GENERAL TERMS AND CONDITIONS

Sanitas Sociedad Anónima de Seguros

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CONTENTS

General terms and conditions

Preliminary clause **6**

Glossary of terms **7**

Clause I: Benefits **11**

PRINCIPAL BENEFITS **11**

1. Primary care **11**

1.1. General medicine: 11

1.2. Paediatrics and Childcare: 11

1.2.1. Care for newborns: 11

1.2.2. Children's Health Programme: 11

1.3. Registered nurse service: 11

2. Emergencies **11**

Sanitas 24 Hours **11**

3. Medical specialities **11**

3.1. Allergy and immunology: 11

3.2. Clinical Analysis 12

3.3. Anatomic pathology 12

3.4. Anaesthesiology, resuscitation and pain treatment: 12

3.5. Angiology and vascular surgery 12

3.6. Digestive system: 12

3.7. Cardiology: 12

3.8. Cardiovascular surgery: 12

3.9. General and gastrointestinal surgery: 12

3.10. Oral and maxillofacial surgery: 12

3.11. Traumatology and orthopaedic surgery: 12

3.12. Paediatric surgery: 12

3.13. Plastic and reconstructive surgery: 12

3.14. Thoracic surgery: 12

3.15. Dermatology 12

3.16. Endocrinology 12

3.17. Geriatrics:....12
3.18. Gynaecology....12
3.19. Haematology and haemotherapy....12
3.20. Internal Medicine....12
3.21. Nuclear Medicine....12
3.22. Consultant physicians and surgeons....13
3.23. Nephrology....13
3.24. Neonatology....13
3.25. Pneumology....13
3.26. Neurosurgery:....13
3.27. Neurology....13
3.28. Ophthalmology....13
3.29. Oncology:....14
3.30. Ear, nose and throat....14
3.31. Psychiatry....14
3.32. Radiodiagnosis/Imaging Diagnosis....14
3.33. Interventional or invasive radiology:....14
3.34. Radiotherapy:....14
3.35. Rehabilitation:....14
3.36. Rheumatology....14
3.37. Urology....14

4. Other care services....15
4.1. Aerosol therapy and ventilation therapy:....15
4.2. Ambulance:....15
4.3. Special home care:....15
4.4. Physiotherapy....15
4.5. Haemodialysis:....15
4.6. Urinary tract lithotripsy....15
4.7. Speech therapy:....15
4.8. Dentistry and stomatology:....15
4.9. Oxygen therapy:....15
4.10. Podiatry (chiropody):....15
4.11. Prostheses....15
4.12. Psychology....16
4.13. Pain treatment:....16

ADDITIONAL COVERAGES OF YOUR INSURANCE....17

Overseas emergency healthcare....18

Clause II: Exclusions from cover....21

Clause III: Qualification periods....24

Clause IV: Form of service provision.....25

Clause V: Other features of the insurance.....27

1. **Basis and loss of rights of the policy.....27**
2. **Duration of insurance.....27**
3. **Insurance premiums.....28**
4. **Registering newborns.....29**
5. **Provision of reports.....30**
6. **Complaints.....30**
7. **Other important legal points.....30**
8. **Others.....32**
9. **Jurisdiction.....32**

Preliminary clause

The present contract is bound by the matters set out in Act 50/1980 of 8 October on Insurance Contracts (Official State Bulletin of 17 October 1980), Act 20/2015 of 14 July on the Management, Supervision and Solvency of Insurers and Reinsurers and its implementing regulation (Royal Decree 1060/2015 of 20 November on the Management, Supervision and Solvency of Insurers and Reinsurers), Act 22/2007 of 11 July on the Distance Marketing of Financial Services for Consumers Act 26/2006 of 17 July on Private Insurance and Reinsurance Brokerage and the matters agreed upon in the General and Particular Terms and Conditions.

Clauses restricting the rights of Insured shall be applicable when highlighted in bold letters and specifically accepted.

Glossary of terms

For the purposes of this document of the **Health Plan Basic** insurance product, the following definitions apply:

INSURANCE TERMS

ACCIDENT
Bodily injury suffered while the policy is in force, stemming from an external, sudden, violent cause beyond the Insured's control.

STANDING MEMBERSHIP
This involves recognition to the Insured of certain rights due to standing membership in SANITAS, which will be specified in the Particular Terms and Conditions.

INSURED
Each person included in the policy and specified in the Particular Terms and Conditions, entitled to receive insurance benefits and who may or may not be the same as the Policyholder.

BENEFICIARY
Person to whom the insurance Policyholder acknowledges the right to receive the compensation or benefit arising from this contract, to the corresponding sum.

CO-PAYMENT
Participation of the Insured in the sum of the cost of the medical action or series of actions, according to the medical service required, received from professionals or the healthcare centres providing it and to be paid directly to SANITAS.

HEALTH QUESTIONNAIRE
Declaration made and signed by the Policyholder or Insured before arranging the policy, which is used by SANITAS to assess the risk subject to insurance.

FRAUDULENT INTENT
Action or omission committed fraudulently or deceivingly with the intention of producing damage or obtaining a benefit that affects the interests of a third party.

INSURED'S HOME
The place where the Insured lives and which specifically appears on the policy's Particular Terms and Conditions.

INSURER OR INSURANCE COMPANY
SANITAS, Sociedad Anónima de Seguros the body corporate taking on the risk as agreed under this Agreement.

DEDUCTIBLE
Sum of medical and/or hospital expenses included in the insurance cover that, according to the corresponding cover, is payable by the Policyholder or the Insured to the care provider.

PARTICIPATION IN COSTS
Prior to access to certain cover, the Insured must pay a single payment to SANITAS, which is specified according to the degree of difficulty of the cover.

QUALIFICATION PERIODS
Period of time (calculated by months elapsed from the effective date of the insurance) during which some of the covers included do not enter into force.

POLICY
Written document that contains the Terms and Conditions governing the insurance and the rights and duties of the parties and that is used as proof of existence thereof. The policy comprises: the insurance application, health questionnaire, General, Particular and Special Terms and Conditions and the supplements or appendices that are added to it either to complete or amend it.

PRE-EXISTING PATHOLOGIES
State or condition of health (illness, injury or defect), not necessarily pathological, suffered by the Insured prior to the date of his inclusion in the policy.

BENEFIT
Implementation by SANITAS of the cover guaranteed in the policy.

PREMIUM
The premium is the price of the insurance, i.e. the amount that the Policyholder or Insured must pay the Insurer. The premium invoice shall also contain any legally applicable surcharges, duties and taxes.

CLAIM
Every occurrence of consequences which are partly or wholly covered by the policy and forming part of the Insurance. The set of services arising from the same cause is considered to constitute a single claim.

EXTRA PREMIUM
This supplementary premium is established by way of express agreement shown in the Particular Terms and Conditions of the policy, in order to take on additional risk that would not be the object of insured cover where such agreement does not exist.

POLICYHOLDER
The physical person or body corporate that, together with SANITAS, signs this contract and who may be the same as or different to the Insured and to whom the obligations arising there from correspond, particularly the payment of the premium, except those that, due to their nature, are the obligation of the Insured.

HEALTH TERMS

HEALTHCARE
Act of assisting or caring for the health of a person.

HOSPITAL HEALTHCARE / HEALTHCARE WITH HOSPITALISATION
This is the care provided when admitted to a hospital, with a record of admission and the Insured remaining there as a patient for a minimum of 24 hours for medical treatment, diagnosis, surgery or therapy.

HEALTHCARE WITHOUT HOSPITALISATION / OUTPATIENT HEALTHCARE
This is medical care, diagnosis, surgery or therapy provided in doctors' offices and/or in hospital that does not involve hospitalisation.

SOCIAL CARE
All care that is not necessary, according to usual practical and compliant with good medical practice, for the treatment of duly diagnosed pathologies.

CONSULTATION
Assistance and examination of a patient by a doctor, performing the necessary examinations and medical tests to obtain a diagnosis or prognosis and prescribe treatment.

DIAGNOSIS
Medical opinion on the nature of a patient's disease or injury, based on assessment of his/her signs and symptoms and on the performance of additional diagnostic tests.

REGISTERED NURSE
Registered nurse or Healthcare Assistant legally qualified and authorised to perform nursing.

ILLNESS
Any alteration of the state of health of an individual who suffers the action of a pathology that is not the result of an accident, which is diagnosed and confirmed by a legally recognised doctor or dentist and which requires professional medical care.

CONGENITAL DISEASE
A disease that exists at the time of birth as a result of hereditary factors or disorders acquired during pregnancy up to the time of birth. A congenital disorder may become manifest and be recognised immediately after birth, or be discovered later, at any time of the individual’s life.

USER GUIDE TO DOCTORS AND SERVICES
Healthcare professionals and centres belonging to the medical network of this policy and recommended by SANITAS for the

provision of the services included in the insurance. The Guide may undergo modifications during the validity period of the policy. There is a full, up-to-date list of the doctors and centres forming the medical network of this policy available to the insured at the SANITAS offices.

CONVENTIONAL ROOM
Single-unit room equipped with the necessary health care systems. Suites or rooms provided with an anteroom are not considered conventional.

HOSPITAL
Any legally authorised public or private establishment for the care of diseases or bodily injuries, provided with the means for performing diagnoses, medical treatments and surgical operations, and able to admit inpatients.

For the purposes of the policy, hotels, rest homes, spas, facilities intended primarily for the treatment of chronic diseases and similar institutions are not regarded as hospitals.

SURGERY
Any operation for diagnostic or therapeutic purposes, performed by means of incision or any other path of internal approach by an appropriate medical specialist at an authorised centre (inpatient or outpatient), which normally requires the use of an operating theatre comprising a special-purpose room and equipped with the necessary systems.

INJURY
Any pathological change that takes place in a tissue or in a healthy organ and which entails anatomic or physiological damage, i.e., a disturbance of physical integrity or functional balance.

OSTEOSYNTHESIS MATERIAL
Pieces or elements of metal or of any other kind used for joining the ends of a fractured bone or for welding joint ends.

ORTHOPAEDIC MATERIAL
Anatomic pieces or elements of any kind used to prevent or correct body deformities.

PHYSICIAN
Doctor or Bachelor in Medicine legally trained and authorised for medical or surgical treatment of the disease or injury that gives rise to a cover contained in the policy.

COMPLEX THERAPEUTIC PROCEDURES
A high-tech therapeutic method is any method requiring technical equipment, a specially designated area and specialised health professionals in a healthcare or hospital setting.

The healthcare facility where it is performed must have adequate personnel and resources to deal with any complications that the patient might experience as a direct or indirect consequence of the method.

NEWBORN
The distinct stage of life comprising the first four weeks after birth.

CHILDBIRTH
The expulsion of one or more newborn children and the related placentas from the interior of the uterine cavity to the exterior. Normal or ‘at term’ childbirth occurs between week 37 and week 42 after the date of the last menstruation. Childbirth occurring earlier than 37 weeks qualifies as premature; childbirth occurring after 42 weeks qualifies as post-term.

ORGAN DISEASE
Structural injury to tissue or organs of the human body.

PROSTHESES
Any element of any kind that temporarily or permanently replaces the absence of an organ, tissue, organic fluid, member or part of any of these. By way of example, this definition encompasses mechanical (joint substitutes) or biological elements (heart valve replacement, ligaments), intraocular lenses, medication reservoirs, etc.

PSYCHOLOGY
Psychology is the science of practical application of knowledge, skills and techniques to diagnose, prevent and resolve

individual or social problems, especially as regards the individual's interaction with his/her physical and social environment.

HOME SERVICES
Visit at the home appearing in the policy at the Insured's request, by a general practitioner, paediatrician, or registered nurse, in those cases in which the Insured is not in a condition to attend the doctor's or registered nurse's surgery because of his/her disease.

EMERGENCY CARE SERVICES
Assistance in justified circumstances both at the Insured's home or anywhere else within the national territory where the Insured is, always so long as SANITAS has an arrangement for the provision of the service in this place. The service will be provided by a GP and/or registered nurse.

TREATMENT
All means (hygienic, pharmacological, surgical or physical) primarily directed to cure or relieve a disease after it has been diagnosed.

EMERGENCY
An "Emergency" is a clinical situation that does not entail a life-threatening situation or irreparable damage to the physical integrity of the patient, that requires immediate medical care.

LIFE-THREATENING EMERGENCY
A life-threatening emergency is a situation that requires immediate medical care as a delay could prove life-threatening or lead to irreparable harm to the patient's physical integrity.

Clause I: Benefits

PRINCIPAL BENEFITS

In general, with the limitations and exclusions highlighted in the terms and conditions of this policy, the healthcare benefits covered correspond to the following specialties:

1. Primary care

1.1. General medicine:

Medical care at the consulting room, indication and prescription of tests and basic diagnostic means (analyses and general radiology), during the days and hours set for this by the physician, and at the Insured's home when s/he is unable to go to the doctor's consulting room for reasons solely dependent on the disease s/he is suffering. In this case telephone requests by the Insured for home care shall be made to the doctor between 9 a.m. and 4 p.m. In emergencies the Insured shall go to the permanent emergency services arranged by the Insurance Company, or else contact the telephone service listed in the User Guide to Doctors and Services.

1.2. Paediatrics and Childcare:

Comprises the care of children up to 14 years of age, both at the consulting room and at home, indication and prescription of tests and basic diagnostic means (analyses, ultrasound and general radiology); the same rules apply as to general medicine.

1.2.1. Care for newborns:

Covers healthcare to a newborn child at the Company.s partner facilities and the related expenses, **provided the newborn is registered with the Insurer**.

1.2.2. Children's Health Programme:

Comprises the psychoprophylactic preparation for childbirth with practical and theoretical classes in childcare and psychology, parent school during the child.s first year of life and health examinations of the newborn, including metabolic testing, hearing tests, otoemissions, visual acuity testing, as well as a programme of health checks scheduled at key ages for the development during the first four years. Similar programmes which do not form part of the Insurer's medical network and are in the second European country of cover named in the Particular Conditions are not included.

1.3. Registered nurse service:

Consulting-room and home care, the latter subject to prior prescription by one of the Insurer's doctors only and making the notification calls as specified in point 1.1 relating to general medicine.

2. Emergencies

These include emergency healthcare provided in permanent emergency centres.

In justified circumstances, the Insured will be treated at the place where he or she is by the round-the-clock emergency services, **only in those towns in which SANITAS has engaged such service.**

Sanitas 24 Hours

Telephone service that provides information from a medical team, which will advise the Insured about his/her questions of medical character, treatments, medication, analysis interpretation, etc., 24 hours a day, 365 days a year.

3. Medical specialities

Diagnostic tests shall be performed by the services designated by the Insurer. Prior written prescription by one of the Company's doctors shall be required.

3.1. Allergy and immunology:

Autovaccination shall be at the Insured's own expense.

3.2. Clinical Analysis

3.3. Anatomic pathology

3.4. Anaesthesiology, resuscitation and pain treatment:

All types of implantable materials are expressly excluded.

3.5. Angiology and vascular surgery

3.6. Digestive system:

Comprises the prevention of colorectal cancer, medical consultation, physical examination, endoscopic examinations, where necessary, **upon written prescription issued by one of the doctors affiliated with the Insuring Entity.**

3.7. Cardiology:

Includes a coronary risk prevention programme for persons over 40 years of age, comprising cardiological consultation, electrocardiograms and the relevant analyses and supplementary tests. **In the case of persons under 40 years of age, prior written prescription by one of the Insurer's doctors shall be required.**

3.8. Cardiovascular surgery:

Consultation only

3.9. General and gastrointestinal surgery:

Consultation only.

3.10. Oral and maxillofacial surgery:

Consultation only.

3.11. Traumatology and orthopaedic surgery:

Includes arthroscopic surgery, hand surgery, percutaneous nucleotomy, chemomyonucleolysis and bone implants of biological materials.

3.12. Paediatric surgery:

Consultation only

3.13. Plastic and reconstructive surgery:

Consultation only

3.14. Thoracic surgery:

Consultation only

3.15. Dermatology

3.16. Endocrinology

3.17. Geriatrics:

Any inpatient admission or care arising from problems of a social nature is excluded.

3.18. Gynaecology

3.19. Haematology and haemotherapy

3.20. Internal Medicine

3.21. Nuclear Medicine

Contrast agents are paid for by SANITAS.

PET and PET/CT are covered only for indications authorised by the Spanish Agency for Medicinal Products and Medical Devices (AEMPS) on the technical data sheet using the drug 18-fludeoxyglucose (18 FDG). Such indications are precisely the following:

A) Oncology Diagnosis:

Diagnosis:

- Characterisation of solitary pulmonary nodule.
- Detection of a tumour of unknown origin evidenced, for example by cervical gland illness, liver or bone metastasis.
- Characterisation of a pancreatic mass.

Staging:

- Head and neck tumours, including assisted guided biopsy.
- Primary lung cancer.
- Locally advanced breast cancer.

- Cancer of the oesophagus.
- Pancreas carcinoma.
- Colorectal cancer, especially in recurrent cases
- Malignant lymphoma
- Malignant melanoma, with Breslow higher than 1.5 mm or metastasis in lymph nodes in the initial diagnosis.

Monitoring of treatment response:

- Malignant lymphoma.
- Head and neck tumours.

Detection in case of reasonable suspicion of recurrence:

- Highly malignant gliomas (III) or (IV).
- Head and neck tumours.
- Thyroid cancer (non medullary): patients with increase of the serum levels of thyroglobulin and body tracking with negative radioactive iodine.
- Primary lung cancer.
- Breast cancer.
- Pancreas carcinoma.
- Colorectal cancer.
- Ovarian cancer.
- Malignant lymphoma.
- Malignant melanoma.

B) Cardiology

- Assessment of myocardial feasibility in patients with severe dysfunction of the left ventricle who are candidates for revascularization, only when conventional imaging techniques are inconclusive.

C) Neurology

- Location of epileptogenic foci in the pre-surgery assessment in the temporary epilepsy.

D) Infectious or inflammatory diseases

- Localisation of anomalous foci to guide etiological diagnosis in the case of idiopathic fever.

Diagnosis of infection in the case of:

- Suspected chronic infection of the bones or adjacent structures: osteomyelitis, spondylitis, discitis or osteitis, even where there are metal implants.
- Diabetic patients with a foot indicating Charcot neuroarthropathy, osteomyelitis or an infection of the soft tissues.
- Painful hip prosthesis.
- Vascular prosthesis.
- Detection of septic metastatic foci in the case of bacteriemia or endocarditis.

Detection of the extension of inflammation in the case of:

- Sarcoidosis.
- Inflammatory bowel disease.
- Large-vessel vasculitis.

Treatment monitoring:

Unresectable alveolar echinococcosis, in the detection of active foci of the parasite during medical treatment and once treatment has discontinued.

3.22. Consultant physicians and surgeons

The Insured may be referred to particular consultant physicians and/or surgeons designated by the Insurer for special cases and upon reasoned request of a specialist included in the medical network.

3.23. Nephrology

Comprises lithotrity of the urinary tract and dialysis techniques in acute processes, **expressly excluding dialysis techniques relating to treatments of chronic processes.**

3.24. Neonatology

3.25. Pneumology

3.26. Neurosurgery:

Consultation only.

3.27. Neurology

3.28. Ophthalmology

Includes laser photocoagulation **exclusively for ischaemic retinopathies, macular oedema, glaucoma and peripheral retinal lesions (holes or tears), kerataconus treatment** and cornea transplant surgery. The transplantable cornea is paid for by SANITAS.

Any kind of refractive surgery (for myopia, hypermetropia and astigmatism) is excluded.

3.29. Oncology:

Includes diagnosis and treatment scheduling by cancer specialists of diseases relating to this speciality. Treatment is paid for by the Insured.

3.30. Ear, nose and throat

It includes laser surgery.

3.31. Psychiatry

3.32. Radiodiagnosis/Imaging Diagnosis

Comprises standard diagnostic techniques. Contrast agents shall be paid for by SANITAS.

It also includes:

A) The colonography performed by computerised tomography (CT) in the following indications:

- Screening of colon cancer and colon polyposis in patients without a known clinical history of colon cancer, polyposis orinflammatory intestinal illness, as long as they present family background of these pathologies or are candidates to screening for age reasons (from the age of 50).

- Screening of colon cancer and colonpolyposis in patients in which the conventional colonoscopy is contraindicated due to their clinical situation or entails a higher risk.

- As a complement to conventional colonoscopy when this has been unable to reach the full length of the colon.

B) CAT coronography: included in the guarantee only for **symptomatic patients presenting a low or medium probability of coronary disease, in whom it is not possible to perform an ischaemia detection test or it is negative or inconclusive; asymptomatic patients but with a positive or uncertain ischaemia detection tests; for the coronary anomaly study; suspected anomaly or identification of the background of the diagnosed patient; for evaluation of pulmonary veins prior to atrial fibrillation ablation; for coronary study prior to heart valve surgery and for evaluation of stents or coronary grafts.**

Assessment of the calcium score is excluded.

3.33. Interventional or invasive radiology:

With a prescription from a Company doctor and after authorisation from the Company.

3.34. Radiotherapy:

Includes treatment with a linear accelerator and radio-neurosurgery for the indications in which this technique is expressly specified and its comparative efficacy in relation to alternative procedures is fully justified.

3.35. Rehabilitation:

3.36. Rheumatology

3.37. Urology

Includes vasectomy, the study and basic diagnosis of infertility and sterility andurinary tract lithotripsy.

Includes Multiparametric Magnetic Resonance of the prostate in the following indications:

- Local, regional or remote staging.
- Detection or guide for diagnostic biopsy where clinical risk is suspected with negative result in earlier biopsies.
- Therapeutic monitoring.

Prostate interventions by any laser technique are excluded.

4. Other care services

Therapeutic Methods

To be performed by the services designated by the Insurer. Prior written prescription by one of the Company's doctors shall be required.

4.1. Aerosol therapy and ventilation therapy:

The Insured shall bear the cost of any medication.

4.2. Ambulance:

An ambulance service shall be provided on land for the transfer of patients to and from hospital, providing that the healthcare resources arranged are not adequate to attend to the Insured at the place where s/he is or the latter requests to go to his/her place of residence. To request this service, it shall be necessary to have the order slip of one of the Insurer's doctors duly processed at its offices, saving urgent cases, when this slip shall not be required. **This benefit does not include any travel required for rehabilitation therapy, diagnostic tests, or outpatient attendance to medical visits.**

4.3. Special home care:

It will be carried out by the health teams designated by the Insurance Company, subject to prior prescription by one of its physicians when the patient's condition requires special care but not going so far as to need hospitalisation, but always subject to prior medical prescription. Does not comprise care for problems of a social nature.

4.4. Physiotherapy

This covers musculoskeletal physiotherapy on an outpatient basis, **exclusively for complaints originating in the musculoskeletal system providing it is not a chronic or degenerative process** and is only covered until the patient has achieved the greatest functional recovery possible in the opinion of his/her rehabilitating physician.

Includes shockwave therapy for osteotendinous injuries of the musculoskeletal system.

Neurologic rehabilitation, pelvic floor rehabilitation and heart rehabilitation as outpatient are excluded, as well as those that are performed with robotic equipment.

4.5. Haemodialysis:

Haemodialysis shall be provided, both on and outpatient and inpatient basis, solely for the treatment for the required number of days of acute kidney failures, while **chronic conditions are expressly excluded.**

4.6. Urinary tract lithotripsy

4.7. Speech therapy:

Only available in connection with organic processes for up **to a maximum of 6 months a year.**

4.8. Dentistry and stomatology:

Only includes extractions, related stomatological cures and buccal cleaning prescribed by the Insurer's dentist.

4.9. Oxygen therapy:

Both in the event of admission to hospital and at home. Outpatient oxygen therapy is only included **for chronic patients requiring treatment with oxygen during at least 16 hours a day.**

4.10. Podiatry (chiropody):

Limited to five sessions a year.

4.11. Prostheses

Only includes **the following Traumatology and Orthopaedic Surgery internal**

prostheses: prosthetic joints, screws and inner fastening plates.
Also includes **the following vascular and cardiac prostheses**: vheart valves, vascular by-passes, stents, temporary and permanent pacemakers and mammary prostheses after mastectomy for a neoplasm.

4.12. Psychology

Includes individual psychological care prescribed by Psychiatrists, General Practitioners, Paediatricians and Medical Oncologists. Also includes simple psychological diagnosis and psychometric tests, **the forms of which shall be paid for by the Insured.**

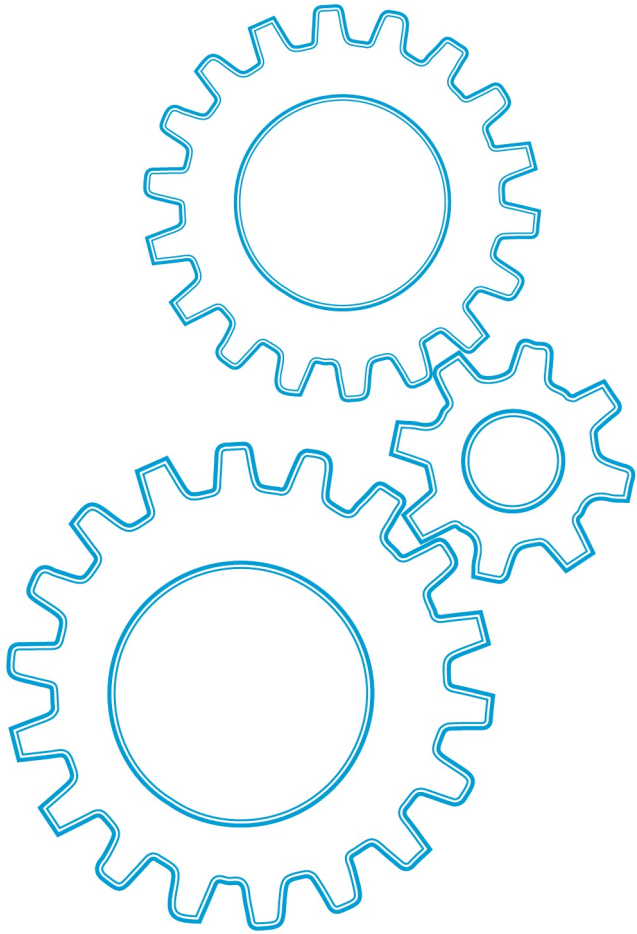
It includes a maximum of 4 consultations per month and with a limit of 15 sessions per Insured and insurance annuity.

Cover excludes psychoanalysis, psychoanalytic therapy, hypnosis, narcolepsy and psychosocial and neuropsychiatric rehabilitation services.

4.13. Pain treatment:

Only implantable reservoirs (of the port-a-cath type) are included. **Implantable pumps for drug delivery and medullar stimulation electrodes are expressly excluded.** Similar programs, performed by professionals not belonging to the Insurer's medical network or performed in the second European country of cover indicated in the Particular Conditions, are not included.

ADDITIONAL COVERAGES OF YOUR INSURANCE



Overseas emergency healthcare

What is this?

This is an additional supplement to your policy covering emergency illness or accident abroad.

Which services am I entitled to?

1. Medical Costs

SANITAS guarantees the Insured parties and all other beneficiaries of the policy, for the period of its validity, healthcare abroad under their responsibility to a limit of €10.000 per person and claim for medical expenses (physicians, surgeons and hospitals/clinics) originating outside Spanish territory, whether provided by its own physician or physicians authorised by the Company, even when provided by physicians and hospitals outside the Company.

What does it cover?

Expenses from doctors, surgeons, hospitals and/or clinics outside Spain as a result of medical attention received abroad, derived from an illness or accident occurring abroad.

- doctors' fees
- drugs prescribed by a doctor or surgeon
- emergency dentistry fees, **excluding endodontics, aesthetic reconstructions from earlier treatments, oral cleaning, prothesis, crowns and implants,** these are covered by the previous amount up to a maximum of €241 per Insured.
- hospitalisation costs
- costs for ambulance services requested by a doctor for a local journey

What is not covered?

- **doctors' fees abroad under €3**
- **costs arising from the diagnosis or treatment of a physiological condition (e.g. pregnancy) or an illness that was known about before the trip began, unless it is a clear or unforeseeable complication; treatments arranged in Spain; pregnancy costs incurred after the first 150 days**
- **costs of glasses, contact lenses, crutches and protheses in general**
- **direct or indirect consequences of the nucleo transmutation of the atom, and radiation caused by the artificial acceleration of atomic particles**
- **consequences arising from war, insurrections, uprisings, earthquakes, floods or volcanic eruptions**
- **assistance or aid due to participation in any kind of competitive motor event (race or rally)**

Limits

€10.000 per person and claim.

2. Extended hotel stay for an accompanying person due to hospitalisation of the Insured

When the Insured has to be admitted to hospital on a doctor's orders and in accordance with the SANITAS medical service, SANITAS shall reimburse the costs arising from a required extended hotel stay for the accompanying person - **also insured - to a maximum of €60 per day for a total of 10 days.**

3. Transport of ill or injured persons

What does it cover?

If the Insured becomes ill or is accidentally injured during the term of the Agreement, SANITAS shall take charge of transporting the Insured under medical supervision, by the following means, according to the severity of the illness or injury:

- air ambulance (aircraft)
- air ambulance (helicopter)
- scheduled flight
- first-class sleeper train
- ambulance – or sledge if injured on a ski slope

The choice of means of transport and of the hospital to which the member shall be admitted shall be based solely on medical

grounds at the discretion of SANITAS medical service.

What is not covered?

- **complaints or injuries that can be treated on site which do not prevent the trip from continuing**
- **mental and chronic illnesses causing alterations in the Insured's health**
- **relapses and convalescence for unhealed conditions or those being treated at the time the trip began**
- **pregnancies**, although clear or unforeseeable complications in the first 150 days are covered.

4. Family member's travel and stay to accompany the Insured in hospital

If the Insured needs to be hospitalised on the trip for more than five days and he/she has no direct family member with him/her, SANITAS shall provide a family member resident in Spain with a return economy-class air fare with a regular airline or first-class rail ticket. SANITAS shall pay up **to €60 euros per day for up to five day**s in respect of hotel accommodation and stay expenses.

5. Transport in the event of death

In the event of death of the Insured, SANITAS shall arrange and take charge of transfer of the coffin to the place of burial in his or her place of residence, including minimum mandatory expenses for coffin, embalming and administrative formalities. **SANITAS shall not pay the funeral and burial costs.** On application from the beneficiaries, SANITAS shall bear the cost of cremation at the place of death and transfer of the ashes to the place of burial in his or her place of residence. **SANITAS shall not pay the funeral and burial costs.**

6. Early return of insured accompanying relatives

If the Insured has been transported in the event of death as specified in the guarantee "Transport in the event of death", and this circumstance prevents the insured accompanying family members from returning home by the means originally arranged, SANITAS shall bear the costs corresponding to the transportation of same to their place of residence in Spain. **Maximum of two adults and accompanied under 14s.**

7. Accompanying children

If, during the term of the contract, Insured persons travelling with disabled persons or children under 14 years of age cannot look after them due to sudden illness or accident covered by the policy, SANITAS shall arrange and cover the costs of outbound and inbound travel of a person residing in Spain named by the Insured or his/her family, or a SANITAS stewardess to accompany children on their return to their habitual residence in Spain as fast as possible.

8. Search and retrieval of luggage and personal belongings

If the Insured has his/her luggage delayed or lost, SANITAS shall help in its search and retrieval, advising on how to file the corresponding formal complaint. If the luggage is retrieved, SANITAS shall send it to the Insured's habitual residence in Spain, providing the presence of the owner is not required for its recovery.

9. Dispatch of documents and personal belongings overseas

SANITAS shall organise and pay the postage of essential items for the journey which have been left at home (contact lenses, prosthetics, spectacles, credit cards, driving licence, ID card and passport). This service extends to posting the same items home if they have been left behind on the journey or recovered after theft.

SANITAS shall only organise the dispatch and postage for parcels weighing no more than 10 kilogrammes.

10. Advance of funds

SANITAS shall advance funds of up **to €1,500 to the Insured, when required.**

SANITAS shall require some kind of special guarantee ensuring the Insured's repayment of the advance. In any event, the amounts advanced shall be returned to SANITAS within a maximum period of 30 days.

11. Legal advice

If the Insured is incarcerated or prosecuted as a result of a traffic accident, **SANITAS shall pay up to €1,500** for lawyer and attorney fees incurred from legal assistance provided. If this service is covered by the Motor Insurance Policy, it shall be considered an advance and SANITAS shall reserve the right to request a special guarantee from the Insured to ensure payment of the advance.

12. Advance of the amount for bail demanded abroad

If the Insured is prosecuted or incarcerated in the country in which it arises, SANITAS shall issue an advance equal to the amount of bail demanded by the local authorities **to a maximum of €10,000.**

SANITAS reserves the right to request a special guarantee from the Insured to ensure repayment of the advance. In any event, the amounts advanced shall be repaid to SANITAS within a maximum period of two months.

13. Dispatch of medication

What does it cover?

If the Insured needs a drug prescribed to him/her by a physician and unavailable at his/her present location, SANITAS shall locate and send the medication by the fastest available means, subject to local laws and regulations.

What is not covered?

This cover excludes events of discontinued manufacture of the medication or unavailability from normal distribution channels in Spain. The Insured shall reimburse SANITAS for the price of the medication against presentation of invoice.

14. Transmission of urgent messages (relating to covers)

SANITAS shall use a 24-hour service to accept and transmit urgent messages from the Insured if they have no other means to send such messages and provided the messages are consequent on a cover under the Agreement.

15. Time frame

This supplement covers travel up **to 90 consecutive days only.**

16. Use of services

This supplement is an addition to the Insured Party's Healthcare Assistance Insurance Policy and is not valid if not accompanied by the latter. The General Terms and Conditions of the Healthcare Assistance Policy are applicable to all the guarantees and services included in this supplement.

To be eligible to use all the services included in this additional supplement to the Travel Assistance Policy, the Insured Party must be up to date with all their obligations to the Insurance Provider. The services shall be rendered through the means granted by SANITAS; therefore, the Insured Party must contact said entity at the phone number indicated on the back of his/her card so that the matter can be managed by the Insured Party at no cost to him/her to the extent that it is covered by the insurance policy. In the event of a life-threatening emergency, the Insured Party shall report to the nearest clinic or hospital and report the event to SANITAS within a period of 7 days of the date of admission.

Clause II: Exclusions from cover

1. All kinds of illnesses, defects or pre-existent and/or congenital diseases, defects or deformities, as a result of accidents or diseases that occurred prior to the date of each Insured's inclusion in the policy; as well as those that may arise from the former.

At the time of subscribing the insurance proposal/application the Policyholder is obliged to declare, on his/her own behalf and that of the beneficiaries and/or each one of these, if they suffer or have suffered from any type of lesion or disease, especially those of a recurrent or congenital nature, or which require or have required studies, diagnostic tests or treatments of any kind; or at the time of subscription they suffered symptoms or signs that might be considered to be the onset of some pathology. When manifested in this way, the condition shall be considered pre-existent and/or congenital and, therefore, excluded from the covers agreed in the insurance contract. If there are pre-existent and/or congenital diseases, the Insurer reserves the right to accept or reject the inclusion of the applicant or applicants, and in the event of acceptance, the corresponding exclusion clause shall be added to the particular conditions of the policy regarding the provision of services for pre-existing and/or congenita diseases, defects or deformations, present prior to the date of each Insured's inclusion in the policy; as well as those that may stem from them.

2. Healthcare for illnesses or lesions occurring as a result of civil, international or colonial wars, invasions, insurrections, rebellions, acts of a terrorist nature in any of its forms (chemical, biological, nuclear, etc.), revolutions, mutinies, uprisings, repressions and military manoeuvres, even in peace time, and officially declared epidemics.

3. Illnesses or accidents directly or indirectly connected with nuclear radiation or radioactive contamination, as well as those arising from such natural disasters as earthquakes, floods, volcanic eruptions and other seismic or meteorological phenomena, except lightning.

4. Healthcare which is required for the treatment of industrial and occupational diseases or accidents or those occurring in sports events; healthcare arising from the use of motor vehicles covered by mandatory motor insurance, and the cost of healthcare provided at social security clinics or centres integrated in the National Health System which are not arranged with the Insurer, except as provided in the final paragraph of section (a) of .Form of service provision.

5. Healthcare derived from chronic alcoholism, drug addiction, intoxications due to abuse of alcohol, psychopharmaceuticals, narcotics or hallucinogens, attempted suicide and self-inflicted injuries, and healthcare for diseases or accidents suffered by the Insured with fraudulent intent.

6. Medicinal products outside the hospitalisation regime .except chemotherapy administered at approved centres. and vaccines of all types and para-pharmacy products.

7. All diagnostic and therapeutic procedures whose safety and efficacy are not duly verified scientifically or which have been clearly surpassed by other available procedures are expressly excluded. Similarly, those procedures are excluded that have not sufficiently proven their effective contribution to the prevention, treatment or cure of diseases, maintenance or enhancement of life expectancy, self-sufficiency, and relief or reduction of pain and suffering, and those consisting of mere leisure, rest, comfort or sporting activities. Spa therapies and rest cures.

8. Homeopathy is excluded unless it is covered by the particular terms and conditions of the policy.

9. Treatments, including surgery, aimed at remedying sterility or infertility in both sexes ("in vitro" fertilisation, artificial insemination, etc.) and voluntary abortion, as well as diagnostic tests connected with such abortion. Study, diagnosis and treatment (including surgery) of impotence and erectile dysfunction.

10. Transplants of organs, tissues, cells or cell components.

11. Healthcare derived from infection by Human Immunodeficiency Virus (HIV), AIDS and the diseases related to this.

12. Hair treatments for cosmetic purposes are excluded.

13. Hospitalisation for social problems.

14. General medical check ups unless established in the description of services in the section What.s covered by the policy?

15. Anything related to education therapy,such as language education in congenital processes or special education in patients with mental disease.

16. Endodontics, fillings, fitting of dental prostheses, orthodontics, periodontics and implants, as well as dental treatments other than those specified in the description of the services in section What's covered by the policy?.

17. Prostheses of any kind or nature, osteosynthesis material, biological or synthetic materials, as well as anatomic and orthopaedic pieces.

18. Chronic dialysis and haemodialysis treatments.

19. Travel expenses, except ambulances, on the terms specified in the description of the services in section What.s covered by the policy?.

20. Refractive surgery of any type

21. Surgical techniques or therapeutic procedures using laser.

22. Genetic map determinations to ascertain the predisposition of the Insured or his present or future offspring to certain diseases related to genetic disorders.

23. Test, treatment or medical care of any kind related to pregnancy, delivery or postpartum is excluded.

24. New diagnostic, surgical and therapeutic techniques which are not included in writing in the policy herein are excluded.

25.The following are expressly excluded: operations, infiltrations and treatments and any other intervention of a purely aesthetic or cosmetic nature; any type of disorder or complication which may occur subsequently and which is directly and mainly caused by the insured.s undergoing an operation, infiltration or treatment of a purely aesthetic or cosmetic nature as mentioned above.

26. Any type of service related to disorders which are not covered such as complications deriving from the former are excluded.

27. Alternative medicine, naturopathy, homeopathy, acupuncture, mesotherapy,hydrotherapy, magnet therapy, pressure therapy, ozone therapy, etc., unless expressly stated otherwise in the Particular Terms and Conditions of the policy herein.

28. Plasma rich in platelets or growth factors is expressly excluded.

29. Advanced therapies (medications for human consumption based on genes, cells or cell therapy and that include products of an autologous, allogeneic or xenogeneic origin).

30. All medications not sold in Spain.

Clause III: Qualification periods

All benefits which under this policy are assumed by the Insurer, on the basis of the approved medical network, will be provided from the time this contract becomes effective.

However, the foregoing general principle does not apply to medical, surgical and/or hospital healthcare in the events detailed below, to which shall apply the specified qualification periods:

Qualification Periods for the modality of Contracted Medical Network:

- **Psychology:** 6 Months

The above qualification periods do not apply to accidents or illnesses that are life-threatening, unexpected and diagnosed after the date the corresponding cover takes effect, provided the care is covered by the insurance policy. Including cases of premature childbirth (before 37 weeks).

Clause IV: Form of service provision

The Insurer hereby assumes, on the terms and with the limits set forth in the General, Particular and, when applicable, Special Terms and Conditions and Policy Supplements that may be issued, the medical and surgical care throughout Spain, according to standard practice, both on an outpatient and inpatient basis, of the diseases or injuries comprised in the description of the Policy services.

As specified in article 103 of the Insurance Contract Act, the Insurer assumes the necessary care of an emergency nature in accordance with the Policy Terms and Conditions

1. Through the contracted medical network

As specified in the applicable regulatory provisions, care shall be provided in **all the towns and cities where the Insurer possesses duly authorised representation or has an approved medical facilities arrangement.** When in any of ythe towns and cities whew such a representation or approved medical facilities arrangement operates any of the services comprised in the contractin the contract is not available, they shall be provided in the province of the Insured`s choosing where such facilities do exist. Policyholders are **free to consult specialists** who are menmbers of the Insurer`s medical network. In addiction, the Insurer may assign the Insured a general practitioner and, where appropiate a paediatrician from amongst those listed on the Insurer`s Medical Staff in order to allocate him/her to act as a family doctor. **The Insured may change family doctor by simply notifying** the Insuser, without having to give any reason.

Upon receiving the due services, the Insured shall show the Sanitas card, as well as the last premium paid receipt as evidence of being up to date in the payments. The Insured is also obliged to show his/her National Identity Card if so required.

As a rule, the Insurer's prior authorisation is needed for surgical operations, hospitalisation, consultants and certain therapeutic methods and diagnostic tests, subject to prior prescription by one of its doctors. The Insurer shall give this authorisation unless it is considered to be a service that is not covered by the Policy. This authorisation shall be financially binding on the Insurer.

In particular, for the highly complex surgical operations detailed in the following (surgery on the central nervous system, cardiac surgery, bariatric surgery and spinal surgery), the Entity reserves the right to designate the healthcare centre and the professionals who will complete the operation, in each individual case and prior to the realisation of the specific surgical operation.

The foregoing paragraph notwithstanding, in **emergency cases** an order by one of the Insurer's physicians shall suffice for these purposes, although the Insured shall notify the Insurer of the fact and obtain its confirmation within 7 days of admission to the hospital institution or the provision of the healthcare service. In these emergency circumstances, the Insurer shall be bound financially up to the time when it expresses objections to the physician's order, in the event of considering that the policy does not cover the medical act.

Any changes to the address of the Insured are to be notified by way of registered post **with a minimum of eight days before any services are requested.**

In the event of travelling temporarily to places where the Insurer does not have an office of its own but does have approved external facilities, the Insured shall present his/her Sanitas card to request the services at the offices of the entities approved by the Insurer and comply with the administrative formalities of said entities.

Where exceptional healthcare needs so require, the Insurer may refer or move the Insured to a public hospital for medical treatment.

2. In providers non contracted with the Insurer

The Insurer shall not accept liability for the fees of physicians not forming part of its medical staff, nor for the expenses of hospitalisation and services that said outside physicians might order. Likewise, the Insurer shall accept no liability for the expenses of hospitalisation or the services occasioned at public or private centres not recognised by the Insurer, irrespective of the physician who prescribes or performs them, except as provided in the final paragraph of Form of service provision., section (a)

In emergency circunstances as defined herein, **the Insurer shall accept liability for the medical-healthcare expenses ocasioned at private centres, although the Insured shall notify it by any means within 7 days of the provision of said care**, in order to transfer him/her to one of the centres approved by the Insurer, providing that the clinical situation so permits. Likewise, he/she shall supply a written description of the claim within a maximum period of 7 days, in accordance with article 16 of the Insurance Contract Act.

Inclusion in the policy cover of new diagnostic and therapeutic techniques and new technologies shall made according to the principles of the medicine based on the evidence once effectiveness and safety has been proven and there are adequate resources for such inclusion as arranged by the Company. The fact that a healthcare technique, consultation, diagnostic or therapy resource is prescribed or arranged by a physician does not automatically imply that it is required from a medical point of view.

Clause V: Other features of the insurance

1. Basis and loss of rights of the policy

1.1. The **present agreement** has been closed on the basis of the **declarations made by the Policyholder and the Insured in the health questionnaire included in the insurance application, where questions are made referring to the state of health of their health, profession, Insured's sport practices and in general those habits of life that can be of relevance for a correct assessment of the risk that is the object of the insurance by this policy being it essential that the Policyholder/Insured provides with complete truthful about the questions posed since these constitute the basis for the acceptance of the risk of the present agreement,** being the mentioned Insurance Application a constituent part of it.

1.2. The Policyholder's duty, before the conclusion of the contract, to declare SANITAS, according to the questionnaire it will submit all the circumstances known to him that might affect the valuation of risk. He is relieved of this obligation if SANITAS did not submit questionnaire or even when SANITAS did, there are circumstances that may influence the risk assessment and that are not included in it.

SANITAS may terminate the contract by declaration addressed to the Policyholder within a month, as of knowledge or inaccuracy of the Policyholder. They correspond to SANITAS except willful misconduct or gross negligence on its part, the premiums for the current period to the time to make this statement.

If the incident occurs before SANITAS makes the statement to which the preceding paragraph refers, the provision will be reduced proportionally to the difference between the agreed premium and that which would have applied had the true risk been known. If there was fraud or gross fault on the part of the Policyholder, the Insurer will be released from payment of the benefit (Art. 10 of the Insurance Contract Act).

1.3. Notwithstanding the foregoing, the Insured also loses the right to the guaranteed benefit, if the incident occurs before the premium has been paid (or, where applicable, a single premium) unless otherwise agreed (Art. 15 of the Insurance Contract Act).

1.4. The Policyholder can terminate the agreement when the medical network is changed, providing the change affects to 50% of the consultants that are part of the national medical network of SANITAS, who will have available for the Insured, at all times, in SANITAS Offices, the complete and updated list of such consultants, for the Insured's information.

1.5. In the event of the Insured not stating his/her correct date of birth, SANITAS may only contest the policy if the Insured's true age exceeds the established limits for this when the policy comes into force.

1.6. Remote subscription of Insurance: As specified in Article 10 of the Distance Marketing of Financial Services Act 22/2007 of 11 July, the Policyholder shall have a term of fourteen calendar days to terminate the remote subscribed contract, without having to indicate any reasons and incurring in no type of penalty.

The term for exercising the right to termination shall begin on the date the Insured Contract is signed. However, where the Policyholder has not received the terms and conditions of the policy and the prior information note about the contracting of the Insurance policy, the term for exercising the right to terminate shall begin to count on the date on which said information note is received.

2. Duration of insurance

2.1. The Insurance Contract expiry date shall be established in its particular terms and conditions and, at its expiry, in accordance with Article 22 of the Insurance Contract Act, it shall be extended tacitly for periods of one

year. Nevertheless, either of the parties may repudiate extension by giving the other party due written notice not less than two (2) months before the date of expiration of the current period, if it is SANITAS that gives this notice and one month if it is the Policyholder who gives it.

2.2. If the insurance policy is terminated unilaterally at the discretion of SANITAS, it may not suspend the provision of cover while the Insured is undergoing hospital treatment, until discharge, unless the Insured waives to continue the treatment.

If the insurance policy is terminated by the Insured, the covers will cease to have effect on the expiry date specified in the Particular Terms and Conditions of the policy, and the provisions of the preceding paragraph will not apply. Therefore, if the Insured is receiving some kind of insured benefit at the time the policy expires, the cover insured by SANITAS shall cease on said expiration date and it will not be obliged to pay for any cost as of said date, even those arising from a claim occurring during Insurance validity.

2.3. With regards to each Insured person, the insurance lapses due

a) To death.

b) Transfer of residence abroad or not residing a minimum of six (6) months in national territory. The premium shall correspond to SANITAS until the date on which the Insured communicates and credits such circumnstance.

2.4. Persons under 14 years of age can only be included in the insurance if the persons that hold their custody or guardianship are also insured, unless the parties agree otherwise.

3. Insurance premiums

3.1. The Insurance Policyholder must pay the premium when the contract is accepted. The arranged covers shall not take effect until the first premium has been paid.

3.2. The first premium shall be requested once the contract has been signed. Successive premiums shall be requested on their respective due dates.

3.3. The Policyholder can apply for the division of the payment of the annual premiums in biannual, quarterly or monthly periods.

In these cases, the corresponding surcharge shall be applied. The division of the premium does not exempt the Policyholder of his/her obligation to pay the complete annual premium.

3.4. If, due to the Policyholder's fault, the first premium is not paid, SANITAS is entitled to terminate the contract or legally demand payment based on the Policy. Where payment is not received before the claim arises, SANITASshall be freed from its obligation, except where otherwise agreed and duly indicated in the Particular Terms and Conditions of the policy.

In the event of non-payment of the second or successive premiums or their divisions, SANITAS coverage shall be suspended one month after the due date of the premium.

Where SANITAS does not claim payment within the six months following said due date, the contract shall be considered terminated.

If the contract is not terminated or discharged according to the above mentioned conditions, the cover shall once again become effective twenty-four hours following the day on which the Policyholder pays the premium or, where applicable, suitable part payments thereof.

The Policyholder shall lose any agreed right to pay part of the premium in the case of non-payment of any receipt and shall, from that moment, be required to

pay the full premium agreed to for the remaining Insurance period.

For premiums paid in installments, in the event of a claim, SANITAS may deduct from the amount payable or reimbursable to the Policyholder or Insured any premium installments for the current annual period not yet collected by SANITAS.

3.5. Where the parties stipulate the application of co-payments for certain benefits insured by this policy, the amounts corresponding to said co-payments shall be specifically established in the Particular Terms and Conditions of the policy. Their amount shall be established each year by SANITAS. The provisions of this Clause in the event of non-payment of the second or successive premiums or part payments thereof shall apply in the case of non-payment of the amount of co-payment.

3.6. Except where otherwise specified in the Particular Terms and Conditions, the place of payment of the premium and co-payments, where applicable, shall be as indicated in the bank debit account order form.

To this end, the Policyholder shall provide SANITAS with the details of his/her bank account where the payment of the receipts for this Insurance are to be debited and shall authorise the bank to pay them.

3.7. SANITAS is only bound by the invoices issued by the Management or by its legally authorised representatives.

3.8. The Insurer may modify the premium and the amount of participation of the Insured in the cost of services with each renewal of the Contract. This review is based on technical-actuarial criteria made and based on the variation in the cost of healthcare services, the type, the frequency of use of the benefits covered and the inclusion of technological medical innovations that were not covered on the initial effective date of the policy.
The premiums to be paid by the Policyholder will vary according to the age achieved by each of the Insured, the geographical zone corresponding to the place of performance of the services, the tariffs established by SANITAS on the date of renewal of each policy being applicable. Such variation of premiums shall be communicated in writing by SANITAS to the Policyholder with at least two months' notice with respect to the renewal date.

3.9. After receiving communication from SANITAS, when appropriate, relating to the **variation in the amount of the premiums for the next annual period, the Policyholder may choose between extending the insurance policy and terminating it at the expiry of the current insurance period.**

In the latter case, the Policyholder shall notify SANITAS in writing of his/her desire to terminate the contractual relationship at its expiration date, with at least one month's notice before the expiry date of the current insurance period.

3.10. Payment of the amount of the premium made by the Policyholder to the insurance broker shall not be considered as made to SANITAS, unless the broker provides the Policyholder with the aforesaid Insurer's premium invoice in return.

4. Registering newborns

Newborn children can be included in the policy with all its rights since their date of birth if the care provided to the mother whilst the child delivery has been provided by SANITAS within the coverage of the mother's policy and if the inclusion of the father as an insured in the policy has taken place at least 240 days prior to the child delivery. For this to be effective, the Policyholder must communicate to SANITAS such circumstance within the 30 natural days following the date of birth, by means of completing an Insurance Application.

In any case, **SANITAS will only cover the newborn's healthcare when and if he/she is included as Insured in SANITAS.** If the inclusion of the newborn is communicated once the term mentioned above has elapsed or without fulfilling all the requirements

indicated in the paragraph above this, SANITAS by virtue of the information provided by the Policyholder in the Insurance Application can deny the inclusion of the newborn as Insured member.

5. Provision of reports

The Policyholder and Insured must provide SANITAS, whenever expressly required so to do, medical reports and/or providers cost estimates enabling the Insurer to determine whether the requested care is covered by the policy. SANITAS is under no obligation to cover the requested care unless and until it is supplied with such reports and cost estimates if the Insured is expressly required to supply them.

6. Complaints

6.1. Complaints control and procedure

a) Supervision of the business activity of SANITAS lies with the Spanish State and is exercised through the Directorate General for Insurance and Pension Funds of the Ministry of the Economy and Competitiveness.

b) In case of any type of complaint in relation to the Insurance Policy, for the settlement thereof the Policyholder, Insured, Beneficiary, Aggrieved Third Party or Successor of any of these should proceed to address:

1. SANITAS Complaints Management Department, by means of a signed written complaint with the claimant's National Identification Document or a document accrediting their identity, addressed to **calle Ribera del Loira Nº 52 (28042 Madrid) or fax to 91 585 24 68 or to the email address reclamaciones@sanitas.es**, which will acknowledge receipt in writing and issue a reasoned written decision **within the statutory deadline of two months** from the date of filing the complaint, so long as it meets all the requirements sought, pursuant to Order ECO /734/2004, of 11 March, on the customer care departments and services of financial entities and the Customer Protection Regulation available at your disposal in our offices.

2. Once this internal process has been exhausted or in the event of disagreement with the decision of SANITAS, a signed written complaint, with the claimant's National Identification Document or a document accrediting their identity, may be lodged with **Complaints Service of the Directorate General for Insurance and Pension Funds, Paseo de la Castellana, 44, 28046 Madrid**. Accordingly, the claimant must prove that the established period for the settlement of the complaint by the SANITAS Complaints Management Department has expired or that the complaint has been denied leave to proceed or has been dismissed.

3. Please be informed that SANITAS is not bound by any consumer arbitration board. The insured may initiate administrative and legal proceedings as set down in the complaints procedure described in the General Terms and Conditions of their policy.

4. In any case, action may be brought before the relevant Courts.

6.2. Actions in connection to this Insurance Agreement shall be subject to a five-year time limit (Article 23 of the Insurance Act).

7. Other important legal points

7.1. Subrogation

Once payment of the covered benefit has been assumed, SANITAS may exercise the rights and actions corresponding to the Insured due to the claim caused with regards to the persons responsible for it, up to the limit of compensation paid.

The Insured must sign the necessary documents for subrogation in favour of SANITAS.

7.2. Notifications.

7.2.1. Notifications to SANITAS on the part of the Policyholder, the Insured or Beneficiary **shall be sent to the Insurer's registered office as stated in the policy.**

7.2.2. Notifications from SANITAS to the Policyholder, the Insured or Beneficiary shall be sent to the physical or email address of the Policyholder or to the telephone number provided by the Policyholder that at the time the Insurance is arranged, except where a change has been notified to SANITAS. The Policyholder authorises SANITAS to send any notifications by email as permitted by law.

7.3. Protection of personal data

The information collected through this document is confidential and protected.The Policyholder undertakes to ensure that all information provided to the Insurer in the insurance application and throughout the term of this policy is accurate and he/she has not omitted any information on the health of each of the Insured parties named in the application.

Furthermore, the Insurer informs the Policyholder and the insured parties and they consent to all their personal data being entered in files held by the Insurer for the purpose of the company's activities, the effectiveness of contractual relations, the provision of integrated care programmes that will allow them to improve their health, the understanding of reasons for cancelling the policy, loyalty programmes and fraud prevention.

Nevertheless, he/she authorises the Insurer to ask physicians, clinics, hospitals, etc. and he/she therefore authorises such persons to provide to the Insurer, any data on the health of the persons included under the policy that the Insurer may deem expedient for the management of the insurance, for offering comprehensive healthcare programs that the Insurer may have available to improve its healthcare process, for the proper appraisal and assessment of the risks to be covered, to prevent fraud, and to attend to the claims put forth by the insured parties.

For the purpose of preventing fraud, the insured parties expressly consent to the Insurer keeping such data as are necessary, even after the contractual relationship has ended.

If the Policyholder/Insured withholds consent for his/her data to be entered in such files and subsequently processes, the insurance contract cannot be arranged.

The Policyholder accepts responsibility for informing all insured parties under the Policy as to the inclusion of their data in the files mentioned above and the processing of such data intended by the Insurer, so that they may exercise as before the Insurer such rights as they think fit. The Policyholder must inform those insured parties that the details of any medical services covered for them under the policy will be disclosed to the Policyholder, unless the Policyholder gives the Insurer a written release from its statutory duty to make such disclosure to the Policyholder, or any of the beneficiaries makes an application in this respect.

In addition, the insured parties and the Policyholder expressly authorise assignment of those data to companies of SANITAS Group identified at http://www.sanitas.es, relating to financial, insurance, social and healthcare, and/or health and welfare products and services, and for the reason of co-insurance and/or reinsurance of the risk and any other person with which the Insurer creates ties of cooperation, for the effectiveness of contractual relations with the insured and for sending advertising from those companies.

The Policyholder declares that he/she has the consent of the insured parties to the Policyholder's disclosure of their personal data to the Insurer and to the Insurer disclosing to the Policyholder the details of any medical services covered for the insured parties under the policy.

He/she may exercise their statutory rights of challenge, access, rectification and erasure of these data at the Insurer's head office at calle Ribera del Loira 52, 28042 Madrid, Legal Advice Department, or through Mi Sanitas on https://www.sanitas.es/misanitas/online/clientes/contacto/index.html. If the Policyholder and/or insured parties do not wish to receive

commercial information from the Insurer or, as applicable, from other companies the Insurer collaborates with, or who do not wish their data to be transferred to other companies except for the effectiveness of contractual relations, they must make this known in writing by the same means.

In the event that no written communication is received within 45 days from the date on which the Policyholder had knowledge of the information contained in the foregoing paragraphs, it will be understood that they agree to the sending of advertising being sent and the transfer of data to other companies under the terms described.

8. Others

The Policyholder and/or Insured grant SANITAS their authorisation so that, **if considered necessary, it may record the telephone conversations** that take place in connection with this policy and use them in its quality control processes and, when applicable, as a means of evidence for any claim that might arise between both parties, but preserving the confidentiality of the conversations held in all circumstances.

The Policyholder and/or the Insured may ask SANITAS for a copy or written transcription of the contents of the conversations recorded between both.

9. Jurisdiction

The Court competent to hear actions arising from the insurance contract shall be the one corresponding to the Insured's address in Spain.

Executed in duplicate in Madrid, 18 October 2016

For the Insured / Policyholder

For SANITAS

Iñaki Peralta
Sanitas, S.A. de Seguros