services. They must also be carried out in all cases by a doctor or centre approved by the Insurance Company for the specific case.**

**Moreover, prior express authorisation by the Insurance Company is required in all cases.**

These services include:

Aerosols, ventilotherapy and oxygen therapy at home using a single source of oxygen **(medication to be paid for by the Insured Party)**: home treatment by means of continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BPAP) (mechanical positive airway pressure devices) is covered **for obstructive sleep apnoea-hypopnoea syndrome, as well as for respiratory insufficiency and chronic obstructive pulmonary disease (COPD)**. Titration polysomnography is also included to adjust the device.

Circulatory system: cardiac catheterisation with or without angioplasty, therapeutic cardiac electrophysiological study (AV node ablation, accessory pathways or ventricular tachycardias). **Ablation or isolation of pulmonary veins is not covered.**

Breast cancer surgery: breast reconstruction is covered **exclusively after mastectomy due to neoplasia**, including breast expanders and prostheses if necessary, as well as DIEP or TRAM flap techniques. In these cases, the symmetrisation of the contralateral breast is also covered **as long as it is done in the same procedure to reconstruct the breast affected by the neoplasia, or within six (6) months following said reconstruction, at the latest.**

Laser surgery: cover is **only provided for otolaryngology, gynaecology, proctology (for haemorrhoids, anal and perianal fistulas and fissures, condyloma and rectal polyps), ophthalmology (photocoagulation in retinal pathologies and laser treatment of glaucoma), pneumology (therapeutic bronchoscopy with laser) and urology (ureteroscopy with laser lithotripsy; also included are green—KTP and HPS—, diode, holmium or thulium lasers to treat benign prostatic hyperplasia).** In angiology and vascular surgery, **endoluminal laser treatment for varicose veins is covered, as well as radiofrequency and microfoam, exclusively in processes with symptomatic clinical venous insufficiency (CEAP class C3 or higher).** Treatment for cosmetic reasons is not covered under any circumstance.

Extracorporeal lithotripsy: to treat urolithiasis. **Gallstones treatment is not covered.**

Nuclear medicine: **the Insured Party will bear the cost of the medication**, except in those treatments that are carried out as a hospital in-patient.

Neurophysiological monitoring: it will be covered **only for surgeries in which a risk to nerve structures is clearly identified during the operation.**

Neuronavigation: it is covered **only for operations on the brain and on major spinal deformities.**

Oncology: The following treatments are covered:

Chemotherapy: includes chemotherapeutic and immunotherapeutic oncological antineoplastic drugs used in intravenous or intravesical chemotherapy administered in oncology units on a day-hospital basis. **Special forms of chemotherapy such as intraoperative chemotherapy or intraperitoneal chemotherapy; radiotherapy, including intensity-modulated radiotherapy, as well as brachytherapy to treat prostate, gynaecological, genital and breast cancer are not covered.** Stereotactic radiosurgery is covered **exclusively for tumours located in the central nervous system (stereotactic radiosurgery for other problems, Gamma Knife or Cyberknife radiosurgery, tomotherapy, intraoperative radiation therapy, proton therapy, and other special forms of radiotherapy are not covered).**

Therapeutic interventional radiology

Rehabilitation: outpatient physiotherapy treatment is covered **only for locomotor apparatus problems with a recoverable functional deficit until the injuries are stabilised.** Physiotherapy, electrotherapy, kinesitherapy, magnetotherapy, lasertherapy, as well as shockwave treatments are included for the following osteotendinous injuries: degenerative tendinopathies, tendinosis, osteonecrosis, pseudoarthrosis, osteochondritis and calcifications.

The following are also covered:

- Pelvic floor rehabilitation.
- Vestibular rehabilitation.
- Cardiac rehabilitation.
- Lymphatic drainage: **only in the case of alterations caused by oncological processes and treatments.**
- In speech therapy/phoniatrics: **only the treatment of recoverable speech and voice articulation disorders arising from organic processes until the stabilisation of the process are covered. Treatments for learning disorders, dyslexia, dysgraphia or dyscalculia are not covered.**
- Orthoptic and pleoptic treatments are covered.

**In addition to prior authorisation from the Insurance Company, a medical report duly signed by the prescriber is required for all rehabilitation benefits.**

Dialysis: haemodialysis and peritoneal dialysis **only for acute or chronic renal failure.**

Pain treatment: **implantable drug pumps, electrodes and devices for spinal cord or brain stimulation are not covered.**

## **6.- Other coverage**

### **6.1.- Chiropody:**

The chiropody service, which includes consultation and/or chiropody treatment, **is provided only in consulting rooms and with a limit of twelve (12) sessions per policy year. If the Insurance Policy has a term of less than twelve (12) months, the number of psychotherapy sessions will be reduced proportionally.**

A biomechanical gait analysis is also covered. **It requires a prescription from a specialist in the area in the Insur-**

**ance Company's Medical Directory/Directory of Doctors and Services. Likewise, the analysis must always be carried out by a professional or centre approved by the Insurance Company for the specific case.**

### **6.2.- Psychotherapy:**

To treat mental health-related illnesses of psychological origin and of a temporary nature (adaptation and stress related disorders, temporary depressive disorders, behavioural disorders, anorexia and bulimia). **A prior prescription and report by a specialist in psychiatry from the Insurance Company's Medical Directory/Directory of Doctors and Services is required, as is express prior authorisation from the Insurance Company for an approved professional/centre.**

**The maximum number of sessions covered by the Insurance Company is twenty (20) sessions per policy year for all the disorders covered by this benefit, except for eating disorders, anorexia and bulimia, the limit for which will be forty (40) sessions per policy year. Treatment of psychological disorders caused by bullying at school, cyberbullying and gender-based violence is covered to a maximum limit of forty (40) sessions per policy year. If the Insurance Policy has a term of less than twelve (12) months, the number of psychotherapy sessions will be reduced proportionally.**

**Psychological or neuropsychological tests, educational psychology, group and couple psychotherapy, psychoanalysis or psychoanalytical therapies, outpatient treatment for narcolepsy and hypnosis are not covered by the Insurance Company.**

### **6.3.- Family planning:**

Consultation, vasectomy, tubal ligation and IUD implanta-

tion, including the cost of the device are covered (**hormonal IUDs are not covered**). Diagnostic study of the causes of sterility or infertility (serological and hormonal tests, karyotype, as well as hysterosalpingography in women and spermogram in men).

#### **6.4.- Preparation for childbirth:**

Through courses that include theoretical and practical training, with physical exercises, relaxation techniques, expulsion techniques and simulation of the period of dilatation and labour.

**A prescription is required from a specialist in obstetrics and gynaecology in the Insurance Company's Medical Directory/Directory of Doctors and Services. Likewise, the analysis must always be carried out by a professional or centre approved by the Insurance Company for the specific case.**

#### **6.5.- Stomatology and dentistry:**

In addition to consultations and check-ups, dental extractions, dental cleaning (tartrectomy) and cures are covered, as is dental radiology for these treatments and fluoride treatment **only for children under 6 years of age.**

#### **6.6.- Second opinion**

The Insured Party will be entitled to the provision of the second medical opinion service for certain disorders and clinical symptoms that are indicated in Schedule II hereto, which also indicates how to avail of this service.

#### **6.7.- Preventive medicine**

This covers paediatrics, gynaecology, cardiology, urology and digestive system programmes in accordance with the generally accepted recommendations that are listed in Schedule III hereto.

## 6.8.- Virtual doctor

This service, which is available to the Insured Party via the private area of the ASISA website ([www.asisa.es](http://www.asisa.es)) or the ASISA app for mobile devices, offers a medical team that attends, informs and advises the Insured Party on any doubts and queries they may have regarding any disorder or health problem.

## 7.- Hospitalisation and Day Hospital

a) Hospitalisation:

Hospitalisation, which must always be at a centre approved by the Insurance Company, comprises a single room with a bed for a companion, **unless this proves manifestly impossible, and except for cases of psychiatric, neonatal or intensive care unit hospitalisation.** In addition to the room and board services for the patient, complementary diagnostic examinations, necessary therapeutic actions, medication, transfusions and possible surgical treatment are covered, including operating theatre expenses, medication and anaesthesia, **all in accordance with the General and Particular Terms and Conditions of the Insurance Policy.**

**It is essential to have the appropriate prescription issued by the doctor who is going to treat the Insured Party, who must be a specialist in the matter belonging to the Medical Directory/Directory of Doctors and Services and expressly authorised by the Insurance Company prior to Hospitalisation. The prescription must state the reason for Hospitalisation, the operation to be done or care to be provided and the expected number of Hospitalisation days. The doctor's order must be issued for a centre approved by the Insurance Company and the reason for Hospitalisation must be one of the services covered by the Mandatory Cover.**

When Hospitalisation responds to an emergency, a written prescription from the doctor in the Medical Directory/Directory of Doctors and Services or the admission report from the centre will suffice. Moreover, **the Insurance Company must be notified of the circumstance requiring Hospitalisation within seven (7) days, requesting the corresponding authorisation to bind the Insurance Company financially.**

**If these requirements are not met, the Insurance Company will not provide this cover and will not be liable for any healthcare benefits or any other financial obligation, directly or indirectly related to the cause of the admission.**

There is no limit to hospital stay, **except for that which is foreseen in each case. The stay will depend on whether or not, according to the criteria of the doctor in charge of the treatment in the Insurance Company's Medical Directory/Directory of Doctors and Services, there is a technical need for this stay or not. Notwithstanding, Hospitalisation authorisations will have a limit on the amount of days stay determined by the written estimate of the doctor who orders the admission, or by the statistical averages for each process estimated by the Insurance Company. To obtain one or more extensions to the Hospitalisation days, a new report must be submitted by the doctor in charge of the case, stating the reasons for the extension of the stay and an estimate to this effect.**

**Under no circumstances will reasons other than medical reasons, such as social problems (family care difficulties at home, absence of relatives, etc.), be accepted as a reason for staying in hospital.**

**Expenses arising from Hospitalisation in a (private or**

public) centre not approved by the Insurance Company are not covered, even if they have been prescribed by professionals in the Insurance Company's Medical Directory/Directory of Doctors and Services, unless they have arisen due to a life-threatening emergency. In these cases, the Insurance Company must be notified and this circumstance accredited within a maximum period of seven (7) days. A prerequisite in these circumstances is that the Hospitalisation be at the centre closest to the place where the life-threatening emergency occurred. As soon as the Insured Party's medical situation allows, the Insured Party must be transferred to an approved centre, which will require prior coordination with the Insurance Company.

Hospitalisation cover includes:

- Maternity Hospitalisation: medical care at childbirth or for caesarean section and the postpartum period, provided by an obstetrician and midwife in the Insurance Company's Medical Directory/Directory of Doctors and Services. It also covers anaesthesia in normal deliveries.
- Paediatric Hospitalisation: **only for children up to and including 14 years of age.**

Care of the newborn, under the paediatrician's instructions, from the moment of birth.

Hospitalisation is also covered for medical or surgical reasons in a centre approved by the Insurance Company, including, if necessary, admission of the newborn (neonatology, incubator). When the age of the child and the centre allow it, the sick person may be accompanied.

**As long as the birth/caesarean section has been cov-**

**ered by ASISA, the newborn will be entitled to paediatric Hospitalisation, exclusively for medical reasons, under the mother's Insurance Policy, up to a maximum of thirty (30) days from the date of birth.** Consequently, in order to obtain cover from the Insurance Company beyond the aforementioned period or for reasons other than Hospitalisation for medical reasons (for example, surgical care, whatever the care regime under which it is provided: Hospitalisation, Day Hospital, outpatient, clinic, etc.), it is essential to have the newborn insured by the Insurance Company via this insurance product (or another healthcare insurance policy with identical or better coverage), within the aforementioned period, as stipulated in the Ninth Clause (b) hereto.

- Hospitalisation for surgical reasons: in addition to the costs of the operation, it also covers the preoperative study, as well as the visits and cures in the immediate postoperative period, along with the prostheses or implants expressly specified in section 10 of this Second Clause.
- Hospitalisation for medical reasons (not requiring surgery). To treat conditions that, in the opinion of the specialist in the Medical Directory/Directory of Doctors and Services, cannot be treated at home or on an outpatient basis using the correct techniques, and which require Hospitalisation.
- Psychiatric Hospitalisation: **only for the treatment of patients suffering from acute or chronic psychiatric disorders that have exacerbated and are recoverable.**

**A companion's bed is not included in these cases. A limitation of a fifty (50) day stay in hospital per policy year is established. If the Insurance Policy has a term of less than twelve (12) months, the number of Hospitalisation days will be reduced proportionally.**

Hospitalisation in specialised units: such as intensive care unit (ICU) or a coronary care unit. **A companion's bed is not included in these cases.**

b) Day Hospital:

includes hospital care for medical and surgical procedures, with or without anaesthesia, involving a registered stay of the patient of less than 24 hours.

**In the Day Hospital regime for medical or psychiatric treatment, medication is not covered, except for oncological antineoplastic chemotherapy medication using cytostatics or other drugs, intravenously or intravesically administered in oncology units.**

**It is essential to have the appropriate prescription issued by the doctor who is going to treat the Insured Party, who must be a specialist in the matter belonging to the Medical Directory/Directory of Doctors and Services and expressly authorised by the Insurance Company prior to Hospitalisation. The prescription will state the reason for the care to be provided. The doctor's order must be issued for a centre approved by the Insurance Company and the reason for Hospitalisation must be one of the services covered by the Mandatory Cover. If these requirements are not met, the Insurance Company will not provide this cover and will not be liable for any healthcare benefits or any other financial obligation, directly or indirectly related to reason for the care to be given under the Day Hospital regime.**

## **8.- Outpatient surgery**

It covers any diagnostic or therapeutic intervention prescribed and carried out by a specialist doctor in the Insurance Company's Medical Directory/Directory of Doctors and Services at an authorised centre, approved for this

purpose by the Insurance Company, and which normally requires an operating theatre.

**A written prescription by a specialist doctor in the Medical Directory/Directory of Doctors and Services and express authorisation from the Insurance Company are required.**

### **9.- Transfer of sick persons (ambulance)**

Cover is provided for transfers by ambulance within the national territory, arranged by the Insurance Company from the Insured Party's home or place of residence to an approved centre where the requisite care services covered are to be provided, and from the centre to their home once the care has been completed, and **provided that a doctor in the Insurance Company's Medical Directory/Directory of Doctors and Services prescribes it in writing and that there are special circumstances of physical impossibility that prevent the Insured Party from using ordinary transport services (public transport, taxi, private vehicle or similar).**

**The ambulance service must always be requested through the ASISA Emergency and Urgent Care Coordination Centre, which operates 24/7 throughout the year at the free telephone number 900 900 118.**

**Under no circumstances are transfers by means of transport other than ambulances (medical aircraft, train, boat, helicopter, etc.) or those using means of transport not approved by the Insurance Company covered, including public services.**

### **10.- Prostheses and implants**

The Insurance Company, **upon express authorisation, covers the costs of prescription, implantation and ma-**

**terials exclusively for the internal surgical prostheses and surgical implants detailed below:**

- Internal skeletal prostheses and osteosynthesis material **(implants made of natural bone or bone substitutes are excluded, except for bone grafts, biological ligaments and osteotendinous grafts provided that they are necessary for a surgical intervention previously authorised by the Insurance Company and are requested from approved national bone and tissue banks).**
- Cardiac valve prostheses **(except transcatheter, transapical or percutaneous valve prostheses of any type: TAVI and others);** bypass prostheses, endoprotheses of the aorta and its branches, aortic valve conduits in cases of aortic valve pathology, and coronary stents.
- Single-chamber and dual-chamber pacemakers **(cardiac resynchronisation and atrial pacing devices and, in general, any type of LLR, automatic implantable defibrillator or ICD are not covered).**
- Breast prostheses including expanders **(exclusively after mastectomy for neoplasms).**
- Monofocal intraocular lenses to treat cataracts. **Bifocal, multifocal, toric or refractive correction lenses of any kind are not covered.**
- Synthetic abdominal or thoracic wall meshes **(biological meshes are not covered).**
- Biliary prostheses.
- Embolisation coils.
- CSF shunting systems for hydrocephalus.
- Testicular prostheses.

- Reservoirs for the administration of oncological or pain management drugs (Port-a-Cath® type).

**No prosthesis, material, element or implantable device of any nature, for internal surgical implantation or for external use, whether or not they are active, synthetic or biological, non-autologous, not expressly included in this section 10 of the Second Clause to these Terms and Conditions (relating to prostheses and implants) is covered; nor are the expenses covered relating to their prescription, implantation or control (by means of any type of diagnostic test, surgical intervention or therapeutic act).**

**The prostheses and implants referred to above that incorporate technical modifications in terms of the design and/or type of device, in the elements of their composition, in the material used or in the methods for their implantation, as well as in the energy sources, in the case of active implants, with respect to those in general use up to the moment of contracting, will not be covered unless they are covered by the Mandatory Cover of this Insurance Policy and the Insurance Company has been expressly notified thereof.**

## **11.- Transplants**

The Insurance Company will cover the expenses arising from the performance of bone marrow transplants (both autologous and heterologous) and corneal transplants **(with the cost of the cornea being borne by the Insured Party).**

**Organ procurement and transplantation may only be carried out in accordance with current health legislation. Whatever the case, the Insurance Company will not manage the procurement of the organ or tissue to be transplanted. The Insured Party must manage the**

**procurement of cornea or bone marrow from the donor. Other types of organ, tissue or cell transplants are not covered.**

**A prescription from a medical specialist in the subject in the Medical Directory/Directory of Doctors and Services of the Insurance Company is required, as is express prior authorisation from the Insurance Company.**

### **12.- Accidents at work and compulsory motor vehicle insurance**

Healthcare arising from accidents at work, professional accidents and those covered by the compulsory motor vehicle insurance is covered, **unless expressly excluded in the Particular Terms and Conditions.**

### **13.- Travel assistance**

Any Insured Party residing in Spain will be covered by travel assistance in accordance with the provisions of Schedule IV hereto.

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## **THREE: MANDATORY HEALTHCARE COVER. EXCLUDED BENEFITS**

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**In addition to the exclusions specifically established in each case, healthcare is excluded from Mandatory Cover in the following cases:**

- 1. Healthcare resulting from events arising from armed conflicts, whether or not preceded by an official declaration of war, or terrorism, as well as officially declared epidemics or pandemics.**
- 2. Healthcare directly or indirectly related to chemical, biological, nuclear or radioactive explosions or contamination.**

- 3. Healthcare resulting from extraordinary or catastrophic events such as floods, tornadoes, hurricanes or typhoons, earthquakes, landslides, etc.**
- 4. Healthcare resulting from disorders, situations or processes prior to taking out the Insurance Policy or present at the time of taking out the Insurance Policy, known and not declared in the Health Questionnaire to be completed by the Insured Party, as well as their after-effects, evolutionary outbreaks and complications.**
- 5. Healthcare resulting from disorders produced by the participation of the Insured Party in professional or sporting activities that involve high levels of danger, whether as a professional or amateur, such as: underground, underwater or aerial activities, motor vehicles, boats, boxing and martial arts, bullfighting, climbing, mountaineering, canyoning, bungee jumping, etc. and any other activity of a similar nature or risk.**
- 6. Healthcare resulting from chronic alcoholism, drug addiction, intoxication due to the abuse of alcohol and/or psychotropic drugs (unless prescribed by a doctor), narcotics or hallucinogens.**
- 7. Plastic surgery for cosmetic reasons, as well as any diagnostic or therapeutic technique performed for aesthetic or cosmetic purposes. Gender reassignment surgery. Bariatric surgery (surgical treatment of obesity or for metabolic control). Robotic surgery (using a da Vinci robot or any other device).**
- 8. Preventive medicine (except for the benefits covered in Schedule III hereto), health check-ups or examinations, as well as genetic testing, except for the cases expressly included in the Second Clause (4) (Means of diagnosis) hereto.**

9. Homeopathy, organometry and acupuncture, as well as diagnostic or treatment techniques that are experimental or not recognised by medical science or performed for clinical trials of any kind.
  10. Fillings, dental prostheses, dental implants, periodontal treatments, orthodontics and endodontics, as well as diagnostic tests or studies prior to or related to these treatments and any diagnostic technique or treatment for aesthetic or cosmetic purposes.
  11. With regard to psychiatry and neuropsychiatry, psychological tests and psychoanalysis treatments or techniques, psychotherapy (except for what is established in the psychotherapy benefit in the Second Clause (6.2) hereto), hypnosis, sophrology, neuropsychological or neurorehabilitation treatments and outpatient treatment of narcolepsy are excluded.
  12. With regard to tocogynaecology, infertility treatment techniques, artificial insemination and in vitro fertilisation, hormonal IUDs, as well as 4D obstetric ultrasound scans or higher (5D, 6D, etc.) are excluded. Voluntary termination of pregnancy is also excluded.
  13. With regard to rehabilitation and functional recovery, processes that require educational therapy such as language education in congenital processes or special education in patients with psychiatric disorders are excluded. Also excluded are maintenance and occupational therapies, early stimulation, neurorehabilitation or cognitive stimulation, and, in general, treatments for neurological or neurodegenerative disorders unrelated to the locomotor system.
- Whatever the case, rehabilitation is excluded for

chronic disorders and/or when the process has entered a state of insurmountable stabilisation, in accordance with the report of the rehabilitation doctor in the Medical Directory/Directory of Doctors and Services, except for cases of process exacerbation.

14. Implants made of natural bone (unless needed for operations authorised by the Insurance Company and provided that they are requested from national bone and tissue banks) or bone substitutes, and platelet growth factors. Orthoses, as well as orthopaedic and anatomical products. Penile and scrotal prostheses, breast prostheses and skin expanders (except as indicated in the section on oncological breast surgery in the Second Clause (5) hereto), dental implants, cochlear implants, middle ear implants and any type of implant or prosthesis that is not general surgical practice in the Public Health System. Any expenses relating to the prescription, implantation or prosthetic product or material for internal surgical implantation or for external use, of any product, material or implantable, active, synthetic or biological, non-autologous substance, not expressly included in the Second Clause (10) hereto (relating to prostheses and implants), are not covered. The prostheses covered in the aforementioned Second Clause (10), when they incorporate technical modifications in terms of the design and/or type of device, elements of their composition, the material used, the methods for their implantation, or which involve changes in the energy sources, in the case of active implants, with respect to those in general use up to the time of contracting, unless their incorporation into the cover of this Insurance Policy is previously and expressly communicated by the Insurance Company, are also excluded.

- 15. Medication, except in cases of Hospitalisation and except for oncological antineoplastic chemotherapy medication using cytostatics or other drugs, intravenously or intravesically administered as party of treatment at oncology units on a Day Hospital basis (excluding any other medication administered on a Day Hospital basis). Special forms of chemotherapy, such as intraoperative chemotherapy or intraperitoneal chemotherapy, are excluded. Experimental treatments, treatments for compassionate use and treatments for symptoms other than those authorised in the package leaflet for the medicinal product concerned are excluded in any case.**
- 16. Regenerative and cellular therapies of any kind, as well as treatments based on tissue engineering and gene or genetic therapies and any treatment based on genetic modifications of the patient's cells using any procedure (including CAR T-cell therapies).**
- 17. Positron Emission Tomography (PET) scans (except for the oncological, cardiac and neurological problems indicated in Schedule I hereto). Spectral CT. 4D or higher (5D, 6D, etc.) obstetric ultrasounds.**
- 18. Neurophysiological monitoring and neuronavigation, except for the cases stipulated in the Second Clause hereto.**
- 19. Laser treatment of myopia, hypermetropia, astigmatism and other refractive disorders, as well as surgical laser, whatever the organ to be treated, except in the cases expressly covered in the Second Clause (5) (Special treatment techniques) hereto.**
- 20. Stereotactic radiosurgery, except for the treatment of localised tumour lesions of the central nervous**

system, Gamma Knife or Cyberknife radiosurgery, tomotherapy, intraoperative radiation therapy, proton therapy, as well as other special radiotherapy techniques, except in the cases expressly covered in the Second Clause (8) (Special treatment techniques) hereto. No type of radiotherapy for benign non-oncological pathologies is covered.

21. All types of transplants, except bone marrow (autologous and heterologous) and cornea (with the cost of the cornea being borne by the Insured Party).
22. All means, procedures and techniques of diagnosis or treatment that are not recognised or universalised in standard medical practice, or that are experimental or investigational in nature.
23. Any diagnostic or therapeutic technique not expressly included in the Mandatory Cover of the Insurance Policy, or newly incorporated into standard medical practice, after its taking out, unless the Insurance Company expressly notifies its inclusion. Any diagnostic or therapeutic act that implies a modification with respect to the general medical practice prior to contracting in terms of the approach route, devices used, materials employed and energy sources, unless it is expressly included in the cover by means of prior notification by the Insurance Company.
24. Any assistance prescribed and/or carried out by professionals or centres not approved by the Insurance Company, except as established in the case of Hospitalisation due to a life-threatening emergency.
25. Any assistance (consultation, means of diagnosis, treatment technique, prosthesis or implant, service, etc.) relating to services not covered under the Mandatory Cover provided by this Insurance Policy.

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## **FOUR: MANDATORY HEALTHCARE COVER. USE OF SERVICES**

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### **1. General considerations**

The Insured Party, to whom the exercise of the entitlements included in the Mandatory Cover corresponds, must identify themselves when requesting the insured health services included in the Second Clause hereto by showing the Insurance Company's Health Card, together with their National Identity Card, where appropriate, or any other document that allows them to be identified (passport or driving licence). The aforementioned Health Card is personal and non-transferable, and therefore the improper or fraudulent use of the same entitles the Insurance Company to take the corresponding legal actions and the right to rescind the Insurance Policy as stipulated in the Tenth Clause (c) hereto.

The healthcare costs covered by this Insurance Policy will be paid directly by the Insurance Company to the approved professionals and centres that have provided the service, thus the Insured Party should not advance payment.

**The Insurance Company will not pay for the cost of any service that is not prescribed or provided by professionals in the Medical Directory/Directory of Doctors and Services at centres approved by the Insurance Company.**

For means of diagnosis, special treatment techniques, Hospitalisation and Day Hospital, out-patient surgery and other cover in which the need for a prescription is indicated, **this must be issued by a doctor specialised in the subject matter in the Insurance Company's Medical Directory/Directory of Doctors and Services. When so indicated, any such prescription must be previously**

**and expressly authorised by the Insurance Company through the different channels established for this purpose, in accordance with the instructions provided by the Insurance Company in this respect from time to time. In the case of emergency services that require authorisation by the Insurance Company, this authorisation must be requested no later than seven (7) days as of the date on which they were provided.** The updated list of the services requiring authorisation at any given time can be consulted on the entity's website ([www.asisa.es](http://www.asisa.es)), as well as on the other available information platforms (app, telephone, branch offices, etc.).

In the event that, under the Second Clause hereto, express authorisation is required from the Insurance Company to be entitled to the corresponding benefit (means of diagnosis, special treatment techniques, hospitalisation, outpatient surgery and other specified benefits), it is hereby established that the form provided for this purpose by the Insurance Company will not be valid if, at the moment in which the Insured Party receives the authorised assistance or service, all the requirements established in these General Terms and Conditions are not met in order to be entitled to the healthcare coverage indicated in the authorisation form (e.g. in the event of non-payment of the premium, withholding or inaccuracy in the Health Questionnaire, etc.).

**Given the variations that may occur in the Insurance Company's Medical Directory/Directory of Doctors and Services, it is recommended that the Insured Party, before requesting and receiving the services covered, should make the necessary checks to verify whether or not the professional and/or centre is approved by the Insurance Company for the said service. For this purpose, you can consult the Medical Directory/Directory**

**of Doctors and Services applicable to the insurance product on the Insurance Company's website ([www.asisa.es](http://www.asisa.es)) or App, or through the different information channels that the Insurance Company makes available to the Insured Party.**

**When the Insured Party is in another province of the national territory, it is recommended that the Insurance Company offices of the Provincial Delegations and Sub-delegations or collaborating entities in the provinces in which there is no Provincial Delegation be contacted to find out the approved Medical Directory/Directory of Doctors and Services available should they need to be attended under this Insurance Policy. This information is also available on the ASISA website ([www.asisa.es](http://www.asisa.es)) and the other information channels that the Insurance Company places at your disposal.**

In the event that the Insured Party travels to another province to receive assistance, either at the Insured Party's discretion or because the service is not available in the province where the Insured Party is registered, any travel expenses must be borne by the Insured Party; **under no circumstances whatsoever will they be borne by the Insurance Company.**

## **2. Freedom of choice of doctor**

The general principle of freedom of choice of doctors from among those appearing on the Insurance Company's Medical Directory/Directory of Doctors and Services applies regarding the provision of the healthcare under cover, except for certain specialities which may be provided by a single service provider. The Insured Party must contact the chosen practitioner directly, except in cases where, under this Insurance Policy, additional requirements are necessary.

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## **FIVE: OPTIONAL COVER**

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The Insurance Company offers the following Optional Cover that can be voluntarily taken out in addition to the Mandatory Cover of the Insurance Policy, depending on the specific needs of the Policyholder/Insured Party or Parties. They will take effect as contracted in the Particular Terms and Conditions or supplement to the Policy, as applicable.

### **A. OPTIONAL ACCIDENTAL DEATH BENEFIT COVER**

#### **1. Subject matter of the Optional Accidental Death Benefit Cover**

Under this Optional Cover, the Insurance Company, in the event of an Accident that meets the requirements established in Article 100 of the Law on insurance contracts, undertakes to pay the Beneficiary the compensation agreed in the event of the death of the Insured Party in accordance with the Insured Sum that is established in the Particular Terms and Conditions.

Under Article 101 of the Law on insurance contracts, the Insured Party must notify the Insurance Company of the conclusion of any other accident insurance covering the same person.

Should the Beneficiary wilfully cause the Claim, the compensation will correspond to the Policyholder or, where appropriate, to the heirs of the latter, as provided for under Article 102 of the Law on insurance contracts.

Without prejudice to the application of the definitions set out in the Definitions clause to these General Terms and Conditions, for the purposes of this Optional Cover, an Accident will be deemed to be a bodily injury resulting from a violent, sudden, external cause beyond the

control of the Insured Party, **which results in death immediately or within twenty-four (24) months as of the date on which the injury was sustained.**

**Acute myocardial infarction or other analogous or similar cardiovascular or cerebrovascular events will never be considered as an Accident.**

## **2. Risks excluded from the Optional Accidental Death Benefit Cover**

**The following risks and events are excluded from this Optional Cover:**

- a) Accidents caused intentionally by the Insured Party.**
- b) Death of persons under fourteen (14) years of age or disabled persons.**
- c) Events that are not considered as Accidents as stipulated in the first condition of this Optional Cover.**
- d) Accidents occurring to the Insured Party under the influence of alcoholic drinks or toxic drugs, narcotics or psychotropic substances not medically prescribed, sleepwalking or quarrelling, mental derangement, defiance or other criminal acts, provided that in the latter case the Insured Party has not acted in legitimate self-defence or in an attempt to save persons or property.**
- e) Death caused by diseases in general, whatever their nature.**
- f) Accidents resulting from blindness, deafness or any other physical defect of the Insured Party.**
- g) Those caused by radioactive or nuclear contamination.**
- h) Competitions of speed or endurance, races of any nature as a professional, and their training and preparatory trials.**

- i) Accidents caused by extraordinary or catastrophic events, which will be covered by Spain's Insurance Compensation Consortium (seventeenth clause).**
- j) The use of sailing or motorised vessels further than two miles offshore; the use of motorbikes and the use of privately owned light aircraft.**
- k) The practice of the following sports: boxing, judo, parachuting, caving, scuba diving, hockey, mountaineering, climbing, hang gliding, paragliding or any other similarly dangerous activity.**
- l) Manipulation of electricity at high voltage currents.**

### **3. Conditions to process compensation under the Optional Accidental Death Benefit Cover**

If as a result of an Accident covered by the Optional Cover the Insured Party dies immediately or within the following twenty-four (24) months, the Insurance Company will pay the Insured Sum to the Beneficiary(ies) named by the Policyholder under the provisions of Article 84 and ff. of the Law on insurance contracts.

In the event of death occurring after the established term, the Beneficiary must prove that the death was caused directly by the Accident in accordance with the Eighth Clause (f) hereto.

The Beneficiary must submit the following documents to have the compensation payment processed:

- a) Certificate from the doctor who attended the Insured Party detailing the circumstances and causes of death.
- b) Death certificate.
- c) Documents accrediting the personality and, where applicable, the status of the Beneficiary.
- d) Inheritance tax settlement or certificate of exemption,

where appropriate, and/or form entitled IRPF, Retenciones del Trabajo Personal-Comunicación de Datos al pagador (Personal Income Tax Withholdings-Communication of Data to the Payer).

In accordance with that which is stipulated in the Eighth Clause (f) hereto, the Insurance Company may request all supporting documentation necessary to assess the Claim.

The Insured Sum will be paid to the Policyholder or Policyholder heirs if at the time of the death of the Insured Party there is no Beneficiary specifically named in the Particular Terms and Conditions or supplement or rules to determine such a party.

The Insurance Company will pay the compensation in accordance with the above conditions and without prejudice to the provisions of Articles 18 and 20 of the Law on insurance contracts.

#### **4. Territorial scope of the Optional Accidental Death Benefit Cover**

This Optional Cover extends worldwide.

### **B. OPTIONAL HOSPITALISATION BENEFIT COVER**

#### **1. Subject matter of the Optional Hospitalisation Benefit Cover**

Under the Optional Hospitalisation Benefit Cover, the Insurance Company guarantees the Insured Party the payment of the daily compensation agreed in the Particular Terms and Conditions or supplement for the time that the Insured Party has to remain hospitalised due to Illness or Accident in a clinic, Hospital or sanatorium, whether public or private, **and up to a maximum of 365 days per Claim. If the term of this Optional Cover is less than twelve (12) months, the maximum number of days per Claim will be reduced proportionally.**

To be entitled to the compensation, the Insurance Company must be notified of the Claim no later than seven (7) days as of its occurrence, using the form available for this purpose (Hospitalisation Benefit Application) together with the hospital Discharge Report or supporting documentation duly signed by the doctor in charge of the treatment, which must at least include the date of admission to the Hospital, the reason for admission, evolution and the date of discharge.

In accordance with the Eighth Clause (f) to these General Terms and Conditions, the Insurance Company may request any supporting documentation it deems necessary to assess the Claim. Once the appropriate verifications have been made, the Insurance Company will proceed to pay the compensation relating to each Claim in a single payment.

## **2. Risks excluded from the Optional Hospitalisation Benefit Cover**

**Hospitalisations caused by any of the following circumstances are excluded from this Optional Cover and will not receive any compensation payment:**

- a) Pre-existing Illnesses, disorders, situations or processes prior to taking out the Optional Cover or present at the time of taking out the Optional Cover, known and not declared in the Health Questionnaire to be completed by the Policyholder/Insured Party, as well as their after-effects, evolutionary outbreaks and complications.**
- b) Illnesses caused by disturbances of public order or war.**
- c) Illnesses resulting from atomic or nuclear energy, unless caused as a result of medical treatment.**
- d) Epidemics and pandemics officially declared by the competent national or international body.**

- e) Accidents occurring in any kind of sport practised on a professional basis.
  - f) Cosmetic medicine/surgery operations or treatments.
  - g) Illnesses or injuries caused by or resulting from chronic alcoholism, drug addiction, intoxication due to the abuse of alcohol and/or psychotropic drugs (unless prescribed by a doctor), narcotics or hallucinogens. Suicide attempts.
  - h) Injuries caused by or resulting from the Insured Party's criminal acts and/or participation in a fight, challenge or bet.
  - i) Psychiatric illnesses.
  - j) Hospitalisations following on or arising from pregnancy, abortion or childbirth.
  - k) Hospitalisations and extensions of Hospital stays due to social problems (family care difficulties at home, etc.).
- 3. Territorial scope of the Optional Hospitalisation Benefit Cover**

This Optional Cover extends worldwide.

## **C. OPTIONAL DENTAL INSURANCE COVER**

### **1. Subject matter of the Optional Dental Insurance Cover**

Within the limits and terms and conditions stipulated in this Optional Cover, and upon payment of the corresponding Premium, the Insurance Company undertakes to provide the following cover:

1. Dental care, through the Insurance Company's Medical Directory/Directory of Dentists and Services.

The Insurance Company will provide the Insured Party with a list of duly approved professionals and centres within the national territory where the Insured Party can request the dental health services required, **in accordance with the coverage established in the corresponding Table of Coverage and Excesses.**

The dental services catered for under this Cover are listed in the aforementioned Table of Coverage and Excesses, which is attached as Schedule VII hereto. The Table also specifies the excess amount for each service. **The dental services, and their amounts, may be modified and/or updated annually, in which case the Policyholder will be notified by the Insurance Company beforehand.**

**In no case whatsoever may optional compensation be granted as a substitute for the benefits covered.**

2. Moreover, the following cover to have dental expenses reimbursed is also included:
  - a) Reimbursement of dental expenses for an Oral Accident. The scope of this cover and the information required to have Claims processed is set out in Schedule V hereto.
  - b) Reimbursement of dental expenses for contingencies following the completion of certain dental treatment. The scope of this cover and the information required to have Claims processed is set out in Schedule VI hereto.

Whatever the case, in accordance with the provisions of Article 103 of the Law on insurance contracts, the Insurance Company undertakes to provide the necessary urgent care, for the time required, in accordance with the terms and conditions of the Optional Cover, which in any case will be provided through the means approved by the

Insurance Company indicated in the Medical Directory/ Directory of Dentists and Services.

**The Policyholder will pay the Premium for the Optional Dental Insurance Cover only for Insured Parties over 8 years of age.**

## **2. Risks excluded from the Optional Dental Insurance Cover**

In addition to those that may be established specifically in each case in the Particular Terms and Conditions or applicable supplement, dental benefits are excluded from this Optional Cover in the following cases:

- a) Benefits resulting from events arising from armed conflicts, whether or not preceded by an official declaration of war, as well as officially declared epidemics and pandemics.
- b) Benefits directly or indirectly related to nuclear or radioactive explosions or contamination.
- c) Benefits resulting from extraordinary or catastrophic events such as floods, tornadoes, earthquakes, landslides, etc.
- d) Benefits resulting from the Insured Party's participation in professional or sporting activities that involve high levels of danger, whether as a professional or amateur, such as: underground, underwater or aerial activities, sporting use of motor vehicles, use of boats, boxing, bullfighting, etc. and any other activities of a similar nature.
- e) Benefits or injuries caused by or resulting from mental illness, chronic alcoholism, drug addiction, intoxication due to the abuse of alcohol and/or psychotropic drugs (unless prescribed by a doctor), narcotics or hallucinogens. Suicide attempts.

- f) Injuries caused by or resulting from the Insured Party's criminal acts and/or participation in a fight, challenge or bet.
- g) Any dental treatment or service not expressly included in the Table of Coverage and Excesses or provided by a healthcare provider (doctor or centre) not expressly indicated in the Medical Directory/Directory of Dentists and Services approved by the Insurance Company.
- h) Any dental treatment or service that requires general anaesthesia and/or is provided under a care scheme other than on an outpatient basis in a dental clinic.

### **3. Provision and use of services covered by the Optional Dental Insurance Cover**

The Benefits covered by this Optional Cover, which are those indicated in the Table of Coverage and Excesses, **will be provided exclusively by the dentists and dental clinics included in the Insurance Company's Medical Directory/Directory of Dentists and Services that the Insurance Company provides the Insured Party with, which also specifies the permanent Emergency centre or centres and the addresses and consultation hours of the dentists or dental clinics.** There are no Waiting Periods for this Optional Cover. Accordingly, the cover agreed will be provided by the Insurance Company from the Start Date of the Insurance Policy, or the taking out of the Optional Cover, or the registering of a new Insured Party.

**The Insurance Company accepts no responsibility and will not be liable for the cost of any Benefit not catered for in the Medical Directory/Directory of Dentists and Services.** Exceptions are made for Emergencies provided that they fall within the Benefits of this Optional Cover,

in accordance with the definition provided thereof in the General Terms and Conditions, which will always require authorisation from the Insurance Company no later than seven (7) days as of the date the services were provided.

- a) For the purposes of this Optional Cover, the Claim is understood to have been notified when the Insured Party requests the Benefits covered by the same.
- b) The Insured Party, to whom the exercise of the entitlements included in this Optional Cover corresponds, must identify themselves when requesting the health services covered by showing the Insurance Company's Health Card, together with their National Identity Card or, where appropriate, any other document that allows them to be identified (passport or driving licence). The aforementioned Health Card is personal and non-transferable, and therefore the improper or fraudulent use of the same entitles the Insurance Company to take the corresponding legal actions and the right to rescind the Insurance Policy as stipulated in the Tenth Clause (c) hereto.
- c) Only outpatient services are covered under this Optional Cover at the dentist's consulting room or clinic, **and therefore any care requiring general anaesthesia and/or Hospitalisation (including Day Hospital) is excluded.**
- d) In the event of an Emergency, the Insured Party must go to the emergency centre/s established by the Insurance Company for this purpose. This information will be available in the Insurance Company's Medical Directory/Directory of Dentists and Dental Services, website ([www.asisa.es](http://www.asisa.es)) or App, and through the Insurance Company's information channels.
- e) If there are alternative treatments for the same pro-

cess, the decision will be taken by the Insured Party, in accordance with the cover provided under this Optional Cover.

- f) Where treatment is needed, the Insured Party will be required to accept the quote provided by the dentist or clinic that figures in the Medical Directory/Directory of Dentists and Dental Services, based on the cover and excesses in force indicated in the corresponding Table of Coverage and Excesses.
- g) Where an Excess applies, the Insured Party will directly pay the doctor or dental centre the amount corresponding to the Benefits provided as per the provisions of the Table of Coverage and Excesses.
- h) All treatments require a dentist's prescription, after prior assessment of the patient in the dentist's consulting room, and **therefore, those that do not comply with this requirement will not be covered.**

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## **SIX: DURATION OF THE INSURANCE POLICY**

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This Insurance Policy has the term set in the Particular Terms and Conditions, or possibly that stated in the supplement whenever one or several Optional Covers have been taken out at a different time to that of the Mandatory Cover, in which case the expiry date of the former will coincide with that set for the latter.

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## **SEVEN: ECONOMIC CONDITIONS OF THE INSURANCE**

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The Policyholder, in accordance with Article 14 of the Law on insurance contracts, is obliged to pay the Premium or price of the insurance as stipulated in the Particular Terms and Conditions. The single Premium to be paid

by the Policyholder must be paid annually. Unless otherwise specified in the Particular Terms and Conditions, the place of payment of the Premium will be the Address of the Policyholder. The Premium must be paid by bank card (credit/debit) by the Policyholder and will be payable upon signing the Insurance Policy.

All existing taxes, surcharges and levies and those that may hereinafter be established on the insurance policies and premiums will be borne by the Policyholder when they are legally chargeable.

The single Premium will be payable on signing the Insurance Policy in accordance with the provisions of Article 14 of the Law on insurance contracts. If it has not been paid due to the Policyholder's fault, the Insurance Company is entitled to rescind the Insurance Policy or to demand payment through enforcement proceedings pursuant to the Insurance Policy. If it has not been paid before a Claim is made, the Insurance Company will be released from its obligation as provided for under Article 15 of the Law on insurance contracts.

The Insurance Company and the Policyholder are only bound by the receipts issued by the management or by their legally authorised representatives.

**In the event of early termination of the Insurance Policy attributable to the Policyholder, the part of the annual Premium not consumed will correspond to the Insurance Company, as the Premium is settled by a single payment for the contractual term.**

UPDATING THE ECONOMIC CONDITIONS OF THE INSURANCE POLICY

**EXCESSES: As regards the Optional Dental Insurance Cover, the Insurance Company may update the applica-**

ble Table of Coverage and Excesses with effect from 1 January of each new calendar year. Accordingly, if this Optional Cover is taken out, the Insurance Company will inform the Policyholder of the Table of Coverage and Excesses that will apply for the following calendar year at least two months in advance of 31 December each year. After this information has been received, the Policyholder is entitled to notify the Insurance Company of their disagreement with the update, requesting cancellation of the cover before 30 November of the current year for the Insured Parties for whom the Optional Dental Insurance Cover was taken out as of the following 1 January, and if the Policy term so permits, where appropriate, to receive the refund of the unearned Premium for the said cover until the end of the current contractual period. Consequently, once the aforementioned period has elapsed without the Policyholder expressing their disagreement with the Table of Coverage and Excesses for the following calendar year, it will be understood to be tacitly accepted as of the following 1 January. Cancellation of the Optional Dental Insurance Cover due to non-acceptance of the new Table of Coverage and Excesses will not entail the cancellation of the rest of the Cover (Mandatory and Optional) under the Insurance Policy.

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## **EIGHT: OBLIGATIONS AND DUTIES OF THE POLICYHOLDER AND/OR INSURED PARTY**

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The Policyholder and, where appropriate, the Insured Party have the following obligations and duties:

- a) To inform the Insurance Company of all the circumstances known to the Insured Party that may influence the assessment of the risk to be insured before the

conclusion of the Insurance Policy and/or incorporation of the Optional Cover at a later time, in accordance with the Health Questionnaire provided by the Insurance Company. The Insured Party is relieved of this duty if the Insurance Company does not provide a Health Questionnaire for completion or when, even if it is provided, it concerns circumstances that may influence the assessment of the risk and which are not covered therein. It is essential that the information provided by the Policyholder/Insured Party is truthful and complete, as it constitutes the basis for the acceptance of the risk covered by this Insurance Policy, of which the said Health Questionnaire forms part.

- b) The Policyholder and, where applicable, the Insured Parties must, during the term of the Insurance Policy, inform the Insurance Company as soon as possible of all circumstances that aggravate the risk and are of such a nature that if they had been known to ASISA at the time of the conclusion of the Insurance Policy, it would not have concluded it or would have concluded it under more onerous conditions for them. Likewise, the Policyholder or the Insured Party may inform the Insurance Company of any circumstances that reduce the risk.

The Policyholder and the Insured Party are also obliged to notify the Insurance Company of the change of address and email address indicated in the Particular Terms and Conditions, as well as the rest of the data provided to the Insurance Company for the purpose of communications, no later than eight (8) days following the occurrence of said change. In order to maintain the right to the Benefits and compensation, if applicable, of the Insurance Policy, the new address must be within the scope of care of the Insurance Company.

- c) To notify the Insurance Company of a Claim within seven (7) days of its occurrence by means of the appropriate supporting documentation.
- d) To mitigate the consequences of the Claim using the means at their disposal for prompt recovery. Non-fulfilment of this duty with the manifest intention of damaging or deceiving the Insurance Company will release the latter from providing any Benefit or, where appropriate, from payment of the compensation related to the Claim.
- e) To provide the Insurance Company with all the information required to exercise the right of subrogation provided for under Article 82 of the Law on insurance contracts in the rights and actions which, on the grounds of the care provided, and up to the limit of the amount thereof, may correspond to the Insured Party against the persons responsible for the illness or injury, or against the persons or entities that legally or statutorily must meet the said care expenses.
- f) The Insured Party or Parties, Beneficiary(ies) or, in their absence, the persons duly authorised to do so by them, are obliged, in those cases where it so expressly requires, to provide the Insurance Company with all medical, diagnostic or supporting documentation and/or estimates related to the Claim that enable the Insurance Company to determine whether the care or compensation required is covered under this Insurance Policy, as well as any inspection visits that may be made by medical personnel. The Insurance Company will not be obliged to cover the service requested until the aforementioned reports and estimates are provided to it in those cases in which the Insured party has been expressly requested to do so. The Insurance Company may claim from the Insured Party the cost of the cov-

erage of any Benefit or compensation that should not be borne, once the required information and documentation is known.

- g) To notify the Insurance Company of the loss, theft or deterioration of the Health Card as soon as possible, so that a new one can be issued and sent to the Insured Party's address indicated in the Particular Terms and Conditions, thereby cancelling the previous one. Likewise, the Policyholder or Insured Party must return their Health Card to the Insurance Company on termination of the Insurance Policy.
- h) To provide the Insurance Company with all documentation and information regarding their status as a non-Spanish national, as stipulated in the contracting rules included in the acceptance signature clause of the limiting clauses.

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## **NINE: POWERS OF THE POLICYHOLDER AND/OR INSURED PARTY**

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- a) The Policyholder may claim from the Insurance Company, within a period of one month from the delivery of the Insurance Policy, that the existing divergences between it and the insurance proposal, if any, or the agreed clauses be rectified, as provided for in Article 8 of the Law on insurance contracts. If no claim is made after the expiry of this period, the provisions of the Insurance Policy will apply.
- b) The newborn child may be registered as an Insured Party under the Mandatory Healthcare Cover of this product (or another healthcare insurance policy with identical or better coverage), eliminating the applicable Waiting Periods in each case and without Health Questionnaire

assessment, **as long as the birth/caesarean section has been covered by the Insurance Company and the application is made no later than thirty (30) days following the date of birth.** For registrations requested outside the aforementioned period, as well as for births or caesarean sections not covered by the Insurance Company, a Health Questionnaire will be required, with an assessment of the risk and the possibility of not accepting the contract, and the application of the Waiting Periods established in the applicable General Terms and Conditions. The terms and conditions established by the Insurance Company at any given time will apply to newborns registered under Optional Cover products.

The registration of the newborn under the rest of the Optional Cover products that can be taken out will be governed by the terms and conditions established by the Insurance Company at any given time.

- c) When the Insurance Policy is signed using a remote mechanism, the Policyholder may unilaterally rescind it, without giving any explanation and unsanctioned, if the Claim covered has not occurred, within fourteen (14) days following the signing of the Insurance Policy or on receipt by the Policyholder of the contractual terms and conditions and the obligatory prior information, if the reception thereof is subsequent to the signing of the Insurance Policy, by means of certified written notification to the Insurance Company to this effect.

An Insurance Policy is considered to have been taken out remotely when for its negotiation and conclusion a remote communication technique is exclusively used, consisting in the use of telematic, electronic, telephonic, fax or other similar means, without the simultaneous physical presence of the provider and the consumer.

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## **TEN: POWERS OF THE INSURANCE COMPANY**

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- a) When the Insurance Company becomes aware of the withholding or inaccuracy of the data provided by the Policyholder/Insured Party in the Health Questionnaire required for taking out the Insurance Policy (Mandatory Healthcare Cover) or the Optional Cover at a later time, the Insurance Company may cancel the Insurance Policy by notifying the Policyholder no later than one (1) month of becoming aware of the said withholding or inaccuracy. If this withholding or inaccuracy affects one of the Insured Parties, the Insurance Company may exclude them from the policy by notifying the Policyholder.
- b) If the Claim occurs before the Insurance Company makes the notification referred to in the previous paragraph, the Insurance Company's Benefit will be reduced proportionally to the difference between the Premium agreed and that which would have been applied had the true nature of the risk been known. Where Wilful Misconduct or gross negligence is involved on the part of the Insured Party, the Insurance Company will be relieved of the obligation of having to pay the Benefit.
- c) If the Health Card is used fraudulently with the knowledge or consent of the Policyholder or Insured Party, the Insurance Company is authorised: (i) to rescind the Insurance Policy, regardless of its validity status; (ii) to claim the cost of the Benefits or compensations unduly enjoyed at its expense; and (iii) to take the corresponding legal actions.
- d) The Insurance Company may claim from the Insured Party the unwarranted cost of covering any Benefit or compensation after the required information is made known to the Insured Party.
- e) If the Policyholder, when applying for the insurance, has

incorrectly declared the year of birth of the Insured Party, the Insurance Company may only rescind the Insurance Policy when the true age of the Insured Party, on the Start Date, exceeds the admission limits established by the Insurance Company upon taking out the Insurance Policy. As regards the Optional Accidental Death Cover and Optional Hospitalisation Benefit Cover, if the Insured Party actually exceeds 70 years of age, the Insurance Company may cancel the Insured Party's cover under these Optional Cover products. If the aforementioned limits are not exceeded, the Insurance Company is authorised to regularise the difference between the amount paid by the Policyholder and the amount that it should have paid if the correct age of the Insured Party had been declared at the time of taking out the policy.

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## **ELEVEN: LOSS OF ENTITLEMENTS, INSURANCE POLICY NON-CONTESTABILITY AND NULLITY**

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1. The Insured Party's entitlement to Benefit will be lost:
  - a) In the event of withholding or inaccuracy by the Policyholder or, where appropriate, the Insured Party, when declaring the risk (on completing the Health Questionnaire) before taking out the Insurance Policy or any of the Optional Cover at a later time, whenever Wilful Misconduct or gross negligence is involved (Article 10 of the Law on insurance contracts).
  - b) If the Claim occurs before the first Premium, or fraction thereof, has been paid, unless otherwise agreed (Article 15 of the Law on insurance contracts).
  - c) When the Claim has been caused in bad faith by the Insured Party (Article 19 of the Law on insurance contracts).

2. If a prior examination has been carried out or full entitlements have been recognised, the Insurance Policy will be incontestable as regards the state of health of the Insured Party and the Insurance Company may not deny its Benefits on the grounds of the existence of previous illnesses, unless expressly, and as a consequence of this examination, a provision is made in the Particular Terms and Conditions of the Policy, or the Insured Party, acting maliciously or with gross negligence, has filled in the Health Questionnaire with withholdings or inaccuracies.
3. Except in those cases provided for in the Law on insurance contracts, the Insurance Policy will be deemed null and void if at the time of its conclusion the risk did not exist or the Claim had already occurred.

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## **TWELVE: NOTIFICATIONS**

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Notifications to the Insurance Company by the Policyholder or the Insured Party must be made at the registered address of the Insurance Company indicated in the Insurance Policy. The notifications made by the Policyholder to the insurance agent who distributes the Insurance Policy will have the same effects as if they had been made directly to the Insurance Company.

Communications from the Insurance Company to the Policyholder or to the Insured Party may be made by post or email, or by any other means of instant messaging provided by the Policyholder at the time of applying for the insurance as long as they do not communicate a change in the same. The Policyholder may object to the sending of electronic communications by emailing the following address: [DPO@grupoasisa.com](mailto:DPO@grupoasisa.com)

For the purposes of this Insurance Policy, the Claim will

be deemed to have been notified as soon as the Insured Party requests the provision of the service covered.

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## **THIRTEEN: CLAIMS AND STATUTE OF LIMITATIONS**

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Without prejudice to any other competent bodies, the Policyholders, Insured Parties, Beneficiaries, injured third parties or rightful claimants of any of them may submit a claim in writing to the following bodies:

1. ASISA Provincial Delegation.
2. ASISA Group Customer Care Service, in accordance with the provisions of Order ECO/734/2004 on customer care departments and services and the customer ombudsman for financial institutions. The procedure for handling complaints and claims before this body can be consulted in the Asisa Group Customer Services Operating Regulations on the company's website ([www.asisa.es](http://www.asisa.es)).
3. In the event of disagreement with the resolution of the Customer Care Service, or if no reply has been received within two months, the interested party may lodge a complaint with the Claims Service of the General Directorate of Insurance and Pensions (Dirección General de Seguros y Fondos de Pensiones), Paseo de la Castellana n.º 44 - 28046 - Madrid, Spain, either in a letter or by electronic means using electronic signature, via the website of said body.

ASISA is not a member of any Consumer Arbitration Board. Conflicts that may arise between Policyholders, Insured Parties, Beneficiaries, injured third parties or rightful claimants among them, and the Insurance Company will be settled by the judges and courts with the pertinent authority and jurisdiction. (Art. 97.1 of Law 20/2015, of 14 July, on the Regulation, supervision and solvency of insurance and reinsurance entities).

For the purposes of this Insurance Policy, regardless of the foregoing, the competent judge of the actions derived from the same will be that of the Insured Party's place of residence, for which purpose the Insured Party must designate an address in Spain, in the event that their regular address is abroad.

Actions arising from this Insurance Policy will lapse within five (5) years (Article 23 of the Law on insurance contracts).

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## **FOURTEEN: SCOPE OF INSURANCE**

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Cover under this Insurance Policy extends throughout the entire national territory of Spain, except as regards that which is stipulated for Travel Assistance Cover (Schedule IV) and, where appropriate, for the Optional Accidental Death Benefit and/or Hospitalisation Cover.

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## **FIFTEEN: PROTECTION OF PERSONAL DATA**

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### **1. Data controller.**

The data controller is ASISA, ASISTENCIA SANITARIA INTERPROVINCIAL DE SEGUROS S.A.U. (hereinafter, ASISA), holder of C.I.F. (Tax Identification Code) A08169294, and with registered address at Calle Juan Ignacio Luca de Tena, 12, 28027 Madrid, Spain.

ASISA has formally appointed a Data Protection Officer, who can be contacted at the following address: DPO@grupoasisa.com

### **2. Processing of personal data.**

Personal identification data, employment data, personal characteristics, social circumstances and socio-economic

data and health data, provided through the insurance application and the Health Questionnaire, as well as during the term of the Insurance Policy and through access to existing files found in public or private sources, will be processed whenever there is a legitimate interest and/or in compliance with a legal obligation to do so.

The Policyholder undertakes to guarantee that all the information provided, including that relating to the Insured Parties, is true and that the Policyholder has not omitted any information about the state of health of each of the Insured Parties. Likewise, in the event of providing data relating to another natural person, prior to the inclusion of such data, the corresponding consent must be obtained and the person must be informed of the points contained in this clause.

### **3. Purpose of the processing of personal data.**

The purpose of the processing of the data will be to attend to, manage and execute the Insurance Policy, as well as to provide services directly or indirectly related to its fulfilment.

In addition, ASISA is protected by the legitimate interest to:

- Assess, select and price the risks associated with the insurance requested, such as assessing financial solvency, carrying out statistical analyses, quality studies or technical analyses, as well as preventing insurance fraud.
- Send commercial information tailored to the interests of the Insured Party, including by electronic means, as well as to conduct opinion polls. In this case, only information that is related to the Insurance Company's own products and/or services and that are similar to those contracted by the Insured Party will be sent in order to improve their degree of satisfaction as a client. If the

Insured Party does not wish to receive advertising by electronic means, the Insured Party may notify Asisa to this effect by writing to the following address: DPO@grupoasisa.com.

- Transfer the Insured Party's personal data within the corporate group for internal administrative purposes.
- Retain the Insured Party's personal data once the Insurance Policy has been terminated as a result of the withholding of information or inaccuracy of the information provided, or due to non-payment of Premiums and in order to detect, prevent, remedy and impede fraudulent conduct or conduct that poses a risk to ASISA.
- In the event that payment is not made within the term foreseen for this purpose and the requirements foreseen in the regulations in force are met, to communicate the data relating to the non-payment to credit information systems with regard to the non-fulfilment of monetary, financial or credit obligations.

Likewise, on the basis of compliance with legal obligations, the purpose of the processing of the data will be:

- To carry out the statistical-actuarial analysis both for the determination of the associated risk and for the pricing of the policies of clients and potential clients either in the process of the insurance application or during the term of the Insurance Policy in response to the new circumstances of the Insured Party or to the change of the actuarial basis.
- To comply with the obligations established in insurance regulations, tax laws and personal data protection regulations in force.

In addition, the consent of the Insured Party will enable ASISA to process their data to:

- Send them personalised offers of products and services from ASISA Group companies and partners. The identity of the companies is available on the website <https://www.asisa.com>
- Share personal data with ASISA Group companies and partners so that they can offer commercial information in relation to their own products and services. The identity of the companies is available on the website <https://www.asisa.com>

Failure to authorise the processing of data for the above purposes will not affect the maintenance or fulfilment of the contractual relationship.

#### **4. Lawful basis for the processing of personal data.**

The basis for the processing of the Insured Party's personal data is:

- To execute the Insurance policy to provide healthcare and to make any possible compensation payments to the Insured Party by ASISA; the foregoing based on the provisions of the Insurance Policy that binds the latter to the Insured Party.
- The fulfilment of legal obligations to comply with the provisions of insurance regulations, tax laws and personal data protection regulations in force.
- The legitimate interest of sending personalised offers and promotions to the Insured Party, as well as to prevent fraudulent conduct and risk for ASISA with respect to clients and former clients and for internal administrative purposes.
- The consent to communicate data to other companies from which personalised offers and promotions may be received and to be able to offer advertising of products and services of third party companies.

## 5. Recipients of personal data.

The personal data processed by ASISA to achieve the purposes detailed above may be communicated to the following recipients depending on the legitimate basis for the communication.

- General Directorate of Insurance and Pensions, public bodies and administrations.
- Reinsurance or coinsurance undertakings for the purpose of entering into, arranging or handling, as the case may be, the benefits contained in this Policy.
- Doctors, medical centres, hospitals and other institutions or persons, identified as health service providers in the Medical Directory/Directory of Doctors and Services drawn up by ASISA which can be consulted on its website [www.asisa.es](http://www.asisa.es).
- Financial institutions for the management of collections and payments.
- Spanish Union of Insurance and Reinsurance Entities (UNESPA) for the inclusion of the Insured Party's personal data, if deemed necessary, in its common fraud prevention file.
- Entities holding information services files on solvency and creditworthiness, both for consultation in the cases established by law and in the event of non-compliance with their monetary obligations.
- In those cases in which the Insured Party has given their consent in accordance with the purposes indicated, ASISA will share their information with the companies of the Group, as well as with collaborating entities so that they may offer commercial information in relation to their own products and services. The identity of the companies is available on the website <https://www.asisa.com>

## **6. Retention period of personal data.**

The personal data will be kept for the duration of the Insurance Policy and, thereafter, as long as the Insured Party has not exercised their right to erasure, and they will be retained while taking into account the legal periods that are applicable in each specific case, in accordance with the type of data, as well as the purpose of the processing.

Upon expiry of the aforementioned period, ASISA undertakes to cease processing all personal data and to duly block them. However, personal data may be retained where necessary for longer periods provided that they are processed exclusively for the purposes of preventing, remedying and deterring fraudulent conduct and conduct that poses a risk to ASISA.

These deadlines may be consulted in the ASISA Data Retention Policy on the website [www.asisa.es](http://www.asisa.es), as well as in other places visible to the data subject.

## **7. Rights in relation to the processing of personal data.**

The Insured Party has the right to access their personal data and to obtain confirmation regarding how such data is being processed. Likewise, they have the right to request the rectification of data that is incorrect or inaccurate or, where appropriate, to request its erasure when, among other reasons, the data is no longer necessary for the purposes for which it was collected by ASISA.

In certain circumstances, the Insured Party may request the restriction of the processing of their data, in which case ASISA will only retain such data for the exercise or defence of possible claims.

Furthermore, in certain circumstances, the Insured Party may object to the processing of their personal data for the purpose informed by ASISA and to avoid being subject to

automated individual decision-making. In this case, ASISA will cease to process the personal data, except for legitimate reasons, or to guarantee the exercise or defence of possible claims.

Lastly, the Insured Party may request the right to portability and obtain for themselves or for another service provider certain information derived from the contractual relationship entered into with ASISA.

These rights may be exercised by the following means:

- By writing to ASISA, ASISTENCIA SANITARIA INTER-PROVINCIAL DE SEGUROS, S.A.U., at the postal address Calle Juan Ignacio Luca de Tena número 12, 28027, Madrid, Spain.
- By sending an email to the following address: DPO@grupoasisa.com

In both cases, the identity of the person exercising their rights will need to be accredited by sending a copy of both sides of their National ID / Foreigner's ID / Passport or equivalent document.

ASISA will provide the requested information within a maximum period of one (1) month following receipt of the request. This period may be extended by a further two (2) months if necessary, taking into account the complexity and number of applications.

Consent may be withdrawn by the Insured Party at any time, if it has been given for a specific purpose, without affecting the lawfulness of the processing based on the consent prior to such withdrawal.

The Insured Party may file a complaint with the competent data protection supervisory authority. However, they may firstly file a complaint with the Data Protection Officer, who will reply to the complaint within two (2) months.

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## **SIXTEEN: EXEMPTION FROM LIABILITY**

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The health professionals, centres and services duly authorised in accordance with the regulations in force—which the Insurance Company places at the disposal of the Insured Party and which the Insured Party requests—for the Mandatory Healthcare Cover and for the Optional Dental Insurance Cover, pursuant to the right to freedom of choice of doctor and centre, enjoy full autonomy, independence and responsibility in the provision of healthcare. **Accordingly, the Insurance Company will in no case be liable directly, jointly and severally or vicariously in relation to the acts and/or omissions of the aforementioned professionals and centres in the exercise of their professional activity, over which it has no control, as it is subject to professional secrecy and taking into account the confidentiality of health information.**

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## **SEVENTEEN: EXTRAORDINARY RISK COVERAGE CLAUSE**

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This clause will only apply in the event that the Optional Accidental Death Benefit Cover has been taken out.

In accordance with the provisions of the revised text of the Legal Statute of the Insurance Compensation Consortium, approved by Royal Legislative Decree 7/2004, of 29 October, the Policyholder of an Insurance Policy, of those that must obligatorily include a surcharge in favour of the aforementioned public business entity, has the power to agree to the coverage of extraordinary risks with any insurance company that meets the conditions required by the legislation in force.

Compensation deriving from claims arising from extraordinary events occurring in Spain and affecting risks

located therein, and also those occurring abroad when the Insured Party's habitual residence is in Spain, will be paid by the Insurance Compensation Consortium when the Policyholder has paid the corresponding surcharges in their favour and any of the following situations occur:

- a) The extraordinary risk covered by the Insurance Compensation Consortium is not covered by the Insurance Policy taken out with the Insurance Company.
- b) Although covered by said Insurance Policy, the obligations of the Insurance Company could not be fulfilled because it has been legally declared bankrupt or because it is subject to a liquidation procedure, intervened or assumed by the Insurance Compensation Consortium.

The Insurance Compensation Consortium will adjust its actions to the provisions of the aforementioned legal Statute, in Law 50/1980, of 8 October, on Insurance Contracts, in the Regulation of the Insurance of Extraordinary Risks, approved by Royal Decree 300/2004, of 20 February, and in the complementary provisions.

## **I. Summary of legal provisions**

### **1. Extraordinary events covered:**

- a) The following natural phenomena: earthquakes and tsunamis, unusual floods (including coastal flooding), volcanic eruptions, atypical cyclonic storms (including extraordinary winds with gusts in excess of 120 km/h, and tornadoes) and meteorite falls.
- b) Those caused violently as a consequence of terrorism, rebellion, sedition, mutiny and civil commotion.
- c) Events or actions of the Armed Forces or of the Security Forces and Corps in peacetime.

Atmospheric and seismic phenomena, volcanic eruptions and the fall of astral bodies must be certified, at the request of the Insurance Compensation Consortium, by means of reports issued by the State Meteorological Agency (AEMET), the National Geographic Institute and other public bodies competent in the matter. In cases of events of a political or social nature, as well as in the event of damage caused by events or actions of the Armed Forces or the Security Forces or Corps in peacetime, the Insurance Compensation Consortium may request the competent jurisdictional and administrative bodies for information on the events that occurred.

## **2. Excluded risks:**

- a) Those that do not give rise to compensation according to the Law on insurance contracts.**
- b) Those caused to persons insured by an Insurance Policy other than those in which the surcharge in favour of the Insurance Compensation Consortium is obligatory.**
- c) Those arising out of armed conflicts, even if there has been no official declaration of war.**
- d) Those derived from nuclear energy, without prejudice to the provisions of Law 12/2011, of 27 May, on civil liability for nuclear damage or damage caused by radioactive materials.**
- e) Those caused by natural phenomena other than those indicated in section 1.a) above, and in particular, those caused by a rise in the water table, movement of slopes, landslides or settlement of land, rock falls and similar phenomena, unless these were clearly caused by the action of rainwater which, in turn, had caused a situation of extraordi-**

nary flooding in the area and occurring at the same time as the flooding.

- f) Those caused by riots during meetings and demonstrations carried out in accordance with the provisions of Organic Law 9/1983, of 15 July, regulating the right of assembly, as well as during the course of legal strikes, unless the aforementioned actions can be classified as extraordinary events as per section 1.b) above.**
- g) Those caused by the Insured Party acting in bad faith.**
- h) Those corresponding to Claims occurring before the payment of the first Premium or when, in accordance with the provisions of the Law on insurance contracts, the coverage of the Insurance Compensation Consortium is suspended or the insurance is terminated due to non-payment of premiums.**
- i) Claims which, due to their magnitude or severity, are classified by the National Government as a “national catastrophe or calamity”.**

### **3. Extension of coverage**

The coverage of extraordinary risks will include the same persons and the same Insured Sums that have been established in the Insurance Policy to cover ordinary risks.

In life insurance policies which, pursuant to Insurance Policy provisions, and in accordance with the regulations governing private insurance, generate a mathematical provision, the coverage of Spain’s Insurance Compensation Consortium will refer to the capital at risk for each Insured Party, i.e. the difference between the Insured Sum and the mathematical provision that the Insurance Company that has issued it must have constituted under the aforementioned regulation. The amount correspond-

ing to the aforementioned mathematical provision will be paid by said Insurance Company.

## **PROCEDURE TO BE FOLLOWED FOR A CLAIM TO BE SETTLED BY SPAIN'S INSURANCE COMPENSATION CONSORTIUM**

1. The request for compensation of damages whose coverage corresponds to the Insurance Compensation Consortium will be made by means of a notification to the same by the Policyholder, the Insured Party or the Beneficiary of the policy, or by whoever acts on behalf of the aforementioned persons, or by the Insurance Company or the insurance intermediary with whose intervention the insurance has been managed.

2. The communication of damages and the obtaining of any information relating to the procedure and the current status of the processing of the Claims may be undertaken as follows:

- By calling the Insurance Compensation Consortium Call Centre (+34 952 367 042 or +34 900 222 665).
- On the website of the Insurance Compensation Consortium ([www.consoseguros.es](http://www.consoseguros.es)).

3. Damage assessment: The assessment of damages that are compensable in accordance with insurance legislation and the content of the Insurance Policy will be carried out by the Insurance Compensation Consortium, without the latter being bound by the assessments that, where appropriate, would have been carried out by the Insurance Company that covered the ordinary risks.

4. Payment of compensation: The Insurance Compensation Consortium will pay the compensation to the Beneficiary of the insurance by bank transfer.

## SCHEDULE I

### **PET/PET CT COVER: FLUDEOXYGLUCOSE (FDG) USE**

In accordance with the provisions of the Second Clause hereto, Positron Emission Tomography (PET or PET CT) **is covered exclusively for those oncological, cardiac and neurological problems for which the FDG marker is approved by the Spanish Agency of Medicines and Medical Devices in accordance with its technical data sheet. These are specified below:**

#### **A) ONCOLOGICAL PATHOLOGIES**

##### **Diagnosis:**

Characterisation of the solitary pulmonary nodule.

Detection of a tumour of unknown origin as evidenced, for example, by cervical adenopathy, liver or bone metastases.

Characterisation of a pancreatic mass.

##### **Staging:**

Head and neck tumours, including guided assisted biopsy.

Primary lung cancer.

Locally advanced breast cancer.

Oesophageal cancer.

Carcinoma of the pancreas.

Colorectal cancer, especially in relapses.

Malignant lymphoma.

Malignant melanoma with Breslow > 1.5 mm or lymph node metastases at initial diagnosis.

##### **Monitoring response to treatment:**

Malignant lymphoma.

Head and neck tumours.

## **Screening in case of reasonable suspicion of relapse:**

Gliomas with a high degree of malignancy (grade III or IV).

Head and neck tumours.

Non-medullary thyroid cancer: patients with increased serum thyroglobulin levels and negative radioiodine body scan.

Primary lung cancer.

Breast cancer.

Carcinoma of the pancreas.

Colorectal cancer.

Ovarian cancer.

Malignant lymphoma.

Malignant melanoma.

## **B) CARDIAC PATHOLOGIES**

Assessment of myocardial viability in patients with severe left ventricular failure who are candidates for revascularisation only when conventional imaging techniques are inconclusive.

## **C) NEUROLOGICAL PATHOLOGIES**

Localisation of epileptogenic foci in the pre-surgical assessment of partial temporal epilepsy.

## SCHEDULE II

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### **SECOND MEDICAL OPINION AND CONSULTATION WITH INTERNATIONAL EXPERTS**

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The Insured Party, or the Insurance Company's specialist treating the Insured Party, may request a second medical opinion concerning both the diagnosis and the treatment of any of the processes or serious illnesses listed below:

1. Oncology.
2. Heart disease, including heart surgery and angioplasty.
3. Organ transplantation.
4. Neurological and neurosurgical diseases, including stroke.
5. Complex orthopaedic surgery.
6. Congenital disorders and syndromes.
7. Degenerative and demyelinating diseases of the nervous system.
8. Diseases and problems resulting from kidney failure.

The service may also be requested for illnesses other than those listed, including those considered rare diseases or complex pathologies, **provided that the requesting Insured Party provides sufficient medical information (diagnosis and treatment) to be able to submit it to medical experts of recognised prestige.**

**Insured Parties wishing to use the second opinion service should call 91 075 71 95, where they will be given the documentation (tests and medical reports) relating to the first diagnosis, which must then be sent to the address provided, together with a questionnaire to be completed for this purpose.**

Medical experts of recognised international prestige in the illness in question will assess the diagnosis and treatment established, issuing the appropriate report within five (5) working days after receiving all the necessary documentation.

This report must always be drawn up based on the patient's medical history and the corresponding first diagnosis made by the attending physicians.

**Consultations, tests and/or treatments that are not carried out in accordance with the regulations established for the Mandatory Healthcare Cover are not covered by the Insurance Company.**

Moreover, the following services are available to those Insured Parties who meet the above criteria by calling the telephone number indicated above:

### **A) MEDICAL GUIDANCE**

This service enables the Insured Party to clear up medical doubts 24 hours a day by consulting doctors. If the Insured Party has arranged for a second medical opinion, they will be assigned a doctor who will be at their disposal to comment on the evolution of the case by telephone and to resolve any doubts that may arise.

The aim of this service is to complement medical care and answer your questions, never to replace your treating physician.

### **B) PSYCHO-EMOTIONAL SUPPORT SERVICE FOR PATIENTS WITH SERIOUS ILLNESSES**

In relation to the serious illnesses listed in the previous section, the Insured Party will have the possibility of requesting psychological support over the phone related to their illness or state of health. This service will comprise arranging a conference with a psychologist, who will provide counselling, guidance and emotional support aimed at overcoming problems.

**The service will consist of a maximum of five (5) telephone sessions per policy year. If the Insurance Policy has a term of less than twelve (12) months, the number of telephone sessions will be reduced proportionally.**

## SCHEDULE III

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### PREVENTIVE MEDICINE

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In the specialities indicated below, programmes are included which include consultation with the specialist doctor, as well as the diagnostic tests indicated, by way of example, and whenever the doctor considers them necessary **(in all cases, both the consultations and the corresponding diagnostic tests according to the different programmes will be carried out by doctors and centres in the Insurance Company's Medical Directory/Directory of Doctors and Services. Moreover, the requirements established in each case in terms of medical prescription and authorisation by the Insurance Company will apply).**

**Paediatrics:** Covers newborn health examinations (including screening for metabolopathies as well as early detection of hearing loss by means of otoacoustic emissions or auditory evoked potentials if necessary) and periodic health checks to monitor child development **(from birth to 11 years of age).**

**Gynaecology:** Annual gynaecological screening to prevent cervical, endometrial and breast cancer. Covers consultation and examination, as well as the diagnostic tests (mammography, cytology and/or gynaecological ultrasound scan) **that the gynaecologist in the Insurance Company's Medical Directory/Directory of Doctors and Services advises for the patient.**

**Cardiology:** Prevention of coronary risk in people over 45 years of age or patients with cardiovascular risk factors (e.g. hypertension or dyslipidaemia). It includes consultation and examination by medical specialists, as well as the necessary tests (e.g. ECG, basic blood and urine tests,

stress test), **as recommended by the cardiologist in the Insurance Company's Medical Directory/Directory of Doctors and Services.**

**Urology:** Early diagnosis of prostate cancer in men of 50 years of age and older (or earlier if there are known risk factors).

This covers medical consultation, as well as blood tests—including prostate-specific antigen (PSA) measurement—, urine tests and other tests (such as ultrasound and/or prostate biopsy) **that the specialist considers appropriate. The urologist in the Insurance Company's Medical Directory/Directory of Doctors and Services will prescribe the frequency and particular examinations required in your case.**

**Digestive system:** To prevent colorectal cancer in people at risk (family or personal history). This covers consultation and physical examination, as well as the diagnostic tests (e.g. faecal occult blood test, colonoscopy or virtual colonoscopy) **that the specialist deems necessary in your case.**

## SCHEDULE IV

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### TRAVEL ASSISTANCE: GENERAL CONDITIONS

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**Insured Parties residing in Spain will be entitled to this cover with the conditions and limits established below:**

#### **INSURED PARTY**

The natural person residing in Spain covered by the Asisa healthcare insurance policy.

#### **FAMILY**

Spouse or common-law partner duly registered in the corresponding Official Register, parents, parents-in-law, children, grandparents, siblings, grandchildren, sons-in-law, daughters-in-law, brothers-in-law and sisters-in-law of the Insured Party.

#### **ACCIDENT**

Bodily injury or material damage suffered during the term of the Insurance Policy resulting from a violent, sudden, external cause beyond the control of the Insured Party.

With respect to vehicles, an accident will be deemed to be a violent, sudden, external and involuntary event causing damage to the covered vehicle.

#### **UNEXPECTED ILLNESS**

Any alteration in the state of health of an individual occurring during the course of a trip covered by the Insurance Policy that is diagnosed and confirmed by a legally recognised doctor or dentist and which requires medical attention. **Unless expressly agreed otherwise, only care arising from an unexpected illness is covered by this Insurance Policy.**

## **SERIOUS ILLNESS**

Any unexpected alteration in the state of health of an individual involving Hospitalisation that makes it impossible for the Insured Party to start the trip, prevents the continuation of the trip on the scheduled date, or entails a risk of death.

## **TERRITORIAL SCOPE**

Assistance is covered worldwide, **except in countries subject to international sanctions by the European Union, the United States of America, the United Kingdom and/or the UN.**

**Whatever the case, countries that are in a state of war, insurrection or warlike conflict of any kind or nature, even if it has not been officially declared, are excluded.**

**Assistance is covered or valid as of 35 km from the Insured Party's habitual residence, except for the Balearic Islands, Canary Islands, Ceuta and Melilla, where it is valid as of 15 km.**

## **TEMPORAL SCOPE**

The defined Benefits will be covered **as long as the time spent away from the habitual residence does not exceed 90 consecutive days per journey or posting.** The limitation on the duration of the posting will not apply when the posting is within Spanish territory.

## **BENEFITS COVERED**

### **1. Medical expenses abroad.**

If the Insured Party falls ill or has an accident in the course of a trip abroad, the Insurance Company will cover the expenses listed below during the term of the Insurance Policy **up to a maximum of €25,000 per Insured Party and trip:**

- Medical fees designated at their discretion.
- Medication prescribed by a physician or surgeon.
- Hospitalisation costs.
- Ambulance expenses for a local journey ordered by a doctor.

**For such expenses to be refunded, the original invoice must be submitted, accompanied by a full medical report, including the history, diagnosis and treatment that establishes the nature of the illness.**

**Whatever the case, dental expenses limited to €120 per person per trip.**

## **2. Extension of hotel stay due to illness or Accident**

When the nature of the illness or Accident does not require admission to a clinic or hospital, the Insurance Company will pay the expenses arising from prolongation of the stay in a hotel, prescribed by a doctor, **up to €60 per day and sick or injured person.**

## **3. Medical transport of the sick and injured.**

If the Insured Party falls ill or has an accident during the term of the Insurance Policy, and as a consequence of moving from the place where the Insured Party normally resides, **the Insurance Company, as soon as it is notified,** will organise the necessary contacts between the Insurance Company's medical service and the doctors attending the Insured Party.

When the Insurance Company's medical service orders the transfer of the Beneficiary to a better equipped or specialised hospital near the Insured Party's habitual residence in Spain, the Insurance Company will take charge of this transfer under medical observation, conducting it in accordance with the seriousness of the case:

- By special medical aircraft.
- By medical helicopter.
- By scheduled airline.
- By first class sleeper.
- By ambulance.

When the Insured Party being transferred or repatriated due to Illness or Accident is under 18 years of age, a companion of the Insured Party will be transferred or repatriated at the Insurance Company's expense.

If once recovered, the Insured Party wishes to continue on the trip, state of health so allowing, the Insurance Company will organise the Insured Party's transfer to the trip destination **as long as the cost of this journey does not exceed the cost of the return to the Insured Party's habitual residence. However, expenses arising from the problem suffered by the Beneficiary will not be covered if the Insured Party decides to continue to the place of destination.**

#### **4. Return of the Insured Party in the event of the death of a family member.**

In the event of the death in Spain of the spouse, common-law partner, parents, children, grandparents, grandchildren, sons-in-law, daughters-in-law, brothers and sisters-in-law or siblings of the Insured Party who is on a trip covered by this Insurance Policy, the Insurance Company, having been notified of the event, will organise and place a return ticket at the disposal of the Insured Party to attend the burial by regular aeroplane, economy class, or by train, first class, or two return tickets when returning together with a companion registered in the Particular Terms and Conditions to the place of burial in Spain.

## **5. Transport of mortal remains.**

In the event of the death of the Insured Party, the Insurance Company will organise and pay for the transport of the mortal remains to the place of burial in the country of the Insured Party's nationality in the municipality of the Insured Party's domicile in that country (or in the municipality of the Insured Party's habitual place of residence in Spain, if so requested), as well as the costs of embalming, the minimum obligatory coffin and the pertinent administrative formalities. **Under no case whatsoever does this cover extend to funeral and burial expenses.**

If the death of the Insured Party takes place during a trip covered by this Insurance Policy and the deceased is accompanied by a minor or disabled person or persons, the Insurance Company will pay the transport expenses, to and from Spain, of a family member to accompany them on their return to Spain.

In the event of the death of the Insured Party in the municipal district where the Insured Party resides in Spain, the Insurance Company will bear the expenses of the transfer of the mortal remains of the deceased to the municipal district of the Insured Party's domicile in their country of origin, within the scope stipulated in the first paragraph to this section.

## **6. Accompaniment of mortal remains.**

If there is no one to accompany the mortal remains of the deceased Insured Party, the Insurance Company will provide the person designated by the Beneficiaries with a return ticket by rail (first class) or economy class aeroplane from Spain to accompany the corpse to the place of burial.

The Insurance Company will pay for the accommodation

expenses of the accompanying person, **upon submission of the corresponding invoices, up to €90/day, and up to a maximum of 3 days.**

## **7. Displacement of a family member.**

If the Insured Party has to be hospitalised for more than five days, or three days in the case of minors or disabled persons during the trip, **and no member of the Insured Party's immediate family is at the Insured Party's side,** the Insurance Company will place a regular airline ticket (economy class) or train ticket (first class) round trip at the disposal of a member of the family, or a person designated by the family, who habitually resides in Spain, to accompany the Insured Party.

If the Hospitalisation of the Insured Party takes place during a trip away from their habitual place of residence, the Insurance Company will pay for accommodation expenses, **upon submission of the corresponding invoices, up to €60/day and up to a maximum of 10 days.**

## **8. Early return of a companion in the event of death or medical transfer of the sick and injured.**

When the Insured Party has been transferred due to an unexpected Illness or Accident under the "Medical transport of the sick and injured" cover, or due to death, and this circumstance prevents the companions of the Insured Party from returning home by the means initially foreseen, the Insurance Company will cover the expenses corresponding to the transport of a single companion to their place of habitual residence or to the place where the transferred Insured Party is hospitalised, by means of a regular airline ticket (economy class) or train (first class).

## **9. Accompanying minors and disabled persons.**

If the Insured Parties travelling with minors or disabled

persons are unable to take care of them due to an illness or Accident covered under the Insurance Policy, or are repatriated by the Insurance Company, the latter will organise and pay the return trip of a person who resides in Spain designated by the Insured Party or the Insured Party's family, or that of an Insurance Company's custodian, to accompany the minors or disabled persons on their return to their habitual place of residence in Spain, and in the shortest possible time.

### **10. Drug shipments.**

Should the Insured Party require medicine that cannot be purchased locally, the Insurance Company will arrange for its location and shipment by the quickest means and subject to local legislation.

**Cases of discontinuation of the manufacture of the medicinal product and its unavailability in the distribution channels in Spain are excluded.**

**Upon presentation of the corresponding invoice, the Insured Party will have to reimburse the Insurance Company the price of the medicine.**

### **11. Searching for and locating luggage.**

If the Insured Party suffers a delay or loss of luggage, the Insurance Company will assist them in searching for and locating it, advising the Insured Party on how to file the corresponding complaint. If the luggage is located, the Insurance Company will send it to the Insured Party's habitual place of residence in Spain or on to the journey destination, provided it is possible to access the luggage and the physical presence of the owner is not required for its recovery, in which case the necessary assistance and collaboration will be provided.

## **12. Transmission of urgent messages.**

The Insurance Company will accept and transmit urgent messages from the Insured Party via a 24 hour service, **as long as the Insured Party has no other means of getting them to their addressee.**

## **13. Civil liability.**

The insurance guarantees first-loss compensation cover of **up to €4,000** for personal injury, material damage and/or consequential damage caused by the Insured Party to a third party and which may be claimed of the Insured Party, in accordance with the legislation in force in the corresponding country, for liability of a non-contractual nature.

**Professional liability, liability arising from vehicle use, operation and traffic, as well as liability arising from the use or ownership of devices and weapons of any kind or nature, as well as compensation for economic damages not resulting from previous personal or material damage, are expressly excluded.**

## **14. Information service.**

The Insurance Company will provide the Insured Party with a free and uninterrupted 24/7 all year round service to provide all types of tourist information and information on administrative formalities, medical precautions, travel conditions and local life, means of transport, accommodation, restaurants, etc.; vehicle-related information such as garages, petrol stations, insurance companies, etc.

## **15. Advance of funds.**

Should they be needed, the Insurance Company will advance funds to the Insured Party **up to a limit of €9,000. The Insurance Company will require some type of guarantee or surety from the Insured Party to ensure**

**reimbursement of the advance payment. Whatever the case, the sums advanced must be returned to the Insurance Company no later than 30 days at the latest.**

### **16. Interpreting service.**

The Insurance Company will provide the Insured Party with a telephone translation service in major languages (English, French and German) and will facilitate contact with interpreters in the country where the Insured Party is located.

### **17. Telephone medical advice.**

This service will consist of clearing up any medical doubts the Insured Party may have regarding the interpretation of clinical analyses, medication, etc. The Insurance Company's medical service will advise the Insured Party, based on the information provided in the request for advice, what the Insurance Company considers appropriate and will recommend the health service it considers to be best for the Insured Party, where necessary. **Under no circumstances will the medical advice service diagnose or prescribe treatment.**

For the most serious and urgent cases, the Insurance Company may activate the necessary healthcare services, prioritising public emergency services, with the Beneficiary having to bear the expenses incurred as a consequence of this service.

This service will be provided at the request of the Insured Party and from 9.00 am to 9.00 pm every day.

### **18. Advice on inheritance.**

The Insurance Company will fully management the extrajudicial testamentary process, while also providing prior advice to the Insured Party. The following services are covered:

- a. Legal advice to the Insured Party when making a will.
- b. Design, drafting, preparation and, where appropriate, intervention in the notarial signing.
- c. Personalised attention to Beneficiaries.
- d. Permanent telephone legal assistance service on inheritance matters.
- e. Obtaining all necessary certificates:
  - Death.
  - Birth.
  - Marriage or cohabitation.
  - Proof of life.
  - Register of last wills and testaments.
- f. Spanish Department of Social Security formalities:
  - Deregistration.
  - Death benefit.
  - Spouse registration.
  - Registration of other Beneficiaries.
- g. Recording of deaths in the Spanish Family Register Book.
- h. Processing widow's, widower's and orphan's pensions.
- i. Advice on uncontested inheritance proceedings:
  - Copy of the last will and testament.
  - Declaration of intestate heirs.
  - Reading of the will.
  - Determination of the estate.
  - Determination and distribution of the inheritance.
- j. Processing of the letter of payment.

- k. Settlement of inheritance tax and other tax obligations.
- l. Management of the necessary registry entries.

All of the aforementioned services, with the exception of those indicated in a) and b), will also be provided to the Beneficiaries of the Insured Parties.

In the event of a conflict of interest arising between the Insured Parties, **the Insurance Company will limit its services to general telephone advice to all Insured Parties.**

### **19. Administrative procedures to obtain visas.**

The Insurance Company, at the request of the Insured Party, will arrange the necessary documentation to apply for the corresponding visa. **Consular fees, intermediaries (where appropriate) and courier fees will be borne by the Insured Party.**

The documentation and the fees required differ depending on the visa. Moreover, visa processing times vary from country to country. Whatever the case, an application form must be completed and the pertinent documentation submitted.

Types of visas in different countries:

- Tourist
- Business
- Study
- Work
- Temporary journalist
- Group
- Private travel
- Transit

- Special (for exceptional reasons)
- Courtesy
- Residence
- Work and residence
- Simple: allowing only one entry
- Multiple: allowing multiple entries for 6 months. (Hashemite Kingdom of Jordan)

## **20. Card cancellation.**

The Insurance Company will proceed, as soon as possible, to take the necessary steps to cancel bank and non-bank cards issued by third parties in Spain as a result of theft, robbery or loss of the same.

The Insured Party must personally provide the following information: National Identity Card, type of card and issuing institution.

Whatever the case, a complaint must be lodged with the competent authorities.

## **21. Mobile phone locking.**

In the event of notification by the Insured Party of the theft or loss of their mobile phone, the Insurance Company will proceed to notify the corresponding operator of this circumstance and request the blocking of the device.

The Insurance Company **accepts no liability for misuse under any circumstances.**

## **22. Communication costs.**

Reimbursement of expenses, **up to a limit of €100**, for telephone calls, faxes or similar procedures involved in the filing and processing of Claims. **In order to make this reimbursement effective, the Insured Party must send the original invoices or a copy of the same, as well**

as proof of payment. Details of the expenses must be indicated in these documents.

## **EXCLUSIONS**

In general, those Benefits about which the Insurance Company has not been previously notified and those for which the corresponding authorisation has not been obtained are excluded, except in cases of duly accredited material impossibility which, in any case, are subject to the exclusions indicated below:

1.- Previous or chronic illnesses, injuries or ailments suffered by the Insured Party prior to the signature of the healthcare Insurance Policy, or its renewal or extension, as well as those that appear during its validity and prior to the beginning of the trip, except for the first emergency assistance or until the Insured Party is stabilised.

2.- Mental illnesses.

3.- Preventive medical check-ups (check-ups, thermal cures and cosmetic surgery).

4.- Cases where the purpose of the journey is to receive medical treatment or undergo surgery abroad.

5.- Diagnosis, monitoring and treatment of pregnancy, voluntary termination of pregnancy and childbirth, except in the case of urgent care and during the first 150 days of gestation.

6.- The Insured Party's participation in bets, challenges or fights.

7.- The practice of sports in competition or motorised competition (racing or rallying), as well as the practice of dangerous or risky activities such as:

- Boxing, weightlifting, wrestling (various classes), martial arts, mountaineering with glacier access,

**sledging, diving with breathing apparatus, caving and skiing with springboard jumps.**

- **Air sports in general.**
- **Adventure sports, such as rafting, bungee jumping, hydrospeed, canyoning and similar.**

**8.- Suicide, attempted suicide or self-harm of the Insured Party.**

**9.- Rescue of people in mountains, chasm, sea or desert.**

**10.- Illnesses or accidents resulting from the consumption of alcoholic beverages, narcotics, drugs or medicines, unless the latter have been prescribed by a doctor.**

**11.- Malicious acts by the Policyholder, Insured Party or their successor in title.**

**12.- Epidemics and/or sudden outbreaks of infectious diseases that spread rapidly among the population, as well as those caused by pollution and/or air contamination.**

**13.- Wars, demonstrations, insurrections, tumultuous popular movements, acts of terrorism, sabotage and strikes, whether officially declared or not. Transmutation of the atom nucleus, as well as radiation caused by the artificial acceleration of atomic particles. Earthquakes, floods, volcanic eruptions and, in general, those unleashed by the forces of nature. Any other extraordinary catastrophic phenomena or events which, as a result of their magnitude or severity, are qualified as disasters or calamities.**

**Irrespective of the above, the following situations are particularly excluded:**

**1.- The medical transfer of sick or injured persons due to illnesses or injuries that can be treated "in situ".**

**2.- The cost of glasses, contact lenses and crutches,**

**as well as the acquisition, implantation, replacement, extraction and/or repair of prostheses, anatomical and orthopaedic parts of any kind.**

**3.- Medical, surgical and pharmaceutical expenses prescribed in Spain even if they are the result of illnesses or accidents occurring abroad and those costing less than €6.**

### **CLAIMS HANDLING**

The Benefits defined above will be provided at the express request of the Insured Party through the ASISA telephone number 34 91 354 37 40, fax number 91 514 99 50, telegram, verbally or by post.

The Insured Party will call the above number indicating: name and surname, Asisa healthcare Insurance Policy number, place where the Insured Party is, address and telephone number, nature of the care required or nature of the problem, in order to guarantee the provision of services with the utmost diligence. This is a 24/7 service, including Sundays and public holidays.

Should situations of force majeure prevent this notice from being given, **it must be notified immediately after the cause preventing notification has ceased to exist.**

To have expenses reimbursed you can go to <https://asi-sa.eclaims.europ-assistance.com/>, where you will be able to access "Online Procedures" to create your own reimbursement request and monitor the procedure, alternatively you can write to PO box 36316 (28020 Madrid).

**Original invoices and supporting documents must be submitted in all cases.**

### **ACKNOWLEDGEMENT OF DEBT**

All the amounts paid by the Insurance Company, along with the cost of the services rendered at the request of the Insured Parties, and which pursuant to this cover

are not payable by the Insurance Company, constitute advances accepted by the Insured Parties. **Accordingly, the Insured Parties are obliged to refund them to the Insurance Company within a maximum period of thirty (30) days from the date of the request made to them to this effect by the Insurance Company.**

In these cases, and as regards all the other Benefits with respect to which the Insurance Company advances a payment on behalf of the Insured Parties, **the Insurance Company reserves the right to request from the Insured Parties a sufficient guarantee or surety to cover it before commencing the provision of the service.**

## **SUBROGATION**

The Insurance Company is subrogated, up to the total cost of the services provided by it, in the rights and actions that have motivated its intervention. Whenever the Benefits provided in execution of the present cover are covered in whole or in part by another insurance company, by the Spanish Department of Social Security or by any other institution or person, the Insurance Company subrogates the rights and actions of the Insured Party with regard to the company or institution in question. Accordingly, the Insured Party is obliged to collaborate actively with the Insurance Company by providing any help or granting any document that could be considered necessary, at no cost to the Insured Party.

In any case, the Insurance Company will be entitled to request the Insured Party to show or hand over the transport ticket (train ticket, plane ticket, etc.) held by the latter when the return expenses have been paid for by the Insurance Company.

## SCHEDULE V

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### **OPTIONAL DENTAL INSURANCE COVER: REIMBURSEMENT OF EXPENSES FOR ORAL ACCIDENTS**

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In the event that the Insured Party suffers damage to the Oral Cavity as a result of an Oral Accident occurring after the Effective Date of the Optional Dental Insurance Cover or the registration of the Insured Party in it, the Insurance Company undertakes to reimburse the Insured Party the amount of the Excesses corresponding to the dental care that the Insured Party requires as part of the cover of the Optional Cover, **up to a maximum limit of one thousand five hundred euros (€1,500) per Claim and per policy year. If the Insurance Policy has a term of less than twelve (12) months, this maximum limit will be reduced proportionally.**

**The reimbursement of dental expenses will be limited to the expenses previously paid by the Insured Party in relation to the care provided by the dentists/centres in the Medical Directory/Directory of Dentists and Dental Services arranged by the Insurance Company and in accordance with the maximum limit of the Excess amounts established in the Table of Coverage and Excesses in the Policy.**

**Only assistance provided during the term of the Insurance Policy and arising from Oral Accidents that also occur during the term of the Optional Dental Insurance Cover will be covered.**

### **SPECIFIC EXCLUSIONS FROM REIMBURSEMENT COVER FOR ORAL ACCIDENT RELATED EXPENSES:**

**In addition to the exclusions indicated in the Fifth**

**Clause C(2) regarding Optional Dental Insurance Cover, the following cases are expressly excluded from this Oral Accident expenses reimbursement cover:**

- a) Accidents caused intentionally by the Insured Party.**
- b) Events that do not qualify as Accidents as stipulated in the definition of an Oral Accident.**
- c) Accidents resulting from blindness, deafness or some other physical defect of the Insured Party.**
- d) Accidents resulting from the consumption of alcoholic beverages, narcotics, drugs or medicines, unless the latter have been prescribed by a registered medical practitioner in a duly signed report.**
- e) Those occurring in competitions of speed, endurance, races of any nature as a professional, as well as their training and preparatory trials.**
- f) Accidents arising from use of sailing or motorised vessels further than two miles offshore; the use of motorbikes and the use of privately owned light aircraft.**
- g) Accidents occurring as a result of the Insured Party's participation in bets, challenges or fights.**
- h) Accidents occurring due to the practice of sports, dangerous or risky activities such as: boxing, weightlifting, wrestling (various classes), martial arts, mountaineering with glacier access, sledging, diving with breathing apparatus, caving and skiing with springboard jumps, aerial sports in general, adventure sports, such as rafting, bungee jumping, hydrospeed, canyoning and similar activities.**

## **HANDLING CLAIMS**

To submit a Claim for reimbursement of expenses, the In-

sured Party or, where appropriate, a person duly authorised for this purpose, and without prejudice to the stipulations of the Eighth Clause (f) hereto, must provide the Insurance Company with the following documentation:

- a) A duly signed full medical report issued by the dentist/centre in the Medical Directory/Directory of Dentists and Dental Services, which must contain the following information: date of the Accident, injuries, diagnosis, treatment carried out and cause-effect justification between the Accident and the treatment carried out.
- b) Discharge Report.
- c) Invoices accrediting the amounts paid for Excesses, in accordance with the Table of Coverage and Excesses in force at any given time.

The related documentation must be sent by e-mail to the following email address: [reembolsodental@asisa.es](mailto:reembolsodental@asisa.es), or by post to: Apartado de correos N.º 736 FD/2812696 - 28080 Madrid, or by any other means that the Insurance Company makes available to the Insured Party.

Once the Insurance Company has received all the related documentation required and the corresponding verifications have been done, it will reimburse, where applicable, the amounts determined under with the terms and conditions established in this cover.

## SCHEDULE VI

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### **OPTIONAL DENTAL INSURANCE COVER: REIMBURSEMENT OF EXPENSES FOR CONTINGENCIES FOLLOWING THE COMPLETION OF CERTAIN ORAL TREATMENTS**

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If after Initial Dental Treatment from among those specified in this document, and once the corresponding Discharge Report has been issued, problems or medical situations unrelated to this treatment were to appear which negatively influence its evolution, the Insurance Company will be obliged to reimburse the Insured Party, within the limits of the Insured Sum, the amount of the cost of the Restorative Dental Treatment that may be required to accomplish the Initially Planned Therapeutic Objective identified in the Initial Dental Treatment.

**The amount to be reimbursed will correspond to 20% of the amount of the invoice for the Restorative Dental Treatment up to the limit of the Insured Sum (20% of the amount of the Initial Dental Treatment to a maximum of €1,500 per treatment and per policy year). If the Insurance Policy has a term of less than twelve (12) months, this maximum limit will be reduced proportionally.**

**Only the expenses paid as Excesses as per the Table of Coverage and Excesses in force at the moment of carrying out the covered Dental Treatments (Initial and Restorative) by the Insurance Company's dentists/centres in the Medical Directory/Directory of Dentists and Dental Services will be taken into account for the purposes of reimbursement.**

For the purposes of this cover, the following dental treatment is considered as Initial Dental Treatment:

1. Stomatognathic rehabilitation using tooth-supported fixed prosthesis.
2. Implantology.
3. Orthodontics.

**Only Restorative Dental Treatment which has been commenced and completed within five (5) years from the date of issue of the Initial Dental Treatment Discharge Report will be covered.**

**To be eligible for this cover, the Optional Dental Insurance Cover must have been in force from the commencement of the Initial Dental Treatment until the completion of the Restorative Dental Treatment.**

#### **SPECIFIC EXCLUSIONS REGARDING COVER TO REIMBURSE CONTINGENCIES FOLLOWING COMPLETION OF CERTAIN ORAL TREATMENTS**

**In addition to the exclusions indicated in the Fifth Clause C(2) regarding Optional Dental Insurance Cover, the following cases are expressly excluded from this expenses reimbursement cover:**

- a) Those arising from Oral Accidents.**
- b) Those arising from dental treatment that has not been completed with a Discharge Report.**
- c) Those arising from any medical-dental procedure covered in the Optional Dental Insurance Cover if the Insured Party has not complied with the provisions of the Discharge Report in relation to the check-ups to be carried out, hygiene, care, etc.**
- d) Those arising from any medical-dental procedure covered in the Optional Dental Insurance Cover required to repair damage resulting from an unexpected situation covered by the Optional Cover if the**

**Insured Party does not present the invoice to the Insurance Company certifying that the treatment has been paid for.**

**e) Those arising from the repetition of a dental treatment due to an allegation of purely aesthetic damage.**

## **CLAIM PROCEDURE**

Notwithstanding the provisions of the Eighth Clause (f) hereto, when making a Claim the Insured Party must submit the following documentation to the Insurance Company:

- a) Copy of the Initial Dental Treatment Discharge Report duly signed by the dentist in charge of the treatment, specifying the Initially Planned Therapeutic Objective.
- b) Invoices accrediting payment of the Excesses for the Initial Dental Treatment.
- c) Copy of the Restorative Dental Treatment Discharge Report duly signed by the dentist in charge of the treatment who figures in the Medical Directory/Directory of Dentists and Dental Services, stating that the covered medical-dental procedures required are related to the Initial Dental Treatment.
- d) Invoices accrediting payment of the Excesses for the Restorative Dental Treatment.
- e) Form established for this purpose by the Insurance Company.

The related documentation must be sent by e-mail to the following email address: [reembolsodental@asisa.es](mailto:reembolsodental@asisa.es), or by post to: Apartado de correos N.º 736 FD/2812696 - 28080 Madrid, or by any other means that the Insurance Company makes available to the Insured Party.

Once the Insurance Company has received all docu-

mentation required and the corresponding verifications have been done, it will reimburse, where applicable, the amounts determined under with the terms and conditions established in this cover.

## SCHEDULE VII

### OPTIONAL DENTAL INSURANCE COVER: TABLE OF COVERAGE AND EXCESSES 2024

SERVICES	EUROS
<b>A. DIAGNOSIS</b>	
Initial examination, diagnosis and estimate	0
Periodontal examination	0
Emergency examination	0
Professional consultation	0
General dental check-up	0
<b>B. DIAGNOSTIC IMAGING</b>	
Intraoral X-ray	0
Occlusal X-ray	0
Bite-wing X-ray	0
Lateral skull X-ray	0
Digital orthopantomography	0
Digital telerradiography	0
<b>Tomographic scan (CT)</b>	
Single arcade CT	85
Two-arch CT	120
<b>C. PREVENTIVE DENTISTRY</b>	
Dental cleaning	0
Fluoride dental treatment	0
<b>D. CONSERVATIVE DENTISTRY</b>	
<b>Fillings</b>	
Provisional	0
Cosmetic	45
Major reconstruction	59
Post crown reconstruction*	94

SERVICES	EUROS
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E. ENDODONTICS	
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Single root endodontics *	120
Double root endodontics*	135
Multi-root endodontics *	155
Root formation per session	0
Root end surgery *	0
Endodontic retreatment (from)	145
Pulp chamber drainage opening (cost of filling not included)	25

F. PAEDODONTICS	
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Fluoride treatments	0
Occlusal sealants	0
Pulpotomies on first teeth *	60
Prefabricated metal crown	65
Fixed space maintainers	70
Removable space maintainers	55
Replantation by tooth	0
First teeth filling (composite)	37
Space maintainer check-up	20

G. PERIODONTICS	
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Non-surgical treatments	
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Tooth splinting (per tooth)	35
Tooth splinting (per sextant)	150
Periodontal maintenance (per quadrant)	22
Periodontogram	0
Quadrant curettage (scaling and root planing) *	39

Surgical treatments	
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Partial gingivectomy (per quadrant) *	35
Periodontal flap surgery (per quadrant) *	175

SERVICES	EUROS
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Quadrant crown lengthening	160
Mucogingival graft *	200
Placement of bio-materials (1g)	225
Membrane regeneration	225
Peri-implantitis treatment *	70

## H. ORTHODONTICS

	Up to 12 months	Up to 24 months	Over 24 months
Orthodontic treatment using metal braces with final retainers	2,060	2,515	2,745
Orthodontic treatment using cosmetic brackets with final retainers	2,460	2,915	3,145
Orthodontic treatment using self-ligating metal braces with final retainers	2,460	2,915	3,145
Orthodontic treatment using cosmetic self-ligating braces with final retainers	3,060	3,515	3,745
Interceptive treatment 1 year	1,090		
Interceptive treatment 2 years	1,450		

## I. PROSTHESES

### Fixed

CAD-CAM crown	330
IMMEDIATE CAD-CAM crown	380

SERVICES	EUROS
<b>Removable or overdenture</b>	
<b>Removable acrylic</b>	
Removable acrylic (1 to 3 teeth)	200
Removable acrylic (4 to 6 teeth)	295
Removable acrylic (over 6 teeth)	410
<b>Flexible removable</b>	
Flexible removable (1 to 3 teeth)	500
Flexible removable (4 to 6 teeth)	595
Flexible removable (over 6 teeth)	690
<b>Complete</b>	
Upper or lower	415
<b>Prosthesis repairs</b>	
Prosthesis repair	50
<b>J. SURGERY</b>	
Simple tooth extraction (per tooth)	0
Surgical tooth extraction (per tooth)	55
Maxillary torus	0
Cystectomy, maxillary cysts *	0
Frenectomy	0
Fenestration	50
Epulis	0
<b>K. IMPLANTOLOGY</b>	
<b>Surgical phase</b>	
Implantology study (including models and photos)	0
Implant	640
Implant maintenance	50
Sinus lift *	450
Placement of bio-materials (1g)	225
Membrane regeneration	225

SERVICES	EUROS
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Prosthetic phase	
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Prosthetic attachment per implant	335
Provisional on implant	220
IMMEDIATE CAD-CAM crown	415
CAD-CAM crown	385

L. TMJ	
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Check-up	30
Diagnosis and placement of neuromyorelaxation (occlusal) splints	315
Selective grinding. Occlusal analysis.	40

**NOTES:**

1. Services marked with an asterisk can be performed using laser therapy, in which case an additional fee of €60 will be charged.
2. All treatments require a doctor's prescription, after prior assessment of the patient in the consulting room.

**ASISA HEALTH STUDENTS: CONTRACTING RULES.**

This Insurance Policy is subject to compliance with the following contracting rules, about which the Policyholder has been informed prior to signing:

- a) The Insured Party must necessarily be a natural person (international student) who does not hold a Spanish passport/National ID Card and who wishes to carry out activities in Spain that require obtaining a study visa.
- b) This status will be accredited by means of the corresponding documentation provided by the Insured Party, including accreditation of the studies to be undertaken, which ASISA may require, both when taking out the Insurance Policy and at any time during its term.
- c) Failure to meet these requirements regarding the identity of the Insured Party, non-accreditation of this status or the refusal to present the required documentation will automatically rescind the Insurance Policy no matter what time is left to complete its term.

**ASISA HEALTH STUDENTS INSURANCE POLICY**

**ADDITIONAL AGREEMENT: Acceptance of restrictive clauses**

The Policyholder hereby declares that the Policyholder has received a copy of these Insurance Policy General Terms and Conditions and specifically agrees to the entitlement limitation clauses and the contracting rules highlighted **in bold print** herein. In witness whereof the Policyholder sets their hand.

....., on .....

Signed:..... Policy No.:.....





**ASISA HEALTH STUDENTS INSURANCE POLICY  
ADDITIONAL AGREEMENT: Acceptance of restrictive clauses**

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....., on .....

Signed:..... Policy No.:.....



CUT ALONG THE DOTTED LINE AND  
RETURN IT SIGNED





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