

# General Conditions

**Salud Familiar Opción  
Medisalud Opción**





**MAPFRE**

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# Salud Familiar Opción Medisalud Opción

In accordance with the provisions of Article 3 of Law 50/80 of October 8 on Insurance Contracts (BOE 17/10/80), the clauses that limit the rights of the insured parties contained in the General Conditions of this policy appear in bold.

# Table of Contents

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	<u>Page</u>
<b>General Conditions</b>	
Introductory Article.....	5
Article 1. Legal framework that regulates the policy .....	5
Article 2. Purpose and extension of the insurance .....	5
Article 3. Description of the benefits provided through approved services.....	6
3.1. Non-hospital benefits .....	6
3.1.1. Primary Care .....	6
3.1.2. Specialized Outpatient Care .....	7
3.1.2.1. Additional Coverages to the Specialized Outpatient Care Benefit .....	9
3.1.2.2. Special Services .....	13
3.1.3. Specialized obstetric care .....	15
3.2. Hospital benefits.....	15
3.2.1. Surgical hospitalization .....	17
3.2.2. Non-surgical hospitalization .....	18
3.2.3. Obstetric hospitalization .....	18
3.3. Second international diagnosis .....	19
3.4. Access to the Hospital Network in the United States of America .....	20
Article 4. Description of the benefits provided through reimbursement of expenses .....	20
4.1. Reimbursement of non-hospital benefits.....	21
4.1.1. Reimbursement of Expenses for Primary Care.....	21
4.1.2. Reimbursement of Expenses for Specialized Outpatient Care.....	21
4.1.3. Reimbursement of Expenses for Specialized Obstetric Care .....	22
4.2. Hospital benefits.....	22
4.2.1. Reimbursement of Expenses for Surgical Hospitalization .....	23
4.2.2. Reimbursement of Expenses for Non-Surgical Hospitalization.....	23
4.2.3. Reimbursement of Expenses for Obstetric Hospitalization.....	24
4.2.4. Second International Diagnosis .....	24
4.2.5. High Coverage .....	24
Article 5. Dental benefit in healthcare assistance and reimbursement of expenses .....	25
Article 6. National and international adoption in healthcare assistance and reimbursement of expenses .....	26
Article 7. Waiting periods.....	27
Article 8. Participation of the insured party in the cost of services .....	28
Article 9. Authorization of healthcare assistance services and reimbursement of expenses .....	28
Article 10. General exclusions for all benefits.....	29
Article 11. Basis of the contract .....	32
Article 12. Drawing up, effect and term of the contract.....	34
Article 12 bis. Taking out insurance at a distance.....	34

# Table of Contents

---

	<u>Page</u>
Article 13. Payment of the premium .....	35
Article 14. Time limits and jurisdiction.....	36
Article 15. Additional benefits .....	37
Article 16. Protection of payments.....	37
Article 17. Death by accident.....	38

## Definitions

Definitions.....	39
------------------	----



# General Conditions

## INTRODUCTORY ARTICLE

The products called “MAPFRE SALUD OPCIÓN” include different benefits that can be taken out upon request in two health insurance policies. The subscribed benefits of the policy holder regarding each insured party will be specified in the Specific Conditions of the policy and/or on the Individual Insurance Certificate.

## ARTICLE 1. LEGAL FRAMEWORK THAT REGULATES THE POLICY

This insurance contract is governed by the provisions of Law 50/1980 of October 8 on Insurance Contracts, by Royal Legislative Decree 6/2004 of October 29, by which the revised text of the Private Insurance Organization and Supervision Act is approved along with its implementation regulation, approved by Royal Decree 2486/1998 of November 20, and by as many standards and legal provisions enacted that may affect the insurance contract and by the agreements in the General, Special and Specific Conditions, their Appendices and Supplements, and on the Individual Insurance Certificate.

MAPFRE FAMILIAR, COMPAÑÍA DE SEGUROS Y REASEGUROS, S.A., hereinafter the Insurance Company, has a registered address in Spain and its activity is supervised and monitored by the Ministry of Economy and Competitiveness of Spain through the General Directorate for Insurance and Pension Funds.

## ARTICLE 2. PURPOSE AND EXTENSION OF THE INSURANCE

Within the limits and conditions set forth in the policy, in accordance with the benefits taken out by the policy holder and regarding the risks described in these General Conditions, and by means of payment of the premium applicable to each case, the Insurance Company commits:

- To directly assume the cost of medical, surgical and hospital care required by the insured party due to illness or injury. This care shall be provided through the services approved by the Insurance Company for that purpose.

Optional monetary compensations may never be granted in lieu of providing healthcare assistance services.

- To assume the full or partial reimbursement for reasonable and customary expenses paid previously by the insured party and resulting from the medical, surgical and hospital care provided to him/her as a result of illness or injury.

Individuals over 65 years of age cannot be insured unless expressly accepted by the company under the terms established in each renewal.

The benefits of the policy will be valid provided that the usual address of residence of the insured party is in Spain. If the insured party moves outside Spain, the benefits of the policy will be automatically terminated.

# General Conditions

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## ARTICLE 3. DESCRIPTION OF THE BENEFITS PROVIDED THROUGH APPROVED SERVICES

The benefits that the policy holder can take out exclusively by means of approved services and which shall be stated in the Specific Conditions and/or the Individual Insurance Certificate, depending on the insurance conditions agreed on by the policy holder and the Insurance Company, are as follows:

### 3.1. NON-HOSPITAL BENEFITS

These include doctor's consultations, outpatient surgery, and the diagnostic and/or therapeutic procedures that are specifically detailed in each of the benefits, as agreed in these General Conditions and in the Specific Conditions and/or on the Individual Insurance Certificate.

All non-hospital benefits include home and outpatient emergency care.

### Services that are not covered

- **Healthcare assistance provided by doctors, services or centers not approved by the Insurance Company, whether public or private, is always excluded even if ordered by approved services, as well as medical, hospital or any other kind of expense arising from services that unapproved doctors, services or centers may prescribe.**

**The Insurance Company may request payment from the insured party of any expenses paid to the public healthcare system for care provided in cases that are not covered, as established in these General Conditions.**

#### 3.1.1. Primary Care

#### What is covered

Healthcare assistance at the doctor's consultation and/or the home of the insured party indicated in the policy, covering the following services:

- **General medicine.**
- **Pediatrics and baby care.** This includes the care of children up to 14 years old and the preventive medicine program called Healthy Child Program (Programa del Niño Sano). This primary care program is mainly intended for all children from the time they are born up to 11 years old, and includes:
  - Provision of a child health document to monitor the health of the child.
  - Neonatal examination and early detection of anomalies.
  - Regular health check-ups to follow up on nutrition and psychophysical development.
  - Vaccinations according to the official schedule.
  - Record of detected incidents and illnesses.
  - Promotion and education for child health.
- **Diagnostic means:** Basic clinical analysis and conventional radiology without contrast.
- **Nursing.**
- **Home and outpatient emergency care through approved services.**

## How the service is provided

- The insured party may freely make an appointment with any service approved by the Insurance Company.
- General medicine, pediatrics and baby care, as well as nursing services, include care at the office or home of the insured party. The latter case shall only occur when, at the discretion of the doctor, the patient may not move due to the illness or injury he/she has.
- The use of diagnostic means and the nursing service will require the written prescription from a doctor included in the services approved by the Insurance Company, indicating, for the nursing service, if the care is at the office or home.
- For home care, the selection of a general doctor, pediatrician or RN outside the locality where the insured party lives will require the prior acceptance of the approved service.
- Home emergencies will require obtaining prior authorization from the Insurance Company. In cases involving a temporary change of address, the authorization will be requested through the emergency telephone service of the Insurance Company. If emergency care is needed at a medical center, the insured party will directly go to an emergency center approved by the Insurance Company. In case of doubt, the insured party should contact the emergency telephone service of the Insurance Company.

## 3.1.2. Specialized Outpatient Care

### What is covered

Care by doctors in the different medical specialties listed below, diagnostic and therapeutic procedures, and surgery that **are exclusively provided on an outpatient basis and/or at outpatient hospitals**. This benefit also includes radiological contrasts used in diagnostic imaging examinations.

- **Allergology.** Vaccines will be paid for by the insured party.
- **Clinical analyses.**
- **Pathological anatomy.**
- **Anesthesiology and resuscitation.** Anesthesia in outpatient surgical processes.
- **Angiology and peripheral vascular surgery. Vein sclerosing treatments are excluded.**
- **Digestive system.**
- **Cardiology.**
- **Cardiovascular surgery.**
- **General surgery and digestive system surgery.**
- **Maxillofacial surgery.**
- **Pediatric surgery.**
- **Plastic and reconstructive surgery.**
- **Chest surgery.**
- **Dermatology. Androgenic alopecia is excluded.**

# General Conditions

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- **Diagnostic imaging.**
- **Endocrinology and nutrition.**
- **Geriatrics.**
- **Gynecology.** Any kind of consultation, additional medical tests and/or treatment associated with pregnancy and birth is excluded.
- **Hematology and hemotherapy.**
- **Internal medicine.**
- **Nuclear medicine.**
- **Nephrology.**
- **Pulmonology.**
- **Neurosurgery.**
- **Clinical neurophysiology.**
- **Neurology.**
- **Odontostomatology.** This **only** includes the treatment proposal, one annual mouth cleaning, plain X-rays and simple teeth extractions. **Periodontics, endodontics, fillings, orthodontics, dental prostheses, implants and other dental treatments are excluded, unless the dental benefit of this policy is taken out.**
- **Ophthalmology.** Photodynamic therapy and refractive surgery are excluded.
- **Medical oncology.** Additional medication to chemotherapy treatment is excluded.
- **Radiation oncology.**
- **Otolaryngology.**
- **Podiatry.** This includes treatments for foot pathologies regarding benign surface tumors and nail pathologies provided by nursing professionals specialized in podiatry. This coverage includes 4 chiropody sessions per year, surgical treatment of ingrown nails and podiatric treatment of papillomas.
- **Psychiatry.** This **only** includes the consultation in acute or exacerbated psychiatric processes. **Drug and alcohol detoxification treatments, as well as outpatient hospitals for psychiatric hospitalization are excluded.**
- **Rehabilitation and logophoniatrics.** This includes the necessary treatments until the insured party has attained total, or otherwise, maximum functional recovery, as a result of having entered the process in a state of unsurpassable stabilization or the treatment is constituted as maintenance or occupational therapy. A doctor designated by the Insurance Company will evaluate the functional recovery attained.

**Neurological rehabilitation treatments and other specific treatments for acquired brain damage have a maximum limit of 90 days on an outpatient basis. This coverage is limited to one time only for the duration of the policy.**

**Rehabilitation of the pelvic floor, language education except in the event of speaking organ pathologies, education, therapy and special rehabilitation in patients with psychomotor disorders caused by congenital or acquired processes, maintenance or occupational therapy, as well as outpatient rehabilitation treatments for spinal cord damage are excluded.**

- **Rheumatology.**
  - **Ambulance service.** This includes ordinary or medical transfers in an ambulance in cases of:
    - Transfer of the insured party to the hospital in the event of an emergency.
    - Transfer of the insured party between hospitals.
    - Transfer of the insured party from the hospital to his/her home after discharge from the hospital.
    - Transfers of the insured party hospitalized at home to a consultation, or for rehabilitation, physiotherapy or diagnostic tests.
- Transfers required for care at medical consultations, performance of diagnostic testing, as well as for physiotherapy and rehabilitation treatments are excluded, except under the circumstances established for patients hospitalized at home.**
- **Pain management.**
  - **Traumatology and orthopedics.**
  - **Urology. Prostate hyperthermia is excluded.**
  - **Ventilation therapy, aerosol therapy, oxygen therapy.** In consultation or at home according to the specifications of the doctor. **CPAP, BIPAP and apnea monitors are excluded.**

## How the service is provided

- The insured party may freely make an appointment with the services approved by the Insurance Company throughout Spain, with the exception of specific therapeutic methods or diagnostic tests that require obtaining express authorization from the Insurance Company. The list of services subject to authorization are included in the current Medical Care Guide.
- Transportation to access specialists or medical centers will always be the responsibility of the insured party, except when there are special circumstances of physical inability that prevent him/her from using the ordinary transportation services (public services, taxi or their own vehicle). In this case, transportation will be by an ordinary or medical ambulance service included in the services approved by the **Insurance Company, and provided that a doctor approved by the Insurance Company orders it in writing. This service exclusively refers to land ambulances and does not limit the number of kilometers.**

### 3.1.2.1. Additional Coverages to the Specialized Outpatient Care Benefit.

This includes the preventive medicine programs designed by the Insurance Company which are indicated below. These are provided at centers specifically approved for that purpose and include medical actions, clinical examinations and the use of diagnostic means specifically aimed at preventing illnesses.

When there are no services approved by the Insurance Company in the province of residence of the insured party, these programs may be undertaken in the approved services of other provinces, after consultation with the Insurance Company.

# General Conditions

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## **Family planning.**

This program includes:

- IUD implantation techniques (including the cost of the conventional or standard IUD).
- Tubal ligation.
- Vasectomy.

The program is mainly intended for couples who would like to plan when and if they have children, whether this means not having them using permanent or temporary techniques (mechanical or pharmacological), or having them after receiving an infertility diagnosis and treatment.

## **Early diagnosis of breast diseases.**

This program includes:

- Analysis of the risk of the insured party based on a questionnaire established for this purpose.
- Consultation and examination by a specialized doctor.
- Breast ultrasound.
- Clinical report with diagnosis, risk assessment and recommendations.

A mammogram will be performed if a situation of risk is detected after the initial tests.

The early diagnosis program of breast diseases is mainly intended for women over 40 years old who have not had children or who had their first child after 35, who have experienced menarche (appearance of the first period) before turning 12 years old, who experienced menopause after turning 50 years old, who are receiving hormone treatment, and who have a history of breast disease or a family history of breast cancer.

## **Early diagnosis of gynecological diseases.**

This program includes:

- Analysis of the risk of the insured party based on a questionnaire established for this purpose.
- Consultation and examination by a specialized doctor.
- Colposcopy and vaginal cytology.
- Gynecological ultrasound.
- Specific analysis.
- Clinical report with diagnosis, risk assessment and recommendations.

The early diagnosis program of gynecological diseases is mainly intended for women over 25 years old who were pregnant before turning 20 years old, who have genital infections, who experienced menarche (appearance of the first period) before turning 12 years old, who experienced menopause after turning 50 years old, who have general alterations of the period, and who have a family history of gynecological cancer or who are obese, have diabetes, hypertension or who smoke.

## **Early diagnosis of coronary heart diseases.**

This program includes:

- Analysis of the risk of the insured party based on a questionnaire established for this purpose.
- Consultation and examination by a specialized doctor.
- Electrocardiogram.
- Stress test.
- Specific analysis.
- Clinical report with diagnosis, risk assessment and recommendations.

An echocardiogram will be performed if a situation of risk is detected after the initial tests.

The program is mainly intended for people over 40 years old, men and women, with high cholesterol, hypertension, who smoke, have diabetes, are obese, have a sedentary lifestyle or have a family history of coronary heart disease.

## **Early diagnosis of prostate diseases.**

This program includes:

- Analysis of the risk of the insured party based on a questionnaire established for this purpose.
- Consultation and examination by a specialized doctor.
- Urological ultrasound.
- Specific analysis.
- Clinical report with diagnosis, risk assessment and recommendations.

The program is mainly intended for men who are over 50 years old and do or do not have symptoms when urinating, and who would like to know the condition of their prostate.

## **Early diagnosis of diabetes and monitoring the diabetic patient.**

This program includes:

- Early diagnosis of diabetes with consultation and examination by a specialist, electrocardiogram, ocular fundus, specific analysis, report and recommendations.
- Monitoring and treatment of diabetic patients with control and monitoring by a specialist, education on diabetes, annual diabetes monitoring consultation with a personalized patient file, specific analysis and other diagnostic examinations, and the start of outpatient insulin treatment.

The early detection program of diabetes is intended for people with a family history of diabetes; who are obese; who are over 40 years old; who have high blood pressure and cholesterol; who are excessively tired; and who experience an increase in appetite, thirst, the volume of urine expelled per day and weight loss.

The program for monitoring and treatment of diabetic patients is intended for all people diagnosed with diabetes.

# General Conditions

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## Early diagnosis of glaucoma.

This program includes:

- Risk assessment questionnaire.
- Consultation and examination by a doctor specialized in ophthalmology, examining visual acuity and the optic nerve and measuring intraocular pressure.
- Exam of the front part of the eye using a slit lamp.
- Clinical report with diagnosis, risk assessment and recommendations.

If an increase in intraocular pressure is detected and/or the optic nerve is affected, a gonioscopy and campimetry will be performed to determine the state of the disease.

This program is mainly intended for people who have a family history of glaucoma; who are nearsighted; who have a cardiovascular disease, migraines or diabetes; who have been taking medicine that may cause intraocular pressure to increase in the last 2 years (mainly antidepressants or corticosteroids); or who are over 40 years old and have not had an ophthalmological exam in the last 3 years.

## Early detection of deafness in children.

This program includes:

- Consultation and examination.
- Otoacoustic emissions.
- Auditory evoked potentials of the brain stem.

This program is intended for insured parties from their birth up to 7 years of age. It is essential that the mother or father has had a policy for more than 8 months at the time of birth for this service to be provided.

This includes speech therapy sessions, **up to a maximum limit of 20 sessions per insured party per year.**

## Cardiac rehabilitation.

This program includes:

- Consultation and evaluation by specialists.
- Cardiac rehabilitation sessions by means of physical exercises under cardiological control and monitoring, **up to a maximum limit of 30 sessions per insured party per year.**
- Follow-up cardiac stress test.
- Conversational talks with patients and family members aimed at changing their lifestyle habits and health education, therefore providing the patient and his/her family members with information regarding the improvement of his/her physical and psychological condition.

This includes rehabilitation programs intended for coronary patients and patients who have received cardiac surgical interventions for the purpose of improving their physical and psychological condition, facilitating reincorporation of the patient in his/her work and social life as soon as possible.

Traveling insured parties may receive part of the treatment at the rehabilitation center approved by the Insurance Company. The patient can undergo the rest of the treatment independently at his/her own home, following the protocols given by the center and under the supervision of the cardiologist responsible for the patient.

## 3.1.2.2. Special Services

### Brief psychotherapy or focal therapy treatments

#### What is covered

- This includes a consultation with the psychologist and treatment, **up to a maximum limit of 20 sessions per insured party per year, with the exception of eating disorders whose maximum limit is 40 sessions per insured party per year. Psychoanalysis, hypnosis, ambulatory narcolepsy, sophrology, psychological tests, as well as psychosocial or neuropsychological rehabilitation, treatment for alcoholism and drug addiction are excluded.**

#### How the service is provided

- The insured party must obtain prior authorization from the Insurance Company. Furthermore, the treatment must have been prescribed by a psychiatrist included in the services approved by the Insurance Company as additional treatment for psychiatric pathologies. The prescription shall always be accompanied by a report from the prescribing doctor, justifying that the requested treatment is within the coverages of the policy. There will be a deductible to be paid by the insured party. This can be found in Appendix I of these General Conditions. This deductible will be reviewed annually and may vary depending on the variations in care costs.

### Osteopathy

#### What is covered

- This includes a consultation with the osteopath and the treatment prescribed by him/her with a maximum of 8 sessions per insured party per year.

The insured party must go to an osteopath included in the Medical Care Guide after authorization by the Company.

The insured party will pay part of the cost of this service in accordance with the deductibles determined based on the agreements established by the Insurance Company with the specialized centers indicated in the current Medical Care Guide and Appendix I of these General Conditions.

These deductibles will be reviewed annually and may vary depending on the variations in care costs.

# General Conditions

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## Biomechanical walking study

### What is covered

- The study, using a specialized walking analysis system, consists of active examination and the walking capacity of the insured party, observing possible alterations that could affect the skeletal structure, for the purpose of preventing injuries or correcting already detected problems.
- **In adults, this only covers conducting one study every five years, and in children (up to 14 years old) it covers conducting one study every two years.**

### How the service is provided

- **To conduct the study, the insured party must go to the centers recommended by the Insurance Company with a medical prescription.**

Once the study is completed, if desired, the insured party can request at his/her expense, the digitalization of the study which will provide a virtual mold of the foot in three dimensions, and the manufacture of customized insoles. The insured party will have to pay for these at the center or service where they are made.

### Services that are not covered

- **Digitalization of the study and manufacture of customized insoles.**

## Assisted reproduction

### What is covered

- The treatment and study of the sterility of the couple, artificial insemination techniques and in vitro fertilization. **Both members of the couple must be insured parties of the policy. They must not have undergone contraceptive surgery (vasectomy or tubal ligation) and one of the members must have a confirmed diagnosis of sterility. Neither one can be 40 years old or have had children. The coverage includes two attempts at artificial insemination and one attempt at in vitro fertilization for the duration of the policy. Medication; freezing/unfreezing embryos, sperm and eggs; preimplantation diagnosis; as well as the expenses for donating oocytes and sperm are excluded.**

### How the service is provided

- In assisted reproduction, the specialist in assisted reproduction techniques designated by the Insurance Company will prescribe and select the treatment based on the corresponding sterility studies. The treatment will be provided at the medical centers and hospitals and by the doctors designated for this purpose by the Insurance Company. It is not necessary for these to be located in the province of residence of the insured parties.
- If ICSI or sperm microinjection techniques are applied, there will be a deductible to be paid by the insured party. This can be found in Appendix I of these General Conditions.

The application of assisted reproduction techniques will always be in compliance with current legislation.

### 3.1.3. Specialized obstetric care

#### What is covered

- Outpatient care by an obstetrician or gynecologist, the diagnostic and therapeutic procedures for monitoring the pregnancy of the insured party, provided that hospitalization is not required. This benefit specifically covers the following in outpatient care and services approved for this purpose by the Insurance Company: cytologies, ultrasounds, laparoscopy, karyotypes, genotypes, amniocentesis, amnioscopy and maternal-fetal monitoring.
- The following preventive medicine programs:

#### Preparation for giving birth

This is mainly intended for pregnant women after the second trimester of pregnancy. This includes the group of breathing and relaxation techniques, prenatal exercise and group psychotherapy, which are applied so the pregnant woman is physically and psychologically prepared for giving birth. The complete treatment shall have a maximum duration of 15 hours.

#### Monitoring and treating diabetes during pregnancy

This is intended for pregnant diabetic women or women who, during their pregnancy, experience alterations in their blood sugar. This includes early diagnosis, interconsultation and education on diabetes, analysis and specific examinations.

#### How the service is provided

- The insured party may freely make an appointment with the services approved by the Insurance Company throughout Spain, with the exception of specific therapeutic methods or diagnostic tests that require obtaining express authorization from the Insurance Company. The list of services subject to authorization can be found in the current Medical Care Guide.

#### Services that are not covered

- **Postpartum recovery techniques.**
- **Tubal ligation.**

### 3.2. HOSPITAL BENEFITS

#### What is covered

- This includes the stay in the hospital with use of a single room, meals for the admitted insured party, companion bed (if the hospital has them), use of the operating room, consumables, osteosynthesis materials, prostheses, implants (according to Appendix I of the General Conditions of the policy), medications, treatments and diagnostic tests, as

# General Conditions

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well as the fees earned by the services approved by the Insurance Company that arise during the hospitalization.

- As an exception, services provided in outpatient hospitals, both for surgical and medical procedures (including medication, products and diagnostic tools used during the stay in the hospital), as agreed in these General and Specific Conditions, will be covered.

**For the purposes of this contract, hospitalization is understood to mean admission of the patient and bed rest in the hospital for at least 24 hours.**

- The provision of hospital services will always be adjusted to the characteristics and capabilities of the hospital and its various special units.
- Within the hospital benefits, the intensive care unit, coronary care unit, isolation units and home hospitalization are included, as well as conventional or emergency ambulance service, in the corresponding hospital mode.
- Hospital emergencies will be covered in the approved services indicated in the Medical Care Guide in force. In case of doubt, the insured party should contact the emergency telephone service of the Insurance Company, where he/she will be directed to the nearest approved service to receive the necessary care.

## How the service is provided

- In general, for any type of hospitalization, prior authorization must be requested from the Insurance Company at least 48 hours in advance.
- The prescription from the specialist for hospital care must be for a service approved by the Insurance Company, stating the reason for admission.
- In cases of emergency hospitalization, the written prescription or admission report issued by the approved service will suffice. In these cases, the insured party must identify him or herself to the administrative services of the clinic as a MAPFRE FAMILIAR insured party, and must inform the Insurance Company of the admission within a maximum period of 72 hours, for the purposes of obtaining the proper authorization.
- If it is an extreme or life threatening emergency, the insured party may be treated by the nearest doctor or hospital. In this case, the insured party or other person acting on his/her behalf must make contact in a reliable way (telegram, fax, or personal appearance) within 72 hours of care and/or admission, and obtain the authorization of the Insurance Company. They must also submit a medical report to justify the extreme or life threatening emergency. Medical services especially designated by the Insurance Company may decide to transfer the insured party to an approved service, provided there is no medical contraindication and, in any case, to assess the severity of the emergency that prompted care by services not approved by the Insurance Company.
- If the insured party or the person representing him/her does not accept the transfer mentioned in the preceding paragraph, the Insurance Company will not pay the expenses accrued from the time of notification. Likewise, the Insurance Company will not pay for expenses when the type of emergency does not justify the unapproved care services.
- Home hospitalization service always requires obtaining prior authorization from the Insurance Company. The authorization shall be subject to the existence, in the locality of

residence of the insured party, of an approved service that can provide the service. This exclusively includes medical care by a general doctor and the participation of nursing personnel for injections, fluid therapy, catheters and healing wounds.

- Ambulance service includes transfers in the cases specified in the special ambulance care benefit, **as long as a qualified doctor orders it in writing and if physical circumstances prevent the patient from using ordinary transportation services (public services, taxi or their own vehicle). This service exclusively refers to land ambulances and does not limit the number of kilometers.**

## Services that are not covered

- **Healthcare assistance provided by doctors, services or centers not approved by the Insurance Company, whether public or private, is always excluded even if ordered by approved services, as well as medical, hospital or any other kind of expense arising from services that unapproved doctors, services or centers may prescribe.**  
The Insurance Company may request payment from the insured party of any expenses paid to the public healthcare system for care provided in cases that are not covered, as established in these General Conditions.
- **All surgical techniques or therapeutic procedures that use a laser, except those expressly included in these General Conditions.**

### 3.2.1. Surgical hospitalization

#### What is covered

- Hospitalization for treatment of illness or injury requiring surgery in different surgical specialties, including endoscopic surgery, endolaser in angiology and vascular surgery, KTP laser and Holmium laser in urology, laser in ophthalmology, general surgery and digestive tract surgery, as well as outpatient surgery.
- Program for treatment of deafness in children, intended for insured parties from their birth up to 7 years of age. It is essential that the mother or father has had a policy for more than 8 months at the time of birth for this service to be provided. **Exclusively** in cases of bilateral deafness and greater than 40 dB HL in the healthier ear, in addition to the above, the Insurance Company will cover:
  - A cochlear implant, with a limit of €22,000 per insured party and for the entire term of the policy.
  - Two hearing aids, **one for each ear**, for the entire term of the policy with a limit of €2,000 each.
- Medical and surgical care for corneal, heart, liver, kidney, lung, pancreas and bone marrow transplants. The transplant will be performed by the medical team and at the hospital designated by the Insurance Company.
- Reimbursement, up to the previously set financial limit, of the acquisition cost of prostheses and implants and which are **exclusively** included in the list of prostheses and implants in Appendix I of these General Conditions, which have been used in the surgery authorized

# General Conditions

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by the Insurance Company. The reimbursement will be made upon presentation of the corresponding invoice from the supplying company of the prosthesis and/or implant, once paid by the insured party. The Insurance Company may annually update the maximum amounts to be reimbursed for prostheses and implants.

## Services that are not covered

- **Stereotactic surgery for Parkinson's Disease.**
- **Epilepsy surgery.**

### 3.2.2. Non-surgical hospitalization

#### What is covered

- Hospitalization for diagnosis and/or treatment of illness or injury requiring hospital admission in various medical specialties which are performed during hospitalization upon the advice of a medical specialist listed in the services approved by the Insurance Company. There is no limit to the number of stays.

In the event of **acquired brain injury** (trauma, vascular, etc.) and **spinal cord injury**: coverage is provided for medical and surgical treatments, functional motor rehabilitation treatments and rehabilitation in specific spinal cord injury units, as well as neurological rehabilitation treatment and other specific treatments, **with a limit of 60 days of hospitalization. This coverage is limited to one time only for the duration of the policy.**

- **Psychiatric hospitalization for the treatment of acute or chronic mental illness. There is a maximum of 60 days per insured party per year, for inpatient or outpatient hospitalization.**
- In the case of pediatric hospitalization there is no limit to the number of stays.

### 3.2.3. Obstetric hospitalization

#### What is covered

- This **exclusively** includes hospital coverage for obstetric reasons, inpatient care for delivery or Cesarean section and care of the newborn not included in the policy with a **limit of 3 days for normal delivery and 5 days for cesarean delivery**, and the cry-preservation benefit of stem cells from the blood and umbilical cord tissue. This includes epidural anesthesia, at the request of the insured party, provided there is a medical indication for it and the center has the technical and professional means to provide it.

## Services that are not covered

- **Tubal ligation.**

## Cryo-preservation of stem cells from the blood and tissue of the umbilical cord (UCB and UCT)

### What is covered

- If care has been provided for the birth, the Insurance Company will also cover the benefit including cryo-preservation of stem cells (obtained from blood and tissue) of the umbilical cord of the newborn in the specialized medical service, and the inclusion of the newborn in the policy, for a period not exceeding 10 days from birth.
- This includes:
  - The sanitary material necessary for collecting the sample.
  - Processing of the sample to determine its viability, and as appropriate, having confirmed viability, storage and maintenance of the sample in a cell bank for a maximum period of twenty years.

### How the service is provided

- To obtain an extraction kit, processing, confirmation of viability and sample storage, the insured party must pay the amounts listed in the specialty services, prostheses catalog, implants and deductibles portfolio, and go to the approved services of the medical diagnosis complying with current legislation in this area which are later agreed with the specialized service designated by the Insurance Company.
- For maintenance of the sample in the cell bank, the Insurance Company will assume, on behalf of the insured party, the payment of annual maintenance fees accrued during the time that it remains insured under the policy of the parent, up to a limit of twenty years. If the sample is not viable for all purposes or if the number of cells obtained was insufficient for processing, the Insurance Company will not assume any payment of maintenance fees.

## 3.3. SECOND INTERNATIONAL DIAGNOSIS

### What is covered

- The doctor who is treating the insured party may request from the Insurance Company an interconsultation with another specialist or hospital accredited worldwide in order to confirm a diagnosis or different therapeutic alternatives, according to their relevance to the condition being treated.

### How the service is provided

- The doctor should contact the medical services of the Insurance Company, which will analyze each particular case and send it to the hospital with the most experience and best reputation in the relevant pathology.
- The doctor responsible for the care will prepare the medical history of the insured party, which will be sent by the Insurance Company to the specialist or centers that are accredited as the most suitable worldwide in the relevant pathology.

# General Conditions

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- The medical services of the Insurance Company, with the proper confidentiality, will send the response of the consultation to the doctor responsible for the care.

## 3.4. Access to the Hospital Network in the United States of America

### What is covered

- The steps necessary to treat the insured party as an inpatient in the U.S. hospital system, with access to a wide network selected by the Insurance Company in that country, **as well as reimbursement to the insured party of 60 percent of the medical and hospital expenses incurred during such treatment, if as a result of the Second International Diagnosis it is decided that the insured party needs to undergo the treatment.**

### How the service is provided

- The Insurance Company will request the budget for medical and hospital expenses from the medical center of the network selected by the insured party and, once accepted, will process his/her transfer to the hospital, and hire interpreters if needed.
- The insured party will be hospitalized at the selected hospital, at preferential prices, and is responsible for the expenses incurred in the transfer, both ordinary and medical costs, costs for companions and those arising from the use of auxiliary services, such as interpreters.
- The Insurance Company, with the support of specialists approved for this purpose, will audit the hospital bill issued by the medical center where the hospitalization took place.
- Once the accuracy of the hospital bill is confirmed, the insured party will make full payment. Subsequently, the Insurance Company shall refund 60 percent of the medical and hospital expenses incurred during the hospitalization.

## ARTICLE 4. DESCRIPTION OF THE BENEFITS PROVIDED THROUGH REIMBURSEMENT OF EXPENSES

The benefits that the policy holder can take out through Reimbursement of Expenses, and which shall be stated in the Specific Conditions and/or the Individual Insurance Certificate, depending on the insurance conditions agreed to by the policy holder and the Insurance Company, as well as the absolute and relative limits of reimbursement for each of the purchased benefits, are detailed below.

Full or partial reimbursement of medical and/or hospital expenses paid by the insured party, within the limits and conditions stipulated in the policy, is included.

Additionally, each reimbursement benefit also includes the identical benefit provided through the services approved by the Insurance Company, as stipulated in Article 3 of these General Conditions.

## Limits of Reimbursement of Expenses.

- The Insurance Company will reimburse expenses that are justified and covered by the policy, which are accrued for medical and hospital services, based on the percentages and reimbursement limits that are specified in the Specific Conditions of the policy and/or the Individual Insurance Certificate. **The rest of the expenses shall be borne by the insured party.**
- **For the purposes of calculating the maximum reimbursement limits, the expenses arising from the use of benefits covered by Reimbursement of Expenses will be added.**
- **For hospital reimbursement benefits, and for the purposes of calculating the maximum reimbursement limit indicated in the Specific Conditions of the policy and/or on the Individual Insurance Certificate, it shall be understood that admissions for the same cause or one related to a previous admission, including its complications, will be considered as a hospital admission for the same condition. For these purposes it will be considered as a continuation of the previous admission and not a new condition.**

## 4.1. REIMBURSEMENT OF NON-HOSPITAL BENEFITS

This includes the full or partial reimbursement of the expenses paid by the insured party and corresponding to doctor consultations, outpatient surgery and the diagnostic and/or therapeutic procedures which are detailed in each of the benefits, as agreed in the Specific Conditions of the Policy and/or on the Individual Insurance Certificate.

### 4.1.1. Reimbursement of Expenses for Primary Care

#### What is covered

- Reimbursement of expenses for primary care in the doctor's office and/or at the home of the insured party, as well as those arising from the use of the following diagnostic means: basic clinical analysis and conventional radiology without contrast.
- Unless otherwise agreed and specified in the Specific Conditions of the policy and/or the Individual Insurance Certificate, primary care service provided through approved services are also included, under the terms established in section 3.1.1 of Article 3 of these General Conditions.

### 4.1.2. Reimbursement of Expenses for Specialized Outpatient Care

#### What is covered

- This includes reimbursement of expenses for the care provided to the insured party by doctors in different medical specialties, diagnostic and therapeutic procedures, radiological contrast scans used in diagnostic imaging and outpatient surgery, **exclusively when performed in an outpatient facility.**

# General Conditions

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- Unless otherwise agreed and specified in the Specific Conditions of the policy and/or Individual Insurance Certificate, the specialized outpatient care services provided through approved services are also included, under the terms established in section 3.1.2 of Article 3 of these General Conditions.

## Reimbursements that are not covered

- **If the insured party must receive hemodialysis or peritoneal dialysis treatment, the Insurance Company will bear the cost of treatment in special hemodialysis and peritoneal dialysis units for a maximum period of 1 year, counting from the time the insured party received the first session.**
- **Sterilization for both sexes, in vitro fertilization, artificial insemination, and the study and/or treatment of sterility/infertility.**
- **Podiatry.**
- **Osteopathy.**
- **Biomechanical walking study.**
- **Psychiatric illness and/or psychological disorders.**

## 4.1.3. Reimbursement of Expenses for Specialized Obstetric Care

### What is covered

- This includes reimbursement of expenses for outpatient care provided by an obstetrics and gynecology specialist, and diagnostic and therapeutic procedures for monitoring the pregnancy of the insured party, provided hospitalization is not required. Specifically, this benefit covers the reimbursement for cytologies, ultrasounds, laparoscopies, karyotypes, genotypes, amniocentesis, amnioscopy and maternal-fetal monitoring.
- Unless otherwise agreed and specified in the Specific Conditions of the policy and/or Individual Insurance Certificate, the specialized obstetric care services provided through approved services are also included, under the terms established in section 3.1.3 of Article 3 of these General Conditions.

## Reimbursements that are not covered

- **Postpartum recovery techniques.**
- **Tubal ligation.**

## 4.2. HOSPITAL BENEFITS

This includes reimbursement of expenses for the hospital stay with use of a single room, meals for the admitted insured party, companion bed, use of the operating room, consumables, osteosynthesis materials, prostheses, implants (according to Appendix I of the General Conditions of the policy), medications, treatments and diagnostic tests, as well as the fees of the professionals involved during the hospitalization and that are detailed in each of the benefits, as agreed to in the Specific Conditions of the policy and/or the Individual Insurance Certificate.

As an exception, it will cover reimbursement of expenses for outpatient hospitals, for both surgical and medical procedures (including medication, products and diagnostic tools used during the stay in the hospital), as agreed in these General and Specific Conditions.

**For the purposes of this contract, hospitalization is understood to mean admission of the patient and bed rest in the hospital for at least 24 hours.**

## 4.2.1. Reimbursement of Expenses for Surgical Hospitalization

### What is covered

- This includes reimbursement of expenses for hospitalization of the insured party in a hospital for treatment of illness or injury requiring surgery in different surgical specialties, including endoscopic and laser surgery. This includes expenses for surgeons, assistants, anesthesiologists, operating room, materials, medication, stay in the ICU, medical visits in the hospital and hospital expenses (room, food and general nursing expenses).
- Unless otherwise agreed and specified in the Specific Conditions of the policy and/or Individual Insurance Certificate, the surgical hospitalization benefit services provided through approved services are also included, under the terms established in section 3.2.1 of Article 3 of these General Conditions.

### Reimbursements that are not covered

- **Sterilization for both sexes.**
- **Rehabilitation treatments for acquired brain injury and spinal cord injury while hospitalized are excluded for all hospital benefits.**

## 4.2.2. Reimbursement of Expenses for Non-Surgical Hospitalization

### What is covered

- This includes reimbursement of expenses for hospitalization of the insured party in a hospital for the diagnosis and/or treatment of illness or injury that requires hospital admission, in different medical specialties. This includes costs for material, medication, stay in the ICU, medical visits in the hospital and hospital expenses (room, food and general nursing expenses).
- Unless otherwise agreed and specified in the Specific Conditions of the policy and/or Individual Insurance Certificate, the non-surgical hospitalization services provided through approved services are also included, under the terms established in section 3.2.2 of Article 3 of these General Conditions.

### Reimbursements that are not covered

- **Psychiatric illness and/or psychological disorders.**

# General Conditions

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## 4.2.3. Reimbursement of Expenses for Obstetric Hospitalization

### What is covered

- This **exclusively** includes the reimbursement of expenses for hospitalization of the Insured in a hospital for obstetric reasons, care during birth, cesarean section, or attendance by a specialist and midwife. This includes expenses for surgeons, assistants, anesthesiologists, operating room, material, medication, stay in the ICU, medical visits in the hospital, and hospital expenses (room, food and general nursing expenses), as well as epidural anesthesia at the request of the insured party, provided there is a medical indication and the center has the technical and professional means provide it.
- Unless otherwise agreed and specified in the Specific Conditions of the policy and/or Individual Insurance Certificate, the obstetric hospitalization services provided through approved services are also included, under the terms established in section 3.2.3 of Article 3 of these General Conditions.

### Reimbursements that are not covered

- **Tubal ligation.**

## 4.2.4. Second International Diagnosis

### What is covered

- **This includes the services of the Second International Diagnostic benefit of section 3.3. of Article 3 of these General Conditions.**

### How the service is provided

- The insured party or the doctor responsible for treatment may request an interconsultation by calling the telephone attention center of MAPFRE FAMILIAR, or directly contacting the medical service of the Insurance Company, which will analyze each specific case and send it to the hospital with the most experience and best reputation in the relevant pathology.
- The specialist doctor of the Insurance Company, responsible for the care, will prepare the medical history of the insured party, which will be sent by the Insurance Company to the specialist or centers that are accredited as the most suitable worldwide in the relevant pathology.
- The medical services of the Insurance Company, with the proper confidentiality, will send the response of the consultation to the doctor responsible for the care.

## 4.2.5. High Coverage

### What is covered

- This benefit increases the maximum financial limit for reimbursement per covered insured party, in accordance with the provisions of the Specific Conditions of the policy and/or the Individual Insurance Certificate.

- The insured parties who have taken out Higher Coverage may use approved services in the U.S. without making any payment for hospitalization. It is only necessary to obtain prior authorization from the Insurance Company.

## **MAXIMUM LIMIT FOR REIMBURSEMENT**

Coverage, reimbursement percentages and agreed limits for the remaining benefits do not change.

The maximum reimbursement limit for Higher Coverage may be used in one or more years and for one or more different reasons, when the reimbursement limits stipulated in the Specific Conditions of the policy and/or the Individual Insurance Certificate have been reached.

For the purposes of calculating the maximum reimbursement limit, the Insurance Company will add the expenses arising from the use of freely chosen services, and the expenses arising from the use of recommended services outside Spain.

In case of extension of the contract, in each successive year of insurance, the Higher Coverage will decrease for each insured party in the amounts used by that insured party, updating the remaining amount, or remnant, according to the variation experienced by the CPI resulting from the application. The amount resulting from this operation is communicated annually to the policy holder.

## **TERMINATION OF THE COVERAGE**

Notwithstanding the termination of this coverage at the time of cancellation of the insurance contract due to any of the causes provided in it, this coverage will automatically cease for each insured party, once he/she has consumed the agreed amount of High Coverage, with any updates that took place according to the stipulations of the previous point.

Since this benefit works as a maximum limit and this coverage is complementary to other reimbursement coverages, subscription to it will not alter any of the General Conditions agreed for the remaining purchased benefits, especially as regards the possibility of both parties not extending the contract at the end of each initial or extended annual period, and the revision of the basic premiums in accordance with the established parameters.

The complementary High Coverage benefit shall be maintained only up to 70 years of age.

## **ARTICLE 5. DENTAL BENEFIT IN HEALTHCARE ASSISTANCE AND REIMBURSEMENT OF EXPENSES**

### **What is covered**

- This includes a series of basic odontostomatological actions, of which the insured party may use without any charge, and other specific actions with a deductible cost, as stipulated in the Special Conditions corresponding to this benefit.
- This includes an extension of the odontostomatological coverages of the specialized outpatient care benefit as stipulated in the Special Conditions of this dental benefit (dental deductible).

# General Conditions

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## How the service is provided

- The insured party may freely make an appointment with a specialist in odontostomatology approved by MAPFRE FAMILIAR at the national level.
- The insured party shall identify themselves as such before the approved service, presenting to that effect their health insurance card before to any dental action or treatment.
- The approved service shall perform an appropriate examination, subsequently providing a document entitled Dental Budget, which must be signed by both parties.
- **The insured party will participate in the cost of the services through the payment of the deductibles** that appear in the Special Conditions of this benefit. The established deductibles are valid for the calendar year for which the insurance was taken out, and the Insurance Company reserves the right to amend them if required, after notice to the insured parties.
- The insured party will directly pay the dental deductibles to the approved service, corresponding to the actions that appear in the dental budget. The amount must be the same as the quantities indicated in the GUARANTEED ACTIONS section of the Special Conditions of this benefit. The approved service will provide the insured party with proof of all the actions performed and receipts for the paid deductibles.

## ARTICLE 6. NATIONAL AND INTERNATIONAL ADOPTION IN HEALTHCARE ASSISTANCE AND REIMBURSEMENT OF EXPENSES

### What is covered

- The reimbursement of the expenses generated by the process of national and international adoption, up to a maximum of €12,000 per adoption, to all insured parties who fulfill the specifications and conditions required by law regarding adoptions and who requested the start of the procedures 48 months after the registration date of the policy. Under no circumstances will adoption procedures be reimbursable which were started before the effective date of coverage in the policy.
- This includes the reimbursement of expenses incurred by undertaking the following activities: issue of the certificate of competence and, where appropriate, of the monitoring commitment, obtaining any documents related to the adoption, legalization or authentication of these documents, translations, donations to orphanages or children's home, issue of passports or visas and travel expenses, accommodation and meals in the place where the adoption is performed.

### How the service is provided

- For the recognition of the right to this service, the insured party shall submit to the Insurance Company, after completing all procedures, a copy of the certificate of competence as well as the application for it a copy of the monitoring commitment, in cases in which the country of origin of the adopted party requests them; as well as of the resolution

agreeing to the adoption registered in the Civil Registry or any other document proving the simple adoption along with the favorable resolution of the corresponding Autonomous Community to process full adoption. Likewise, he/she must also provide original invoices and receipts, duly completed, with the proper legal guarantees of authenticity.

- Once this documentation is verified, if reimbursement corresponds, it will be paid through bank transfer to the account designated by the insured party in the policy.
- Expenses in currency other than the euro will be paid in this currency, calculating the currency exchange rate at the official exchange rate that the Banco de España has set for the day on which the expense was generated.

## ARTICLE 7. WAITING PERIODS

The covered services will enter into force once the policy takes effect, unless the determining cause of the service is illness, in which case the following waiting periods must have elapsed, unless otherwise agreed in the Specific Conditions of the policy:

<b>Outpatient surgical interventions or surgical interventions with hospitalization</b>	<b>6 months</b>
<b>Hospitalization of any type, except extreme or vital emergency</b>	<b>6 months</b>
<b>Cardiac CT</b>	<b>6 months</b>
<b>Magnetic resonance, PET, vascular and interventional radiology, polysomnography, nuclear medicine and radioactive isotopes</b>	<b>6 months</b>
<b>Hemodynamic</b>	<b>6 months</b>
<b>Dialysis</b>	<b>6 months</b>
<b>Lithotripsy</b>	<b>6 months</b>
<b>Medical or radiation oncology</b>	<b>6 months</b>
<b>Access to the Hospital Network of the United States of America</b>	<b>6 months</b>
<b>Rehabilitation and cardiac rehabilitation</b>	<b>6 months</b>
<b>Brief psychotherapy consultation/treatments</b>	<b>6 months</b>
<b>Brief osteopathy consultation/treatments</b>	<b>6 months</b>
<b>High Coverage</b>	<b>6 months</b>
<b>Pregnancy, karyotypes, genotypes, amniocentesis, preparation for giving birth and care at childbirth or Cesarean section, cryopreservation of stem cells from the umbilical cord</b>	<b>8 months</b>
<b>Study of infertility and treatment by means of assisted reproduction techniques (both members of the couple must be included, calculating the waiting period from the date of inclusion of the most recent member)</b>	<b>48 months</b>
<b>National and international adoption (the start of the adoption procedures must be requested 48 months after the date of registration of the insured party in the policy).</b>	<b>48 months</b>

# General Conditions

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No waiting period shall apply in cases in which the determining cause of the service is an accident.

The calculation of the waiting period will start from the date of inclusion of each insured party in each of the purchased benefits.

## ARTICLE 8. PARTICIPATION OF THE INSURED PARTY IN THE COST OF SERVICES

For each received service, the insured party shall pay the amount that, for participation in the cost of the services, appears in the Specific Conditions of the policy and/or the Individual Insurance Certificate.

The amount of participation of the insured party in the cost of the services will be reviewed annually, and may vary depending on modifications of care costs.

## ARTICLE 9. AUTHORIZATION OF HEALTHCARE ASSISTANCE SERVICES AND REIMBURSEMENT OF EXPENSES

### **MAPFRE FAMILIAR CARD**

The Insurance Company will provide the insured parties the MAPFRE FAMILIAR card, which has a validity limited to a determined period of time.

The insured party must identify themselves at the approved service as an insured party of MAPFRE FAMILIAR by showing his/her card, imperatively accompanied by their national identity card, passport or foreigner identification number. In the case of minors or people with a disability, identification will be performed by their guardian or legal representative.

The MAPFRE FAMILIAR card is personal and non-transferable, and the Insurance Company reserves the legal applicable actions in the event of its fraudulent use. In case of theft, robbery or loss, the insured party is obliged to communicate this circumstance to the Insurance Company as soon as possible; in addition, the insured party must return the MAPFRE FAMILIAR card at the end of the contractual relationship.

### **AUTHORIZATION OF BENEFITS THROUGH APPROVED SERVICES**

**The insured party must comply with the following rules:**

- Before going to the health professional or health center, verify that it is a service approved by the Insurance Company.
- Each health action provided will require a single pass of the card, which may be performed in paper format or through a credit card terminal.
- For services which require express authorization by the Insurance Company, the insured party must supply a medical report including the medical history, start date, date of diagnosis, causes, origin and progress of the condition.
- In the event that the service arises from an accident, it will be necessary to provide a

healthcare assistance report from the emergency service, and, where appropriate, an accident report, statement and judicial proceedings.

- Not pay the expenses incurred by the use of approved services, which will be paid by the Insurance Company on his/her behalf directly to the health professionals and/or centers that provided the service.

## REIMBURSEMENT OF EXPENSES

**The insured party must submit the following documentation:**

- Duly completed application form for reimbursement, in which it is essential that the part relating to illness or accident is filled in by the doctor who attended the insured party or, in the absence whereof, the full medical report must be attached.
- A reimbursement application form must be completed for each medical action, unless the successive ones are identical and arising from the same condition. In this case, it will be sufficient to make reference to the first submitted application form.
- Original invoices of the expenses accrued by the healthcare assistance provided to the insured party, as well as proof of payment.
- In the event of hospitalization, in addition to the documentation indicated above, the insured party must provide a clinical report including the medical history, start date, date of diagnosis, causes, origin and progress of the condition.
- In the event that the reimbursement arises from an accident, it will be necessary to provide a healthcare assistance report from the emergency service, and, where appropriate, accident report, statement and judicial proceedings.
- If the care was provided outside national territory, in addition to the aforementioned documentation, it must be accompanied by the corresponding translation into Spanish, where appropriate.
- **Expenses in a currency other than the euro will be paid in euros, calculating the currency exchange rate according to the official exchange rate that the official monetary authority in Spain has set for the date on which the invoice was paid.**
- If in a period of three months after the incident, the Insurance Company has not reimbursed the amount for unjustified reasons or for reasons attributable to it, the amount that it owes shall increase by an annual interest equal to the legal interest of money in force at the time of accrual, increased by 50 percent. Two years from the time of the incident, the annual interest from that day on may not be less than 20 percent.

**For the purposes of insurance coverage, the following shall not be valid:**

- Invoices issued by spouses, siblings, ascendants and descendants, as well as second degree collaterals.
- Invoices that do not comply with the requirements established in the legislation in force.

## ARTICLE 10. GENERAL EXCLUSIONS FOR ALL BENEFITS

Care or reimbursements resulting from the risks listed below are excluded from the policy coverage:

# General Conditions

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1. Healthcare assistance and/or expenses arising from for all types of diseases, defects and malformations (including congenital ones) whether contracted, manifested or known by the insured party before the effective date of their registration in the policy, as well as the effects caused by these, and birth defects, unless expressly accepted by the Insurance Company in the Specific Conditions of the policy and/or Individual Insurance Certificate.
2. Accidents that occurred before to the entry into force of the policy.
3. All medical, surgical and diagnostic procedures that are considered new techniques or newly implemented techniques as established in these General Conditions, except those in the benefits provided through reimbursement of expenses.
4. Interventions and/or treatments for esthetic reasons in general, unless the plastic or reconstructive surgery or treatment are necessary as a result of an accident covered by the policy.
5. Breast reduction and reconstructive surgery, except after mastectomy as a result of cancer of the affected breast, as well as obesity and/or bariatric surgery.
6. Vein sclerosing treatments and interventions and cosmetic treatments.
7. Orthopedic anatomical parts, orthopedic material, osteoconductive implants, osteoinductive and cellular implants, as well as growth factors, prostheses and implants, except those included in Appendix I of these General Conditions and up to the financial limits specified in the policy.
8. All types of products or devices used in medical care, except that provided in outpatient hospitals or medical emergency centers, such as: orthoses, prostheses, artificial limbs or organs, pharmaceutical products, vaccines, syringes, any orthopedic device, passive rehabilitation devices, as well as maintenance and repair expenses of these, and in general, any product used for social purposes.
9. The cost of cochlear implants, except the one included in the program for treatment of deafness in children.
10. Treatments with hyperbaric chamber, aerosols, oxygen therapy, ventilation therapy and PUVA light treatment, unless the services approved by the Insurance Company are used, as well as CPAP, BIPAP and apnea monitors, vaccines and pharmacological treatment.
11. Experimental treatments and alternative medicine, such as organometry, acupuncture, homeopathy and similar treatments.
12. Healthcare assistance and/or medical expenses arising from infection by the human immunodeficiency virus (AIDS) and treatment for alcoholism and drug addiction.
13. Complementary medication to chemotherapy treatment.
14. Reconstructive surgery of previous contraceptive techniques.

15. Refractive surgery (myopia, astigmatism, hyperopia), presbyopia surgery, as well as the costs of glasses, contact lenses and hearing aids.
16. Checkups, general preventive medical examinations, except those included in the preventive medicine programs expressly agreed to in the policy, as long as the services approved by the Company are used; as well as any genetic studies except when, within the framework of the clinical diagnosis, the confirmation of a genetic diagnosis requires the establishment of a specific treatment or its modification and provided that in such a case, the necessary study appears in the list included in Appendix I. Genetic studies of family members and of a preventive nature are expressly excluded.
17. Periodontics, endodontics, fillings, orthodontics, dental prostheses, implants and other dental treatments, unless the dental benefit is purchased and the services approved by the Insurance Company are used.
18. Transfers required for attending medical consultations, performance of diagnostic testing, as well as physiotherapy and rehabilitation, unless the circumstances are met which are established for patients hospitalized at home, in accordance with the provisions of the Ambulance Service section, as well as the travel expenses incurred to attend medical centers and hospitals outside the locality of residence of the insured party.
19. Healthcare assistance and/or medical expenses arising from the consequences of suicide attempt or self-harm, whether or not the insured party has full possession of their mental faculties.
20. In organ transplants, the management, transport and expenses arising from their acquisition and preservation.
21. Healthcare assistance and/or medical expenses arising from the consequences of the insured party's participation in racing or betting, and those produced by practicing any sport as a professional or amateur in air sports, scuba diving with artificial lungs, boxing, climbing, motor vehicle racing (including training), caving, bullfighting, enclosing of bulls and any other activity of similar risk.
22. Healthcare assistance and/or medical expenses arising from the direct participation of the insured party in criminal acts, riots, brawls or fighting, unless acting in legitimate self-defense.
23. Healthcare assistance and medical expenses arising from illness and accidents resulting from civil or international war (whether or not there is a declaration of war), acts of terrorism, insurrection, popular riots, earthquakes, flooding, hurricanes, volcanic eruptions, direct or indirect consequences of nuclear radiation or radioactive contamination, or any other phenomenon of catastrophic or extraordinary nature, or events which due to their magnitude and seriousness are qualified by the national government as a "national catastrophe or disaster," as well as officially declared epidemics.

# General Conditions

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24. Catering and social services such as telephone, television and alternative meals or those of the companion, private duty nursing, suite-like rooms and similar, as well as the companion's bed in the admission of the patient in special units.
25. Treatments and hospitalizations for rest or weight loss cures. Stays in assisted residences, nursing homes, or old people's homes and treatments or stays in health resorts, as well as any hospitalization in which circumstances of a social type concur.
26. Hospitalization in chronic psychiatric processes, psychological tests, psychoanalysis, hypnosis, sophrology and narcolepsy, psycho-social or neuropsychological rehabilitation performed during the hospitalization of the patient.
27. The policy does not cover healthcare assistance and/or expenses corresponding to the care of newborns, unless they are included in the policy, as provided for in these General Conditions.
28. Reimbursement of the expenses arising from the processing of a national or international adoption process started prior to the effective date of this benefit.
29. The voluntary termination of pregnancy, as well as all healthcare assistance and reimbursement of expenses related to such termination.

These exclusions include the indicated illness, accident or event, as well as the consequences, complications, exacerbations, specific treatments and other consequences, including incidents caused by, or as a consequence of, any of the above.

## ARTICLE 11. BASIS OF THE CONTRACT

1. This contract is established based on the statements expressed by the policy holder and/or insured parties, who have the duty, before the termination of the contract, to declare to the Insurance Company, in accordance with the health questionnaire it gave him/her, all circumstances known by him/her which might influence the risk assessment.
2. In case of reservation or inaccuracy in the statement, the Insurance Company may cancel the contract by statement addressed to the policy holder within the period of one month, starting from the knowledge of the reservation or inaccuracy. The Insurance Company will be responsible for the premiums for the current period at the time this statement is made, except in the case of fraud or gross negligence by it.  
If the aforementioned reservation or inaccuracy is only attributable to one of the insured parties, the Insurance Company may exclude him/her from the policy through a notice addressed to the policy holder.
3. In the event of inaccurate indication of the age of the insured party, the Insurance Company can refute the contract if the true age of the insured party at the time of its entry into force exceeds the admission limits established by the Insurance Company.

If, as a result of this inaccuracy, the premium paid is lower than the one that would correspond, the policy holder or the insured party will be obliged to compensate the Insurance Company for the difference between the agreed premium and that which would have applied, if the true age of the insured party were known. If, on the contrary, the premium paid is higher than the one that should have been paid, the Insurance Company will be obliged to return the excess of the received premiums, interest-free.

4. If the content of the policy differs from the proposition of insurance or the agreed clauses, the policy holder, or the insured party as applicable, may claim to the Insurance Company, within a month counting from the delivery of the policy, for it to remedy the existing difference. If the claim is not made within this period, the provisions of the policy shall apply.
5. The policy holder and, where appropriate, the insured parties must, during the term of the contract, 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 by the Insurance Company at the time the contract was drawn up, it would not have entered into it or would have entered into it under more burdensome conditions for them. Likewise, the policy holder or the insured party must inform the Insurance Company of all circumstances that decrease the risk.

The policy holder must also notify the Insurance Company, as soon as possible, of a change of the family address.

#### 6. Registration of insured parties.

Newborn children of the insured party will be incorporated into the policy from the date of birth in identical conditions as those purchased by the insured party, without the calculation of more waiting periods than those applicable to the insured party, provided that they comply with the following requirements:

- That the request is made to incorporate the newborn in the policy within ten work days from the date of birth, by completing the application established for that purpose.
- That the registration of the insured party took effect in a time equal to or greater than 8 months immediately prior to the birth.

If the aforementioned requirements are not met, the incorporation of the newborn will be subject to the selection and contracting regulations of the Insurance Company.

#### 7. Registration of newborns.

Newborn children of an insured mother or father whose registration in the policy took effect in a time greater than or equal to 8 months prior to the birth will be incorporated in the policy, effective from the date of birth, with the same benefits as the mother or father if, within ten workdays from the date of birth, registration was requested by completing the application. In this case, no more waiting periods than those applicable to the mother or father will be applied. Otherwise, the admission of the newborn will be subject to compliance with the conditions established by MAPFRE FAMILIAR, and the waiting periods established in the policy may be applied, as well as the corresponding exclusions.

The registration of the newborn in the policy, if the company accepts his/her insurance coverage, will not take effect until the supplement is issued and the corresponding

# General Conditions

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premium is paid, which will be determined by the application of the rates that the Insurance Company has in force on the date on which the registration takes place.

Regardless of the provisions of the preceding paragraphs, if the newborn has any congenital disease and/or malformation, the Insurance Company guarantees the acceptance of his/her registration in the insurance, always after payment of the corresponding premium, and with the essential and additional requirement that the registration in the policy of the mother or father took effect at least 8 months prior to the birth.

## 8. Subrogation of the Insurance Company.

The Insurance Company may exercise the rights and actions that, due to the incident, would correspond to the insured party before the individuals responsible for it.

## ARTICLE 12. DRAWING UP, EFFECT AND TERM OF THE CONTRACT

1. The insurance will enter into force on the day and time indicated in the Specific Conditions of the policy, provided that, unless agreed otherwise, the Insurance Company has collected the first premium invoice.
2. The insurance is stipulated for the period indicated in the Specific Conditions and upon its expiry, it will be automatically extended for annual periods, unless:
  - a) Any of the parties opposes the extension by means of written notice to the other party, undertaken at least two months prior to the expiry of the current period.
  - b) The policy holder opposes the extension as provided in Article 13, letter C), section 2.
3. The insurance coverage will automatically cease from the date of termination of the policy. From that moment on, the insured party will not be entitled to subsequent health services even if they are caused by illnesses or accidents prior to the aforementioned date of termination.

## ARTICLE 12 BIS. TAKING OUT INSURANCE AT A DISTANCE

- When taking out insurance at a distance, the provisions of this Article shall apply. It is considered taking out insurance at a distance when the only communication technique used for its negotiation and entering into the contract is at a distance without the physical and simultaneous presence of the supplier and the consumer, consisting in the use of telematic and electronic means, telephone, fax, or other similar means.
- When taking out insurance at a distance, the insurance will enter into force at midnight the day after the policy holder has given their consent, unless another date is selected by express agreement. In any case, the effective date will be included in the Specific Conditions of the policy.
- Notwithstanding the indications of the preceding paragraphs, the contract and its modifications or additions must be formalized in writing. The Insurance Company is obliged to deliver the insurance policy to the policy holder. The policy holder must return a

copy of the Specific Conditions of the policy, signed by him/her to the Insurance Company, as well as the supporting documents of the circumstances that comprise the risk.

- The policy holder, when it is a consumer, i.e., a natural person acting with a different purpose than that of a commercial or professional activity, shall have a period of 14 calendar days to withdraw from the contract taken out at a distance, without indicating reasons and without any penalty, provided an incident has not occurred.
- This period will start from the day of entering into the contract or from the date on which the Insurance Company delivers the policy.
- The policy holder must notify the Insurance Company through a procedure that allows proof of notice in any manner permitted by law, and shall be obliged to pay the corresponding premium up to the time of the withdrawal. If the premium has been collected, the Insurance Company shall reimburse the amount to the policy holder, within a maximum period of 30 calendar days, except the part corresponding to the time period in which the contract was valid until, the time of withdrawal.

## ARTICLE 13. PAYMENT OF THE PREMIUM

### A) GENERAL REGULATIONS

1. The insurance policy holder is required to pay the premiums according to conditions stipulated in the policy.
2. Invoices for premiums must be paid by the policy holder on their corresponding expiry dates by advance complete annuities. However, it may be agreed for the payment of the premium to be in the form of installments, with the application of the corresponding surcharge. These installments and the corresponding surcharge will be stated in the Specific Conditions of the policy and/or the Individual Insurance Certificate.
3. If the location of the payment of the premium is not specified, it will take place at the residence of the insurance policy holder.
4. The premium is indivisible and fully corresponds to the Insurance Company for the duration of the contract, even if the payment method in installments was agreed on. Should the contract or any of its extensions be terminated before the agreed expiry date, the Insurance Company is not required to reimburse the policy holder for any amount of the premium paid in whole by the latter, except in those cases required by law.
5. **The Insurance Company is only obligated for the invoices it has issued. The payment of the amount of the premium by the policy holder of the Insurance to the agent, or if applicable to the broker, shall not be understood to have been made to the Insurance Company, unless the agent, or if applicable the broker, delivers the premium invoice issued by the Insurance Company to the policy holder.**
6. The Insurance Company may apply a system of individual adjustment of premiums based on the expenses generated by the policy.

# General Conditions

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## B) INITIAL PREMIUM

1. The initial premium is the one stated in the Specific Conditions of the policy and/or the Individual Insurance Certificate corresponding to the initial period of coverage indicated therein.
2. If for reasons attributable to the insurance policy holder, the first premium has not been paid, or the sole premium is unpaid before its expiry, the Insurance Company has the right to terminate the contract or to demand the payment of the premium through enforcement based on the policy.
3. **Unless otherwise agreed, if the premium has not been paid before there is an incident, the Insurance Company shall be released from its obligation.**

## C) SUBSEQUENT PREMIUMS

1. In the event of implied renewal of the contract, the premium for the subsequent periods will be calculated by applying the premium rates which, based on technical and actuarial criteria, the Insurance Company has established at any given time, also taking into account any modifications of benefits or causes of risk aggravation or reduction that may have occurred, in accordance with the provisions of these General Conditions, the ages of the insured parties, the history and the claims ratio recorded in preceding insurance periods.
2. At least two months before the contract expires, the Insurance Company will inform the insurance policy holder of the premium amount for the new coverage period, by sending a timely notice of invoice collection to the address designated for this purpose or, in its absence, to the policy holder's usual address.
3. **The non-payment of one of the subsequent premiums will cause the suspension of the coverage one month after its expiry date. If an incident occurs during that month, the Insurance Company may deduct the amount of the outstanding premium for the current period from the compensation amount.**

**Incidents that occur when the coverages are suspended will not be compensated.**

If the Insurance Company does not demand the payment within six months of the expiry date of the premium, it will be understood that the contract is terminated. The Insurance Company, when the contract is suspended, may only demand the payment of the premium for the current period. If the contract had not been resolved or terminated, the coverage will be effective again at midnight on the day on which the policy holder pays the premium.

## ARTICLE 14. TIME LIMITS AND JURISDICTION

### TIME LIMITS

The actions arising from this contract shall expire in a period of 5 years. The expiration period will begin from the date that the actions can be undertaken.

## CLAIMS AND JURISDICTION

1. This contract is subject to Spanish jurisdiction and within this system, the competent judge for hearing actions arising from it shall be that of the residence of the insured party, for which purpose it shall appoint one in Spain if he/she lives overseas.
2. In accordance with the established regulations for the protection of users of financial services, in the event of controversy in the interpretation or execution of this insurance contract, the policy holder, the insured party, the beneficiaries and injured third parties or their rightful claimants may submit a claim in writing to the Claims Division of MAPFRE by letter (P.O. Box 281-28220 Majadahonda, Madrid) or by email (reclamaciones@mapfre.com), in accordance with the regulations for the solution of conflicts between the companies of the MAPFRE Group and the users of its financial services, which can be found on the web page “mapfre.es,” and with the rules of conduct which summarize it and which are provided to the policy holder along with this contract.
3. Likewise, claims and complaints may be submitted by clients of the Insurance Company, as well as by rightful claimants, regarding the performance of its insurance agents and bank insurance operators, in conformity with the aforementioned regulations and procedure.
4. The claim can be submitted in paper or by computer, electronic or telematic media, as established in Law 59/2003 of December 19 on electronic signature.
5. If the claim is dismissed or a period of two months has transpired from the date of submission, the claiming party may submit the claim to the Claims Service of the General Management of Insurance and Pension Funds (Paseo de la Castellana 44, 28046, Madrid; email: reclamaciones.seguros@mineco.es, Virtual Office: oficinavirtual.dgsfp@mineco.es).
6. Only by express agreement by the parties, shall the discrepancies arising from the interpretation of and compliance with this contract be submitted to judgment by arbitrators, in accordance with current legislation.

## ARTICLE 15. ADDITIONAL BENEFITS

**In accordance with what has been agreed in the Specific Conditions of the policy and/or the Individual Insurance Certificate, the Insurance Company offers various insurance policies to the insured parties to which they may additionally subscribe, in accordance with the contractual terms that govern each of them and which will be delivered along with this policy.**

## ARTICLE 16. PROTECTION OF PAYMENTS

**MAPFRE FAMILIAR offers its policy holders the services of “protection of payments due to temporary unemployment and disability” arising from illness or accident in accordance with the limits and conditions included in Appendix 3 attached to this policy.**

## ARTICLE 17. DEATH BY ACCIDENT

**MAPFRE FAMILIAR** guarantees payment to the beneficiaries of a maximum capital of €12,000 if the death of the insured party is caused by an immediate accident or within a maximum period of 365 days, counting from the date of the accident. For the purposes of this benefit, the following are defined as:

**Insured party:** any insured party included in the policy who does not have a disability, older than fourteen years of age and younger than sixty-five years of age.

**Beneficiary:** persons to whom the insured party concedes the right to receive compensation in case of death. In the absence of express designation by the insured party, the following shall be considered beneficiaries, in order of preference: the spouse, the children of the insured party, the parents of the insured party in equal parts or the survivor of the two, the legal heirs of the insured party.

In the event that the policy holder owes any amount to **MAPFRE FAMILIAR** at the time of the incident, this company will be the first beneficiary up to the amount of the debt.

This benefit covers accidents undergone by the insured party anywhere in the world, except those that occurred in unexplored or desert regions or on exploration trips. In any case, incidents with causes of an extraordinary nature will be compensated by the **Consortio de Compensación de Seguros**, in accordance with the provisions of the legislation in force.

In addition, for the purposes of this benefit, the following shall not be regarded as incidents and are therefore excluded from coverage:

- a) Incidents occurring prior to the incorporation of the insured party in the policy, those caused by participation in criminal acts, duels, fights, acts of reckless imprudence or gross negligence, as well as those that occur when under the influence of alcohol or drugs.
- b) Actions caused intentionally by the insured party or beneficiaries such as suicide or conscious or unconscious suicide attempt and self-injuries.
- c) Accidents caused by driving motor vehicles when the insured party does not have the corresponding administrative authorization, as well as those undergone as a passenger in means of transportation which do not meet current legal requirements.
- d) Those occurring during declared or undeclared wars, revolutions, invasions, riots, insurrections, rebellions and military measures.

Compensation will be paid at the end of the necessary investigations for establishing the existence of the incident and its consequences. To obtain payment, the beneficiaries must send the following supporting documents to the Insurance Company:

- a) Official death certificate of the insured party in the corresponding civil registry.
- b) Certificate or report from the doctor(s) who attended the insured party, indicating the origin, nature and progress of the consequences of the accident that caused his/her death, or if applicable, a testimony of the judicial proceedings or documents certifying death by accident.

- c) Documents certifying the personality of the beneficiary(ies) by testament or legal statement of heirs, when such beneficiaries were designated in the policy.
- d) Letter of payment or provisional self-payment of inheritance tax completed by the delegation or tax authorities. However, the Insurance Company is authorized to withhold the part of the insured capital that, according to the circumstances it is aware of, it deems to be the resulting tax debt on the settlement of the inheritance tax.

If there are several policies issued by MAPFRE FAMILIAR in case of incident for one insured party, only one compensation will be paid to the beneficiaries.

## Definitions

For the purposes of this contract, the following are defined as:

- **Accident:** Bodily injury due to a sudden violent cause, external and beyond the control of the insured party. Cardiovascular diseases and injuries related to these conditions are not considered accidents.
- **Adoption:** Formal act submitted for judicial approval which includes parents and children that are not biological.
- **Approved services** (by MAPFRE FAMILIAR): Health professionals, medical centers, hospitals and other health services approved directly by the Insurance Company at the national level. They will appear published in the Medical Care Guides when they can be directly accessed by the insured party, and the insured party can receive information at the Insurance Company regarding the rest of the approved health services of MAPFRE FAMILIAR.
- **Basic clinical analyses:** The following medical analyses are included: Hemogram, glucose, urea, creatinine, cholesterol, TG, GOT, GPT, GGT, Uric Acid, and simple urine analysis.
- **Beneficiary:** The person entitled by law to receive, if applicable, the service derived from the policy. In this insurance modality, this right corresponds to the insured party.
- **Brief psychotherapy or focal therapy treatment:** Treatment in addition to the psychiatrist and prescribed by him/her.
- **Congenital disease:** Any health alteration at birth, whether it is hereditary or contracted in the mother's womb.
- **Consultation:** The action and effect of a doctor attending and examining a patient, performing the usual examinations, with or without support from other complementary diagnostic tests, for obtaining a diagnosis, a prognosis and prescribing treatment.
- **Conventional ambulance:** Non-medical land vehicle intended for the transport of patients who need it for justified medical reasons, but whose condition does not require medical care en route.
- **Conventional x-rays without contrast:** This includes all simple x-rays of any part of the body.

# Definitions

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- **Deductible:** Expressly agreed amount or percentage, borne by the insured party, as his/her participation in the cost of the health care services.
- **Dependent insured parties:** These are persons who live with the insured policy holder on a permanent basis in the family home and are included in the policy.
- **Doctor:** Person who is legally authorized to practice medicine.
- **Emergency ambulance:** Land vehicle intended for the transport of patients who need it for justified medical reasons, equipped with medical care personnel and the technology required to address situations of extreme seriousness and urgency en route, which differentiates it from a conventional ambulance.
- **Emergency surgical intervention:** That in which the delay in its performance could mean a serious and immediate danger to the life of the person or his/her functional capacity.
- **Extreme or vital emergency:** When in the emergency situation, the risk of imminent death, major injuries or major disabilities is imminent, and the most immediate treatment possible is required.
- **Family group:** The group of persons comprised by the insured policy holder and the insured dependents.
- **Family residence:** Place designated in the policy at which the insured policy holder and his/her dependent family members live. It is the address considered for purposes of home care.
- **Growth factors:** Protein substances that are implanted in the body to stimulate proliferation and cell survival, and which are used in biological therapy.
- **Home hospitalization:** This consists in healthcare and nursing attention of the bedridden patient at his/her own home, with the cooperation of their family, which enables care, without the need for hospitalization, of chronic illnesses or injuries, or recovery after surgical interventions.
- **Hospital or hospital center:** Any public or private establishment legally authorized for the treatment of illness or bodily injury, equipped with the means for performing diagnoses, surgical interventions and hospitalization for more than 24 hours. These centers may also have special hospitalization units and an outpatient hospital.

For purposes of the policy, hotels, nursing homes or convalescent homes, health resorts, facilities devoted primarily to the hospitalization and/or treatment for chronic diseases, treatment of drug addiction or alcoholism, and similar institutions are not considered as hospitals.
- **Hospitalization in special units:** This is the occupation of a hospital bed, which due to its characteristics regarding technical means, doctors and nursing care, differ from general or routine hospitalization.

These units are primarily intended for: monitoring and intensive treatment of serious or high-risk patients (intensive care, coronary disease, neonatal care); the specific treatment of certain diseases or injuries (burn unit, spinal cord injuries); or isolation of the patient, whether due to being infectious (infectious disease unit, radioactive isotopes treatment unit) or to avoid the patient's infection due to having an altered immune system (isolation unit in transplant patients).

- **Hospitalization:** This is defined the registration of entry of the patient and his/her stay in the hospital for a minimum of 24 hours.
- **Illness or injury:** Any involuntary health alteration whose diagnosis and confirmation is made by a doctor and which requires medical care. The following illnesses are not considered for coverage purposes, including but not limited to: weight loss treatments; sleep or rest cures; psychological treatments; interventions and/or treatments for esthetic reasons, or congenital defects or conditions; alcoholism and drug addiction.
- **Implants:** All materials inserted into the body for therapeutic, diagnostic or esthetic purposes.  
For the purposes of this policy, the following are not considered prostheses or implants:  
**Optical devices (glasses, contact lenses), hearing devices (hearing aids), artificial limbs or organs (orthopedic limbs, eye, testicle or breast prostheses) penis prostheses and any other not included expressly in the list of prostheses and implants covered by the Insurance Company by reimbursement to the insured parties of the monetary amounts up to a pre-established limit in euros, included in Appendix I of these General Conditions.**
- **Incident:** The occurrence of any event which is the subject of the provision of service or the reimbursement of expenses generated by applying any of the services taken out in the policy. The group of damages, effects and consequences arising from one event shall be considered as a sole incident.
- **Innovative or new implementation techniques:** Any medical, surgical or diagnostic means procedure whose effectiveness in the diseases in which they are applied is not sufficiently proven or endorsed by the scientific community of the corresponding specialty, **not expressly included in this policy**, as well as those that, having proven their effectiveness, are not generally practiced in hospitals, medical centers or other establishments classified as centers or hospitals of reference by the Ministry of Health. To define whether any technique or procedure is generally performed in the centers of reference, it must be practiced at least in the majority of the Autonomous Communities. In the case of Autonomous Communities with various hospital centers of reference, it must also be performed in the majority of these centers.
- **Insurance Company:** MAPFRE FAMILIAR DE SEGUROS Y REASEGUROS S.A., issuing company of this policy, which assumes the purchased risk coverage pursuant to the conditions of the policy, by means of the collection of the premium.
- **Insurance policy holder:** Natural or legal person who, jointly with the Insurance Company, subscribes to this contract and to which the rights and obligations arising from it correspond, except those that due to their nature should be fulfilled by the insured party.
- **Insured policy holder:** Each one of the insured parties that meets the conditions for joining the insurance policy and which, in the absence of the insurance policy holder, assume the obligations arising from the contract.
- **Major outpatient surgery:** This is an organizational module of care for patients who require surgical care, whether it is general, local or regional anesthesia or sedation, which require low complexity, short-term postoperative care, do not require hospital admission,

# Definitions

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and can be discharged a few hours after surgery. This includes surgical procedures that do not require more than 24 hours.

■ **Medical Care Guide:** The current list, taking into account the last published list, of healthcare professionals, medical centers, hospitals and other health services approved directly by the Insurance Company, to which the insured party has direct access. Since it is subject to modifications, the validity of the information on this list should be confirmed before using one of these services for the first time. The insured party may request information from the Insurance Company regarding the guides from other provinces.

■ **Orthopedic material:** Any type of device used to correct or prevent deformities of the human body or to replace part or all of the functions of a limb or organ.

For the purposes of this policy, orthopedic material is defined as: orthopedic devices in general (wheelchairs, orthopedic beds, corsets, collars and support canes), as well as any other not expressly included in these General Conditions.

■ **Osteosynthesis material:** Any element used for the synthesis or union of the ends of a bone.

■ **Outpatient care:** Health care provided to a sick or injured person at a doctor's office or hospital, without being hospitalized for a period longer than 24 hours.

■ **Outpatient hospitalization:** This is the occupation of a hospital bed of a medical center or hospital for a period less than 24 hours, and with the patient spending the night at his/her home.

■ **Policy:** Group of documents containing the regulatory conditions of the insurance. The following form an integral part of the policy: the application for insurance, the questionnaire on health condition, the General, Special and Specific Conditions that customize the risk, and the supplements or appendices added to it, to complete it or to modify it, as well as the Individual Insurance Certificate.

■ **Pre-existing illness, defect or malformation:** An alteration which already exists before taking out the insurance or registration in the insurance, and that normally would have been perceived by signs or symptoms, regardless of the existence of medical diagnosis.

■ **Premium:** Price of the insurance accrued for annual periods, whose invoice shall also include the applicable surcharges and taxes.

■ **Prostheses:** All material that replaces an organ or a part of it to attain proper function of the part or organ replaced, or simply to improve the esthetic effect.

For the purposes of this policy, the following are not considered prostheses or implants:

**Optical devices (glasses, contact lenses), hearing devices (hearing aids), artificial limbs or organs (orthopedic limbs, eye, testicle or breast prostheses) penis prostheses and any other not included expressly in the list of prostheses and implants covered by the Insurance Company by reimbursement to the insured parties of the monetary amounts up to a pre-established limit in euros, included in Appendix I of these General Conditions.**

■ **Reasonable and usual medical expenses:** Those expenses that do not exceed the commonly billed rates for doctors or hospitals, in the exercise of their private activity.

- **Sterility of the couple:** The lack of offspring after two years of sexual intercourse for procreation purposes.
- **Surgical intervention:** Any operation by incision or another method of internal operation carried out by an authorized healthcare professional for therapeutic purposes.
- **Waiting period:** Period of time during which the benefits of the policy do not apply, the calculation of which begins from the effective date of inclusion of the insured party in the policy.



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