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FULL TERMS AND CONDITIONS

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Sanitas S.A.

Entered on 10 February 1958 in the Register of the Directorate General for Insurance.

Entity domiciled in Spain and entered in the Madrid Companies Register at page 4,530, volume 1,241, book 721, section 3, entry 1.

Registered offices at Calle Ribera del Loira, 52, Madrid 28042.

Tax ID Code A-28037042

Glossary of terms

For the purposes of these Special Terms and Conditions of Health Plan Complete, the following definitions shall apply:

ACCIDENT

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

ACUTE CONDITIONS

These are illnesses and injuries that occur unexpectedly, without any warning.

APPOINTMENT/CONSULTATION

A healthcare relation between a patient and a healthcare practitioner at a given place and time, the physical presence of both being required.

BENEFICIARY

This status shall correspond to the Insured who is to receive the benefit from the Insurer when a claim is filed.

BENEFIT

A benefit is the healthcare arising from the filing of a claim. Care is the act of attending to or looking after a person's health.

CANCELLATION

This covers the period from the Insurance policy's date of effect or the extension date to its termination at midnight the day before the following date of extension or the termination date.

CHILDBIRTH

Normal childbirth at term occurs between week 37 and week 42 after the date of the last menstruation. Pre-term or premature childbirth occurs between week 28 and week 36 of gestation.

CHILDCARE PROVIDER

General practitioner entrusted with the care of a healthy child, both in physical and mental aspects of its development.

CHRONIC CONDITIONS

These are illnesses and/or injuries (mental included) with at least one of the following characteristics:

- They have no known cure or are recurring
- They lead to permanent incapacity
- They are caused by irreversible changes in the Insured's body
- They require the Insured to undergo special training or rehabilitation
- Supervision, monitoring or care is required for a period exceeding twelve months.

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CLAIM/LOSS

Every occurrence of consequences which are partly or wholly covered by the Policy. The set of services arising from the same cause is considered to constitute a single claim.

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.

CONSULTANT PHYSICIAN/SURGEON

Doctor or Bachelor of Medicine who is legally trained and authorised by the relevant authorities of the country in which he/she practises, specially trained in a one particular medical or surgical discipline to treat special cases and upon reasoned request of one of the Insurer's specialists.

CONSULTATION

A healthcare relation between a patient and a healthcare practitioner at a given place and time, the physical presence of both being required.

CONVENTIONAL ROOM

Single-unit room equipped with vacuum and oxygen healthcare facilities. Suites or rooms provided with an anteroom are not considered conventional.

DATE OF EFFECT

This is the date from which the Policy begins to take effect in line with the Particular Conditions.

DAY HOSPITAL CARE

Medical and/or surgical care provided to the Insured normally requiring the occupation of a hospital bed.

DENTIST

Practitioner who is suitably qualified to perform the whole range of prevention, diagnostic and therapeutic activities relating to anomalies and diseases of the teeth, the mouth, the jaws and their adjoining tissues, both on an individual and on a collective basis.

DIAGNOSIS

Medical opinion about the nature of the condition or injury of a patient, based on an examination of his/her symptoms and signs and on the completion of additional diagnostic tests.

DISPUTABILITY PERIOD

Period of time during which the Insurer may withhold its benefits or contest the contract claiming prior undeclared diseases on the Insured's part. At the end of this period, this option shall only be open to the Insurer if the Policyholder and/or Insured has acted fraudulently.

EMERGENCY

An 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.

EMERGENCY HOME SERVICES

Home care of the Insured in cases of emergency, provided by a general practitioner and/or registered nurse.

EXTENSION DATE

Every year from the Policy's date of effect.

GENERAL PRACTITIONER

Doctor or Bachelor of Medicine who is legally trained and authorised by the relevant authorities of the country in which he/she practises, to medically treat the illness or injury that gives rise to a cover contained in the Policy.

HOME SERVICES

Visit at the home appearing in the Policy at the Insured's request on the part of the family doctor (general practitioner), paediatrician, 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.

HOSPITAL

Any legally authorised public or private establishment for the treatment of diseases or bodily injuries, provided with the means for performing diagnoses and surgical operations. Such an establishment must be attended by a physician 24 hours a day. 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.

HOSPITAL CARE OR CARE ON AN IN-PATIENT BASIS

Medical and/or surgical care provided to the Insured as a result of admission as an in-patient.

HOSPITALISATION

Hospitalisation entails recording of the Insured's admission as a patient and his/her stay at the hospital for at least 24 hours.

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.

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.

INSURED

The individual or individuals, designated in the Particular Terms and Conditions, in relation to whom the policy is arranged.

INSURED OR INSURANCE COMPANY

"Sanitas, Sociedad Anónima de Seguros", the body corporate taking on the risk as agreed under this Agreement.

INSURED SUM

The maximum annual limit payable by the Insurer for each cover. The amount of the insured sums for each cover shall be expressly stated in the Special Terms and Conditions of the Policy. However, for some covers the Policy sets lower partial limits within the overall insured sum.

NEWBORNS

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

ORTHOPAEDIC MATERIAL

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

OUTPATIENT CARE SERVICES

Medical consults (outpatient hospital and non-hospital) and emergency home visits, as well as diagnostics testing, therapeutic treatments and ambulances.

OUTPATIENT HEALTHCARE

any type of medical, diagnostic, surgical or therapeutic healthcare that does NOT involve hospitalisation or home hospitalisation. This healthcare shall always be provided in an authorised centre (not at home). It includes all of the services performed within the practice infrastructure.

OUTPATIENT HOSPITALISATION

Involves the use, by an Insured Party registered as a patient, of hospital healthcare units specifically designated as such, to receive any kind of medical, diagnostic, surgical or therapeutic healthcare that requires a stay of less than 24 hours.

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.

PHYSICIAN/DOCTOR

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.

PHYSICIAN/SURGEON

Consultant health practitioner belonging to the medical staff of the Entity specifically designated thereby to attend special cases at the reasoned request of one of the Insured's specialists.

POLICY

Written document that contains the terms and conditions governing the insurance. The following form an integral part of the Policy: 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.

POLICYHOLDER

The policyholder is the individual or company that signs this contract, together with the Insured, and that is responsible for the obligations arising from it, barring those that have to be fulfilled by the Insured on account of their nature.

PRE-EXISTING DISEASE

A disease suffered by the Insured prior to the date when the Policy is arranged or takes effect.

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.

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, such mechanical or biological elements as heart valve replacements, replacement joints, synthetic skin, intra-ocular lenses, biological materials (cornea), fluids, gels and synthetic and semi-synthetic liquid substitutes for humours or organic fluids, medicinal product reservoirs, outpatient oxygen therapy systems, etc.

QUALIFICATION PERIOD

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.

REGISTERED NURSE ('ATS','DUE')

Person holding a Diploma in Nursing who is qualified and authorised to provide nursing care in disease or injury giving rise to any of the covers contained in the Policy.

SANITAS 24 HOURS

Telephone helpline run by a medical team answering the Insured's medical queries 24 hours a day, 365 days a year. The information thus provided is intended as a guideline only. It cannot substitute direct medical care.

SECOND EUROPEANCOUNTRY COVER

This is a country (besides Spain) named by the Insured in the Particular Conditions at the time of subscribing to the policy to receive medical cover, in accordance with the Policy's terms and conditions. Once named it cannot be changed without the Insurer's authorisation.

SPECIAL HOME CARE

Care given to the Insured by a general or family practitioner or registered nurse at the address appearing in the Policy, when the patient's condition needs special attention but not to the extent of requiring admission to hospital, and always by prior medical prescription.
Special home care does not include the expenses generated by social assistance, catering, underwear, food, medication, monitoring, healthcare material and non-specific care provided by a general practitioner or registered nurse or the continual presence of health professionals at the Insured's home.

SPECIALIST

Doctor or Bachelor of Medicine with specific training in a distinct medical or surgical discipline, trained and authorised by the relevant authorities of the country in which he/she practises, to medically or surgically treat the illness or injury which gives rise to a cover contained in the Policy.

SURGERY

Any operation for diagnostic or therapeutic purposes, performed by means of incision or any other path of internal approach by a surgeon at an authorised centre (inpatient or outpatient), which normally requires the use of an operating theatre.

TREATMENT

Services and/or actions controlled or administered by a medical team to improve or cure an acute or chronic disorder.Services and/or actions provided to improve or cure an acute or chronic pathology which are necessarily controlled or administered by a medical team.

Preliminary clause

This policy is governed by the Ley 50/1980, de 8 de octubre de Contrato de Seguro ('the Insurance Contract Act'), Royal Legislative Decree 6/2004 of 29 October 2004 enacting the consolidated text of the Ley de Ordenación y Supervisión de Seguros Privados ('the Private Insurance Supervision Act'), the implementing Regulations of that Act (Royal Decree 2486/98 of 20 November 1998), and these General Terms and Conditions and the Particular Terms and Conditions, although clauses restricting the rights of Policyholders shall not be valid unless specifically accepted by them in writing.

No such acceptance shall be required for mere transcriptions or references to mandatory legal or regulatory provisions.

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What's covered by the policy?

1. PRIMARY MEDICINE

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. This cover also includes payment or partial reimbursement by the Insurer of expenses relating to medical and/or hospital care required by a newborn during the 28 days following birth, as a result of any kind of congenital disease.

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,neonatal ultrasound 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

In the Insurer's medical network in Spain, healthcare in the event of outpatient emergencies will be provided in the permanent emergency centres listed in the User Guide to Doctors and Services. The Insured may also call the telephone number which appears in the User Guide of Doctors and Services for this very purpose. In justified circumstances, a house call may be made by the 24 hour on-call service but only in those towns and cities where the Insurer has arranged the provision of this service.
Healthcare for outpatient emergencies received by a healthcare provider other than that listed in the Insurer's medical network in Spain or in the second European country covered named in the Particular Conditions, is not subject to that established in the paragraph above, it should be provided in centres authorised for the purpose by the relevant authorities of the country in which the medical service is received. If it is medically justified, care may be received in the Insured's own home by a general practitioner or family physician who is legally trained and recognised by the relevant authorities of the country in which care is received.

3. MEDICAL AND SURGICAL SPECIALTIES AND DIAGNOSTIC TESTS

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 and resuscitation

3.5. Angiology and vascular surgery

3.6. Digestive system: Includes a colorectal cancer prevention programme for persons over 40 years of age, comprising medical consultation, physical examination, a specific test and colonoscopy, if required. In the case of persons under 40 years of age, prior written prescription by one of the Insurer's doctors shall be required. 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.

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. 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.

3.8. Cardiovascular surgery

3.9. General and gastrointestinal surgery
Includes the laparoscopic approach for procedures in the gastrointestinal tract in which its efficacy has been proven**.**

3.10. Oral and maxillofacial surgery

3.11. Paediatric surgery

3.12. Plastic and reconstructive surgery

3.13. Thoracic surgery

3.14. Dermatology

3.15. Endocrinology

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

3.17. Gynaecology: This includes preventive medicine with regular examinations aimed at the early diagnosis of breast and cervical cancer. It also includes study and diagnosis of infertility and sterility, and laparoscopic gynaecological procedures. Also includes lymphatic drainage. Includes family planning with oral contraceptives (consultation, treatment and check-up), IUD implantation (the cost of the device being at the Insured's expense) and the treatment of possible complications.
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.

3.18. Haematology and haemotherapy

3.19. Internal medicine

3.20.Nuclear medicine

Contrast media shall be borne by the Insured Party.

PET and PET/CAT are only covered by the Policy for the indications authorised by the

Spanish Agency for Medications and Healthcare Products regarding the drug fludeoxyglucose. These indications are specifically the following:

A/ Oncology Diagnosis:

- Indication of a solitary pulmonary nodule.
- Evidence of detection of tumour of unknown origin, for example, due to cervical adenopathy.
- Hepatic or bone metastases.
- Indication of a pancreatic mass.

B/ Staging:

- Head and neck tumours, including guided and assisted biopsy.
- Primary lung cancer.
- Locally advanced breast cancer.
- Oesophageal cancer.
- Pancreatic carcinoma.
- Colorectal cancer, particularly in recurring cases.
- Malignant lymphoma.
- Malignant melanoma, with Breslow thickness above 1.5 mm or lymph node metastases at initial diagnosis.

C/ Monitoring of response to treatment:

- Malignant lymphoma.
- Head and neck tumours.

D/ Detection in the event of reason to believe suspected relapse:

- Gliomas with a high degree of malignancy (III or IV).
- Head and neck tumours.
- Thyroid cancer (non-medullary): patients with an increase in serum thyroglobulin levels and negative radioactive iodine whole body scan.
- Primary lung cancer.
- Breast cancer.
- Pancreatic carcinoma.
- Colorectal cancer.
- Ovarian cancer.
- Malignant lymphoma.
- Malignant melanoma.

E/ Neurology:

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

3.21. Nephrology

3.22. Neonatology

3.23. Pneumology

3.24. Neurosurgery

3.25. Neurology

3.26. Obstetrics

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

3.28. Ophthalmology: includes laser treatments **strictly for medical reasons and cornea transplant. (The cornea to be transplanted shall be at the Insured's own expense).**

Also includes one annual vision test per member. Excludes aesthetic procedures and correction of myopia, hypermetropia and/or astigmatism.

3.29 Oncology: Includes autologous bone marrow and parent peripheral blood cell transplants solely for treatment of haematological tumours. Also covers implantable intravenous infusion reservoirs used in chemotherapy.

3.30. Ear, nose and throat: It includes CO2 laser surgery.

3.31. Proctology

3.32. Psychiatry. Limited to a total of 90 days throughout the life of the policy and of any other with Sanitas or Bupa Intl.

3.33. Rheumatology

3.34. Radiodiagnosis-Diagnostic Imaging: it also comprises the colonography performed by computerised tomography (CT) in the following indications:

· Screening for colon cancer and polyposis of the colon in patients with no known clinical history of colon cancer, polyposis or inflammatory bowel disease, provided they have a family history of these conditions or are candidate to screening for their age (from 50 years of age).

· Screening for colon cancer and polyposis of the colon in patients where conventional colonoscopy is contraindicated for their clinical condition or involves a higher risk.

· As a complement to conventional colonoscopy when this has not reached the entire length of the colon.

To obtain the insurance coverage for this diagnostic test, the policyholder should pay the cost of the service at the amount expressly set out under the particular policy conditions.

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

3.36. Urology: includes study and diagnosis of infertility and sterility. Vasectomy is also included in the Insurer's medical network.
This service is not included if it does not form part of the Insurer's medical network and is in the second European country of cover named in the Particular Conditions.

3.37. Consultant physicians and surgeons

To be designated by the Insurer's Management for special cases and upon the reasoned request of one of its own specialists.

4.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. 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.**

4.3. Urinary tract lithotripsy

4.4. Speech therapy: This is only included when it is medically necessary as part of the treatment of an organic process.
6 months' treatment per insured member per year is covered in the Insurer's medical network.
This service is not included if it does not form part of the Insurer's medical network and is in the second European country of cover named in the Particular Conditions.

4.5. 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.**

4.6. Chemotherapy: The Insurer shall provide the antitumour medication that the patient may need in as many cycles as could be necessary. This medication shall always be prescribed by the Oncology specialist in charge of the patient's care. The Insurer shall be liable for the cost of the treatments, providing that they are applied at a healthcare centre both on an outpatient and inpatient basis, should admission become necessary. In all cases the specialist responsible for the care shall be the one to decide what the therapies should be and how they are to be performed. In these therapies, insofar as medications are concerned, the Insurer shall only be liable for the expenses corresponding to the specifically

cytostatic drugs that are commercially available on the home market and are duly authorised by the Ministry of Health, for the indications specified in the product data sheet.

4.7. 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.

4.8. Rehabilitation: To be provided solely for conditions of the musculo-skeletal system, on an outpatient basis, at centres designated by the Insurer. For inpatient treatment, this cover includes post-surgical rehabilitation for recovery of the musculo-skeletal system secondary to orthopaedic surgery and cardiac rehabilitation for recovery after surgery with extra-corporal circulation. **Neurological rehabilitation is excluded.**

4.9. 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 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.

5. OTHER SERVICES

5.1. 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.**

5.2.Podiatry (chiropody): limited to five five sessions a year.

5.3. 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.

5.4. Prostheses: Includes only, after prior written prescription by a specialist physician of the company, joint prostheses and internal fixation screws and plaques used in orthopaedic surgery, that should be implanted by the departments designated by the Insurer. Also includes the following vascular and cardiac prostheses: heart valves, vascular bypasses, stents, and temporary and permanent pacemakers. Breast prostheses after a mastectomy for neoplasic reasons, as well as monofocal intraocular lenses (IOL) for cataract surgery prescribed by a specialist physician from the company are also included. **Orthopaedic material of any kind, external fixating devices, biological or synthetic materials, grafts (except bone grafts), implantable automatic defibrillators and artificial hearts are all excluded.** In the Insurer's medical network protheses will be provided at no expense to the Insured.
When not part of the Insurer's medical network in Spain, and in the second European country of cover applicable, reimbursement will be made up to the financial limit stated in the Policy's Particular Conditions.

6. HOSPITALISATION

In the Second European Country of Cover, and when not part of the Insurer's Medical Network in Spain, a prior prescription from the physician will be written. For Hospitalisation in the Insurer's Medical Network in Spain a prior prescription from the Insurer's physician will be necessary.
Hospitalisation will be in a clinic or hospital whereby the patient occupies a conventional

single room with a bed for an accompanying person, except in psychiatric, intensive care and incubator hospitalisations. In the Second European Country of Cover no additional expenses are covered for the accompanying person's stay.
The Insurer will bear full payment or partial reimbursement of hospital expenses relating to treatment, stays, patient's board, cures and materials thereof, as well as surgical expenses, anaesthetic products and medication.

6.1. Medical hospitalisation: Provided subject to prior prescription by one of the Insurer's doctors, at the centres it may designate for the care of persons over 14 years of age.

6.2. Paediatric hospitalisation: Hospitalisation shall take place, subject to prior prescription by one of the Insurer's doctors, at an Insurer-designated centre for the care of children under 14 years of age. The cover includes conventional and incubator hospitalisation **(in the latter case a bed for an accompanying person is not included).**

6.3. Psychiatric hospitalisation: Admissions shall take place, subject to prior prescription by one of the Insurer's doctors, at psychiatric centres designated by the former, in an individual room, if the condition so requires, without a bed for an accompanying person. Comprises the costs of the stay, medication and relevant medical therapies. **To be provided for treatment of acute attacks not corresponding to chronic conditions, the stay being limited to a maxim period of fifty (50) days throughout the life of this policy and of any other taken out with the Insurer.**

6.4. Intensive-care hospitalisation: Provided subject to prior prescription by one of the Insurer's doctors, at the centres designated by the former, in suitable facilities, not including a bed for an accompanying person.

6.5. Surgical hospitalisation: Surgical operations so requiring shall be performed at the clinic designated by the Insurer. Dystocia and premature childbirth also qualify for this benefit.

6.6. Obstetric hospitalisation (normal nursing-home delivery): Attended by an obstetrician aided by a midwife, and including delivery room expenses.

7. SECOND OPINION

This cover includes a second opinion on medical diagnosis or treatment in the event of serious chronic diseases requiring scheduled care of which the course necessitates exceptional diagnostic or therapeutic measures and/or whereof the life prognosis is seriously compromised. Such second opinion shall be issued by leading specialists, healthcare centres, physicians or academics in any country in the world. To use this service, the Insured shall send the clinical dossier comprising written medical information, X-rays or other image diagnoses, excluding dispatch of any biological or synthetic materials. The dossier shall be delivered with due confidentiality to the relevant specialist or centre, according to the disease in question.

8. SANITAS 24 HOURS

A telephone service comprising information provided by a medical team that shall answer the Insured's medical queries on treatments, medication, test reading, etc., 24 hours a day, 365 days a year.

9. ASSISTANCE IN THE UNITED STATES

The covers under this policy can be provided to the insured in the United States via healthcare facilities with agreements in place with UHC, provided such services are previously approved by Sanitas, which will manage and process the covered services.

Coverage in the United States extends to one hundred percent of medical expenses up to the insurance limits per insured and annual period indicated below:

Total sub-limit for outpatient care:€30.000
- hospital care up to €24.000, with a sub-limit for childbirth of €1.500

· outpatient care up to €6.000

This cover is provided under a partnership agreement with United Healthcare, and will be without effect if that agreement terminates.

10. QUALIFICATION PERIODS

All the benefits assumed by the Insurer by virtue of the Policy shall be provided from the time it enters into force. **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:**

1.- 180 days for vasectomy and fallopian tube ligation (in all cases in which cover is included in the policy).

2.- 300 days for childbirth healthcare.

3.- 2 years for psychiatric treatment on both an inpatient and outpatient basis. This qualification period is not applicable in the Insurer's medical network in Spain.

4.- 90 days for surgical operations and hospitalisations. This qualification period is not applicable in the services provided through the Insurer's medical network in Spain or in the Second European Country of cover.

5.-150 days for radiotherapy, chemotherapy, cobaltotherapy, radioactive isotopes, linear accelerator, scanner, magnetic resonance, nuclear medicine, bone densitometry, lithotrypsy, digital arteriography, radio-neurology and prostate hyperthermia. This qualification period is not applicable in the services provided through the Insurer's medical network in Spain or in the Second European Country of cover.

6.-90 days for physiotherapy, rehabilitation, laser therapy, pathological anatomy, and for special home care. This qualification period is not applicable services provided through the Insurer's medical network in Spain or in the Second European Country of cover.

The above qualification periods shall not apply to accidents covered by the Policy, life-threatening diseases supervening and diagnosed after the effective date of the Policy, or premature childbirth.

What's not covered?

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 congenital 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 illnesses 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. If the Insured has signed another policy that covers the cost of services or treatments also covered under this Policy, he/she must notify the Insurer in writing. In such an instance, the Insurer shall assume the corresponding proportion of the cost.

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 - 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.

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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, except autologous transplant of bone marrow peripheral blood parent cells due to tumours of a haematological strain, and cornea transplant. In the last case, the Insurer is not liable for the cornea to be transplanted

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 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. Protheses of any kind or nature, except those indicated in Clause 1.B, 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 for myopia, hyperopia, and astigmatism. Surgical techniques or therapeutic procedures using laser, except for intraocular ophthalmic surgery, procedures using surgical laser in haemorrhoids, peripheral vascular surgery and devices used in musculoskeletal rehabilitation.

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

22. Sex change surgery.

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

24. 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.

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

26. 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.

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

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

29. All medications not sold in Spain.

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.

To subscribe to an insurance policy the Insured must be resident in Spain, hold a bank account in Spain and have named a second European country in which he/she wishes to receive healthcare cover.

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. In Spain:

1.1. Hospital and out-patient care in the Insurer's medical network.

Medical care costs shall be paid directly by the Insurer, the Insured does not need to make any payments. As specified in the applicable regulatory provisions, such care shall be provided in all Spanish towns and cities where the Insurer possesses duly authorised representation or has an approved medical facilities arrangement.

This cover includes expenses arising from surgical procedures, provided they are prescribed and conducted by a doctor (fees due to surgeon and his/her assistants, anaesthetist, use of operating theatre, materials and medicinal products), stays in intensive care units, and hospital expenses including board and a conventional room with a supplementary bed.

Upon receiving the due services, the Insured should show his/her Sanitas Health Plan card and the last premium payment receipt, if required. The Insured is also obliged to show his/her national identity card, passport or any other official document proving identity, if required.

As a rule, the Insurer's prior authorisation is needed for surgical procedures, hospitalisation, consultants and certain therapeutic methods and diagnostic tests in the arranged medical facilities, subject to prior prescription by one of its physicians. This authorisation shall be given unless it is considered to be a service 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 72 hours 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.

The Insurer undertakes to provide home services at the address appearing in the policy only. Any change thereof must be communicated by registered post at least eight days prior to the request of any service.

In the event of travelling temporarily to places where the Insurer does not have an office of its own but does have approved facilities, the Insured shall present his/her Sanitas Health Plan card to request service 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 or hospitalisation.

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1.2. Hospital and out-patient care not covered by the Insurer's medical network.

As a rule, the Insurer shall reimburse only the percentage set out in the General Terms and Conditions of the Policy of the medical and/or hospital costs. The remaining percentage shall be paid by the Insured.

To process a claim partly covered by this Policy (reimbursement of the costs percentage set out in the Special Terms and Conditions of the Policy), the following rules apply:

1. The Insured, or any person on his/her behalf, must notify the claim to the Insurer within the following deadlines:
   a) For emergency healthcare, five (5) working days after the date of medical or surgical care or hospital admission.
   (b) For scheduled hospital surgery or admission, seven (7) working days immediately prior to the date of such hospital surgery or admission.
   (c) The above deadlines shall be without prejudice to article 16 of the Insurance Contract Act, which provides that: "The Policyholder or Insured or Beneficiary must advise the Insurer of occurrence of the claim no later than seven (7) days of becoming apprised of it, unless a longer period is agreed."

2. For surgery, hospitalisation, diagnostic tests and therapeutic methods, together with the notice of illness or accident the Policyholder or Insured shall send the Insurer a medical report specifying the diagnosis(es) and nature of the illness(es), and, if applicable, the healthcare facility, date of admission and type and likely duration of treatment.

3. The Insured must, furthermore, faithfully follow all the prescriptions of the physician in charge of treatment and provide the Insurer with all details of the circumstances and consequences of the claim.

4. The Policyholder or the Insured or his/her family relatives must allow the Insurer's appointed physicians to visit the Insured any number of times thought fit by the Insurer and any investigation or check the Insurer deems necessary on his/her state of health.

5. After termination of any hospitalisation, the Policyholder or the Insured shall advise the Insurer of such, stating the duration of the hospital stay.

6. The Policyholder or, as the case may be, the Insured shall file the following documentation with the Insurer:
   6.1. A duly completed reimbursement application form.
   6.2. Proof(s) of payment or original invoice(s) for the expenses actually incurred by the Insured, duly broken by invoice item, indicating:
      a/ The person receiving medical and/or hospital care.
      b/ The nature of the medical act(s) performed (consultation, diagnostic tests, therapeutic methods, surgery, etc.) and their dates and costs.
      c/ Identity of the natural person or body corporate providing the healthcare (doctor, registered nurse, clinic, hospital, etc.), indicating, as applicable, name or corporate name, address, medical association membership number and tax registration number.
   6.3. Proof or original certification of payment of the invoice(s) by the Insured.
   6.4. Original medical prescriptions for the medical and/or hospital services provided to the Insured, except podiatry consultations and services, for which prescriptions need not be filed.
   6.5. Original medical report explaining the medical and/or hospital services provided to the Insured, the disease process and its progression; and the medical or hospital discharge report, indicating, if applicable, any need for continued healthcare.

Non-fulfilment of the requirements set forth in the six sub-paragraphs above shall operate as an express waiver of the respective reimbursement, unless fulfilment was unfeasible for reasons beyond the Policyholder's, the Insured's or his/her relatives' control.

If the Insured suffers any of the consequences set out in the Policy Terms and Conditions giving rise to reimbursement, the Insurer shall pay the Policyholder or Insured, as applicable, by such means as shall be agreed, the respective reimbursement amount.

After receipt of all required documentation and performance of appropriate checks to establish the existence of the claim, the Insured shall within ten working days reimburse or deposit the assured amount in accordance with the known particulars.

If the claim lasts more than three months, the Policyholder or, if applicable, the Insured, shall send the Insurer the invoice(s) for the expenses incurred in the previous quarter.

If within three months from occurrence of the claim the Insurer fails, on unreasonable grounds or for reasons attributable to the Insurer, to pay the respective benefit, the outstanding amount shall increase at the legally applicable interest rate in force at the time of accrual, increased by 50 percent. This interest shall be deemed to accrue daily without need of application to a court. However, two years after occurrence of the claim, annual interest may not be less than 20 percent (article 20 of the Insurance Contract Act).

Reimbursement of the care received in Spain outside the medical facilities arranged by the Insurer shall be made in euros only, by way of transfer to a Spanish bank account belonging to the Insured or the Policyholder.

2. In the second European country covered:

2.1. Hospital care in approved hospitals and clinics.

Outside Spain the Insurer shall provide access for the Insured to approved clinics and hospitals in the Second European Country Covered only.

In order to access these services the Insured must identify themselves with the Sanitas Health Plan.

In this event the Insurer shall pay the corresponding percentage of the amount of medical costs covered by the policy which are laid down in its Special Terms and Conditions, paying the hospital directly for the corresponding services. The remaining percentage shall be paid by the Insured who shall pay the hospital directly before being discharged.

As a rule, the Insurer's prior authorisation shall be required for surgical procedures and hospitalisation in approved hospitals and clinics, unless the treatment required is not covered by the policy.

In emergencies the Insured shall request the authorisation mentioned in the paragraph above 72 hours following admission to hospital or provision of care.

The Insured shall, in any event, complete a reimbursement form before leaving hospital so the Insurer can pay the corresponding percentage of the medical costs incurred.

2.2. Hospital care in hospitals and clinics other than those approved and out-patient care.

For out-patient care or operations or hospital admissions in hospitals or clinics which are not approved, the Insured shall pay the full amount of medical care received directly to the care provider.

Once care is received, the Insured shall send all documentation to the Insurer who, once the claim is accepted, shall reimburse the corresponding percentage of care costs as determined in the policy's Special Terms and Conditions.

To be entitled to reimbursement of costs, the Insured shall send the Insurer the following documentation, within a period not exceeding six months following the date of termination of care:

- Duly completed reimbursement application form.
- Original invoices with receipt of payment.

If the Insurer wishes, the Insured shall also provide:

- Medical prescriptions (except for consultations).
- Medical reports (for surgical procedures and hospitalisation).
- Diagnostic test results.
- Written confirmation stating whether costs may be recovered from another person or entity.

Reimbursement shall be made in a period not exceeding fifteen days, by way or cheque or bank transfer in the official currency of the country in which care has been provided or in euros. Reimbursement shall not be made in any other currency.

If the Insurer needs to change currency for the reimbursement, the rate of exchange shall be the mean of buyer and seller rates set by the Bank of England for the actual exchange and the exchange rate in force on the date of issue of the invoices or on the date of the last treatment, if later, shall be used. In the event that this date is a national holiday, the effective exchange shall be applied to the last working day.

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.

Other special terms and conditions

These special conditions will only apply to members who have purchased Sanitas Dental cover.

In this type of services the Policyholder does not need to pay any amount to the odontologist.
The medical care covered will be only provided by the doctors included in the list of odontologists of the medical staff corresponding to this policy.
This medical care will be provided only at the clinic of the odontologist, excluding expressly care out of it.
The services and acts listed below are object of coverage:

GENERAL AND PREVENTIVE ODONTOLOGY

. General odontology services: examination and diagnosis
. Topical fluoridations
. Mouth/tracheotomy cleaning
. Dental sensitivity treatment
. Fissure sealers

SURGICAL PROCEDURES

Extractions
. Simple extraction
. Third molar extraction not included
. Tooth extraction included (third molars also included)
. Removal of root fragments
. Dressings
Minor surgery
. Removal of epulis/small mucosal cysts
. Drainage of gingival/paradontal abscesses
. Apicoectomies
. Dental cyst
Orthodontic surgery
. Orthodontic surgical treatment (fenestration) (per tooth)

CONSERVATIVE DENTISTRY

. Temporary filling

COSMETIC DENTISTRY

Tooth bleaching
. Soft splint for bleaching

ODONTOPAEDIATRICS

. Visits (up to 12 years)
. Dental education
. Intraoral X-ray (up to 12 years)
. Topical fluoridations
. Fissure sealers
. Extraction of deciduous teeth

IMPLANTOLOGY

. Implant study
. Implant maintenance (includes checks, cleaning, others)

PROSTHESIS

. Occlusal analysis
. Selective carving
Fixed prosthesis
. Adhesive Recement

PERIODONTIA

Non-surgical treatments
. Periodontal assessment (periodontogram) (per arch)
. Periodontal radiographic series

Surgical treatments
. Gingivectomy (per sextant)
. Tooth sectioning

ORTHODONTIA

Treatments beyond maximums
. Visits (up to 12 years)
. Orthodontic x-ray and photographic study
. Extraction of deciduous teeth
. Simple extraction
. 1st replacement of metal brackets
. 1st replacement of ceramic brackets

. 1st replacement of self-ligating brackets
. 1st repositioning of sapphire brackets
. Orthodontia box
. Checks (in latency or rest periods)
. Orthodontic mouthguard

IMAGING DIAGNOSIS:

RADIOLOGY/OTHERS
. Periapical / wing / occlusal X-ray
. Periodontal radiographic series
. Lateral skull X-ray
. Orthopantomography (panoramic)
. Cephalometry
. Photographs or slides
. Dentascan
. Computerised axial tomography

EMERGENCIES

In emergency cases, the policyholder should go to the permanent emergency centres set out in the Practical Guide.

SERVICES WITH PREMIUM PAID BY THE POLICYHOLDER:

a) The Insurer should accept the prescription and the relevant premium provided by the odontologist, and the policyholder shall pay directly to the odontologist this premium for the cost of the service requested.

b) The Policyholder will assume the cost of the appropriate services in compliance with the schedule for premiums applicable at the time provided.

c) In case any change is made in the amount of the premiums supported by the Policyholder, Sanitas shall notify the new premiums to it two months in advance to the effective date, and payment of the premium shall involve accepting these changes.

d) The premiums of these services are set out in the Particular Conditions of the policy, and these premiums will be supported by the Policyholder. These services re as follows:

SURGICAL PROCEDURES

Minor surgery
. Frenectomies (upper or lower)
Pre-prosthetic surgery
. Vestibuloplasty (per quadrant)
. Regularisation of alveolar edge (per quadrant)
. Removal of torus (per quadrant)

CONSERVATIVE ODONTOLOGY

. Filling / obturation
. Reconstruction
. Direct pulpar coating
. Indirect pulpar coating

ENDODONTIA

. Visit for symptom treatment (opening, instrumentation and drainage)
. Retro-obturator material (MTA)
. Fibreglass or carbon post
. Biradicular endodontia
. Polyradicular endodontia
. Uniradicular endodontia
. Uniradicular re-endodontia
. Biradicular re-endodontia
. Polyradicular re-endodontia

COSMETIC ODONTOLOGY

Tooth bleaching
. Dental whitening with splints (per treatment)
. Internal tooth whitening, non-vital (per session)
. Dental whitening by photoactivation (laser, plasma, xenon) (per tooth)
. Dental whitening by photoactivation (laser, plasma, xenon) (per arch per treatment)
. Dental whitening by photoactivation (laser, plasma, xenon) (both arches per treatment)
Dental reconstruction
. Reconstruction of composite cosmetic front (per tooth)
. Intraoral porcelain repair (per tooth)
. Porcelain facing
. Injected facing
. Zirconium facing
. Injected crown
. Zirconium crown

ODONTOPAEDIATRICS

. Obturation in deciduous teeth
. Pulpotomy without reconstruction
. Pulpectomy
. Preformed metal crown
. Apicoformation (complete treatment)
. Fix space holder
. Removable space holder
. Remove bridge / crown /space holder (per tooth)

PROSTHESIS

. Assembly and study in semiadjustable articulator
. Diagnostic wax-up (per tooth)

FIX PROSTHESIS

. Remove bridge / crown /space holder (per tooth)
. Metal incrustation
. Composite incrustation
. Porcelain incrustation
. Provisional resin crown
. Metal-porcelain crown or bridge
. Noble metal-porcelain crown or bridge
. Conventional porcelain crown or bridge
. Injected crown or bridge
. Zirconium crown or bridge
. Glass fibre crown or bridge
. Single root cast iron post
. Multiple root cast iron post
. Zirconium core
. Maryland support (unit)
. Attaches
. Overdenture (upper or lower, per device)

REMOVAL PROSTHESIS

. Acrylic removable (1 to 3 teeth)
. Acrylic removable (4 to 6 teeth)
. Acrylic removable (more than 6 teeth)
. Hypoallergenic resin supplement (per arch)
. Repair (simple)
. Repair (relines) (per apparatus)
. Repair (adding holder)
. Repair (metal reinforcement)
. Repair (add piece to acrylic removable)
. Complete (one arch, upper or lower)
. Skeletal (each tooth)
. Skeletal (base structure)
. Flexible removable 1-3 teeth (Flexite, Valplast, others)
. Flexible removable 4-6 teeth (Flexite, Valplast, others)
. Flexible removable 7 or more teeth (Flexite, Valplast, other)
. Porcelain shoulder or neck (per tooth)

PERIODONTIA

Non-surgical treatments
. Periodontal maintenance
. Curettage (scraping and root smoothening) (per sextant)
. Periodontal splinting (per tooth)
Surgical treatments
. Flap surgery (per sextant)
. Regeneration with biomaterials (freeze-dried bone, etc.)
. Membrane (unit)
. Coronary elongation
. Apical repositioning flap (per sextant)
. Gum-free graft

ORTHODONTIA

Treatments beyond maximums
. Study and diagnosis (including study models and cephalometry)
. Holding device (end of treatment) (per arch)
. Renewal of mobile apparatus, change or loss
. Repair of devices (for breakage of devices)
. Orthodontic microscrews
. 2nd replacement of metal brackets (unit)
. 2nd replacement of ceramic brackets (unit)
. 2nd replacement of self-ligating brackets (unit)
. 2nd repositioning of sapphire brackets (unit)

· Treatment with fix devices with metal brackets
  - Start of one arch; upper or lower (includes first device)
  - Start of both arches (includes first devices)
  - Personalised monthly payment

· Treatment with fix devices with ceramic brackets
  - Start of one arch; upper or lower (includes first device)
  - Start of both arches (includes first devices)

- Personalised monthly payment

· Treatment with fix devices with sapphire brackets
  - Start of one arch; upper or lower (includes first device)
  - Start of both arches (includes first devices)
  - Personalised monthly payment
· Treatment using fixed appliances with clear self-ligating braces technique
· Treatment with fix devices with self-ligating brackets
  - Start of one arch; upper or lower (includes first device)
  - Start of both arches (includes first devices)
  - Personalised monthly payment

· Treatment with fix devices with invisible technique
  - Start of treatment less than 12 months
  - Start of treatment from 12 months

· Interceptive treatment with fix devices
  - Start of one arch; upper or lower (includes irst device - quad helix)
  - Start of both arches (includes first devices)
  - Personalised monthly payment

· Interceptive treatment with emovable devices
  - Start of one arch; upper or lower (includes first device)
  - Start of both arches (includes first devices)
  - Personalised monthly payment

· Mixed treatment: orthopaedic force with fix devices
  - Start of one arch; upper or lower (includes first device)
  - Start of both arches (includes first devices)
  - Personalised monthly payment

· Mixed treatment: orthopaedic force with removable devices
  - Start of one arch; upper or lower (includes first device)
  - Start of both arches (includes first devices)
  - Personalised monthly paymen

IMPLANTOLOGY

Implant surgery
. Osteointegrated implant (unit)
. Closed elevation of maxillary sinus
. Open elevation of maxillary sinus
. Regeneration with biomaterials (freeze-dried bone, etc.)
. Membrane (unit)
Guided surgery
. Guided implantologic surgery study
. Implant supplement guided surgery (unit)
. Barium splint for dental scan
. Surgical splint (for guided surgery)

Prosthesis over implants
. Metal-ceramic crown over implant
. Noble metal-ceramic crown over implant
. Ceramic crown over implant
. Injected crown or bridge over implant
. Crown or zirconium bridge over implant
. Provisional crown for immediate loading
. Titanium implant (per tooth)
. Zirconium core on implant (per tooth)
. Overdenture over implants (per device)
. Hybrid dentures (per arch)
. Supra or mesostructure (unit)
. Precious metal supplement
. Prosthesis addition (intermediate parts)
. Prosthetic attachment for immediate loading

TEMPOROMANDIBULAR JOINT DISEASE

. Assembly and study in semi-adjustable articulator
. Discharge splint
. Revisions, splint adjustments
. Neuromyorelaxation splint (Michigan type)

Other features of your insurance

BASIS, LOSS OF RIGHTS, TERMINATION AND INCONTESTABILITY OF THE POLICY

1. This **policy** has been agreed on the basis of the **statements made by the Policyholder and the Insured in the insurance application questionnaire regarding the Insured's state of health, regular occupation and sporting activities.** These declarations constitute the basis for the acceptance of the risk of this policy and form an integral part thereof.

2. The Insured shall forfeit entitlement to the insured benefit:

a) If when filling out the questionnaire the Policyholder or the Insured has been inaccurate or has omitted with fraudulent intent any circumstance known by him/her that may affect appraisal of the risk, the Insurer may rescind the policy during the thirty days following the date on which it has become aware of this omission (article 10, Insurance Contract Act).

b) In event of aggravation of the risk, if the Policyholder or the Insured does not inform the Insurer and has acted in bad faith (article 12, Insurance Contract Act).

c) When the loss is caused by bad faith on the Insured's part (article 19, Insurance Contract Act).

d) If the event assured arises prior to payment of the premium, unless otherwise agreed (article 15, Insurance Contract Act).

3. The Policyholder may rescind the policy when the doctors' list is altered, providing that it affects the family doctor or the obstetrician or the local paediatrician or 50% of the specialists making up the doctors' list provided by the Insurance Company, which shall keep the full updated list of these specialists at its offices at the Insured's disposal so that it may be consulted. .

4. The policy shall be incontestable with regard to the Insured's state of health and the Insurer may not withhold its benefits alleging the existence of prior diseases when one (1) year has passed from the effective date hereof, unless the Policyholder or the Insured has acted with fraudulent intent.

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

Otherwise, if the premium paid is lower than that really due because the Insured has not stated his/her age correctly, s/he shall be under the obligation to pay the Insurer the difference between the amounts actually paid to it in the form of premiums and those that should have been paid in accordance with the Insured's true age.

On the other hand, if the premium paid is higher than what should have been paid, the Insurer shall be obligated to refund the excess premiums received without interest.

6. Right to terminate: If the insurance Agreement is executed using a remote contracting technique, the Policyholder may unilaterally terminate the Agreement, without penalty, if the covered loss event has not occurred, 14 days after execution of the policy or receipt by the Policyholder of the contract terms and conditions and the mandatory prior information, if such receipt came after execution of the policy.

This right applies only to natural-person Policyholders acting for purposes other than their own business or occupational activity.

To exercise this right, the Policyholder shall notify the Insurer using any durable medium accessible to the Insurer. The Policyholder may issue such notice electronically, provided he/she has the devices to assure the completeness, authenticity and non-alterability

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of the notice and record the times of issue and receipt

DURATION OF THE INSURANCE

1. The insurance is stipulated for the **period of time specified in the Particular Terms and Conditions** and at its expiration, in accordance with article 22 of the Insurance Contract Act, it shall be extended tacitly for periods not exceeding one year. Nevertheless, either of the parties may repudiate extension by giving the other party due written notice not less than two months before the date of expiration of the current period.

2. The Insurer may not terminate the Policy while the Insured is undergoing hospital treatment until discharge, unless the Insured waives continued treatment.

3. In respect of each Insured, the insurance lapses:

a) By reason of death.

b) If **relatives living with the Policyholder are included** in the Policy, when they cease to live at the Policyholder's home on a regular basis, notification of which should be given to the Insurer. If these persons take out a new policy before one month has passed from the afore-mentioned notification, the Insurer shall maintain the policy standing rights acquired by them, providing that they subscribe the same covers.

c) The Insured moves his/her place of residence outside Spain or does not reside in Spain for at least nine (9) months a year.

4. . Persons under 14 years of age may only be included in the insurance if their legal guardian(s) or the person or persons responsible for their custody are also insured, unless agreed otherwise.

5. The arranged covers shall not take effect until the first premium has been paid.

INSURANCE PREMIUMS

1. In accordance with article 14 of the Insurance Contract Act, the Policyholder is under the obligation to **pay the premium, which payment shall be effected by direct debit, unless otherwise agreed in the Particular Terms and Conditions**.

2. Under article 15 of the Act, the **first premium shall fall due once the contract has been signed.** If it has not been signed for the Policyholder's fault, the Insurer is entitled to terminate the contract or demand payment in an enforcement procedure based on the Policy, and if it has not been paid before the claim is made, the Insurance Company shall be relieved of its obligation, unless agreed otherwise.

3. **If the second and successive premiums are not paid, the Insurer's cover is suspended one month after its expiration date,** and if the Insurer does not claim payment within six months of said expiration, the contract shall be considered to have lapsed. If the contract has not lapsed or been terminated in accordance with the foregoing conditions, the cover becomes effective again twenty-four hours after the day on which the Policyholder pays the premium. In any case, when the contract is in abeyance, premium payment may only be demanded for the current period.

4. **The Insurer is only bound by the receipts issued by the Management or by its legally authorised representatives.**

5. **At each renewal, the annual premium shall be determined in accordance with the age reached and the gender of each of the Insured** by applying the rates that the Insurer has in force at the time of renewal. The Policyholder grants his/her approval of the premium variations that may occur for this reason.

6. After receiving the Insurer's notice, 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 expiration of the current insurance period. In the latter case, the Policyholder shall notify the Insurer in writing of his/her desire to terminate the contractual relationship at its expiration date. Payment of the first premium corresponding to the premium for the current extension period shall signify acceptance of the set of new insurance contract conditions.

7. Payment of the amount of the premium made by the Insured to the insurance agent or broker shall not be considered as made to the Insurer, unless the agent issues the Insured the aforesaid Insurer's premium receipt in return.

RIGHTS AND DUTIES

1. Policyholder's and/or Insured's duties and obligations

The Policyholder or, as the case may be, the Insured shall have the following obligations:

a) Declare to the Insurer, prior to the conclusion of the contract and in accordance with the questionnaire to which s/he is subjected, all the circumstances known by him/her that may affect appraisal of the risk. S/he shall be relieved of this duty if the Insurer does not submit the questionnaire or when, even when he/she does so, it is a question of circumstances that may affect appraisal of the risk but are not comprised in it.

The Insurer may terminate the contract by means of a declaration addressed to the Policyholder within one month of becoming aware of the reservation or of the Policyholder's or Insured's inaccuracy. The premiums for the period in progress at the time this declaration is made shall correspond to the Insurer, unless there is fraudulent intent or gross negligence on its part.

If the claim arises before the Insurer makes the declaration referred to in the previous paragraph, the benefit for this shall be reduced proportionally to the difference between the agreed premium and the one that would have been applied if the true entity of the risk had been known. If there was fraudulent intent or gross negligence on the Policyholder's part, the Insurer would be released from payment of the benefit.

b) Notify the Insurer, during the course of the contract and as soon as possible, of all the **circumstances that may aggravate the risk** and are of such a nature that if they had been known by the Insurance Company at the time of the execution of the contract, it would not have executed it or would have concluded it on more onerous terms.

The Insurer may propose an amendment in the contract within two months of the day on which the aggravation was declared to it. In this case the Policyholder has fifteen days as of receipt of this proposal either to accept or reject it. In case of rejection or of silence on the Policyholder's part, the Insurer may terminate the contract at the end of this period, after giving the Policyholder prior notice, offering him/her a further period of fifteen days to answer, after which and within the next eight days notify the Policyholder of the final cancellation.

The Insurer may also terminate the contract notifying the Insured in writing within one month as of the day on which it became aware of the aggravation of the risk. If the Policyholder or the Insured has not made his/her declaration and a claim arises, the Insurer is released from its benefit provision if the Policyholder or the Insured has acted in bad faith. Otherwise, the Insurer's benefit provision shall be reduced proportionally to the difference between the premium agreed and the one that would have applied if the true entity of the risk had been known.

c) Inform the Insurer as soon as possible of any change of address. If the change of address represents a lowering of the risk, the provisions of article 13 of the Insurance Contract Act shall apply. 'In this case, at the end of the current period covered by the premium, the amount of the future premium shall be reduced proportionally, otherwise the Policyholder shall be entitled to terminate the contract and be refunded the difference between the premium actually paid and what s/he should have paid,

as of the notification of the reduction of the risk.' If it represents an aggravation of the risk, however, the stipulations of the preceding letter b) shall be applicable.

d) Lessen the consequences of the claim by using all the means at his/her disposal for early recovery. Non-compliance with this duty with evident intent to harm or deceive the Insurer shall release the latter from all benefit obligations stemming from the claim.

e) For the use of the services provided by the physicians referred to as consultants herein, the Insured shall obtain the relevant document associated with the care, which shall be handed over when any service of this type is given. These services may only be used subject to prior prescription by one of the Insurance Company's specialists and with its authorisation.

f) For the use of the relevant services as described in Clause One, the Insured shall present his/her Sanitas card, which is a personal and non-transferable document. In case of loss or theft of this card, the Policyholder and/or Insured is/are under the obligation to inform the Insurer thereof within forty-eight hours, whereupon a new card shall be issued and the mislaid or stolen one cancelled.

In addition, the Policyholder and/or Insured is/are obligated to return Sanitas card(s) to the Insurer in the event of cancellation, termination and, in general, ending of the contractual relationship, irrespective of what the cause thereof may be.

g) If the assistance the biological mother receives during the delivery is covered by Sanitas, newborn infants are entitled to be included in the mother's policy when the inclusion of the biological mother in the policy came into effect at least 365 prior to the birth. The Policyholder must notify Sanitas of the birth within 30 calendar days following the date of birth by completing an insurance application. In any case, Sanitas shall cover the newborn's healthcare providing its inclusion has been made in the Insurance Company.

If inclusion of the newborn is requested after the period above has lapsed, a health questionnaire will need to be completed and Sanitas may deny inclusion.

2. Policyholder's and/or Insured's rights

a) The respective benefits set forth in the Special Terms and Conditions of the Policy.

b) The Policyholder and/or Insured may require the Insurer to remedy the differences between the actual Policy and the insurance or agreed clauses proposal within one month of the delivery thereof, as stipulated in article 8 of the Insurance Contract Act..

c) The Policyholder or Insured may inform the Insurer in the course of the contract of all the circumstances that may reduce the risk and are of such a nature that, if they had been known by the latter at the time the contract was formalised, it would have concluded it on more favourable terms. In this case, at the end of the current period covered by the premium, the amount of the future premium shall be reduced proportionally, otherwise the Policyholder shall be entitled to terminate the contract and be refunded the difference between the premium actually paid and what s/he should have paid, as of the notification of the reduction of the risk.

3. Insurer's obligations

a) Besides fulfilling the assured covers, the Insurer shall furnish the Policyholder with the Policy or, as the case may be, either the provisional cover or other applicable document as stipulated in article 5 of the Insurance Contract Act, as well as a copy of the questionnaire and other documents that may have been undersigned by the Policyholder.

b) The Insurer shall provide the Policyholder and/or Insured with the Sanitas card (s), stating the emergency services information telephone number.

COMPLAINTS

1. Complaints book

There is an **official complaints book** at the Insurer's offices so that Policyholders may set forth therein those complaints that they consider fit.

2. Lapse of right to claim

The right of the Policyholder and the Insured to bring a legal claim for denial of a benefit lapses after five years, as of the day on which it could have been exercised.

3. Supervision and venues of complaint

A. Supervision of the Insurance Company's business activity lies with the Spanish State and is exercised through the Directorate General for Insurance and Pension Funds of the Ministry of the Economy.

B. In case of any type of claim in relation to the insurance policy, for the settlement thereof the Policyholder, Insured, Beneficiary, Aggrieved Third Party or Successor of any of these shall proceed to address:

1.The Insurer's Customer Service Department – by means of a letter addressed to Calle Ribera del Loira no. 52 (28042 Madrid) or to fax no. 91 585 24 80 or to the e-mail address departamentocalidad@sanitas.es-, which shall acknowledge receipt in writing and issue a reasoned written decision within the legal deadline of two months from the date of filing the complaint.

2. Once the Insurer's abovementioned internal process has been exhausted, or in the event of disagreement with the former's decision, a complaint may be lodged with the Insurance Ombudsman designated by the Insurer in the following cases:

a) In the case of complaints whose amount does not exceed EUR 21,000 and which concern the interpretation of the General and Particular Terms and Conditions of the Policy. Complaints concerning the personal or professional conduct of doctors, hospitals and medical services in general who give service to members shall not be submitted to the Insurance Ombudsman.

b) When, even though not meeting the foregoing requirements, the Insurer so agrees. To file a claim with the **Insurance Ombudsman,** the claimant shall remit a written statement to post office box no. 50.072 (28080 Madrid) setting forth the grounds for his/her claim. The Ombudsman shall issue a written acknowledgement of receipt and declare whether or not he/she is authorised to examine the complaint. If the Ombudsman declares that he/she is authorised, he/she shall examine the complaint and within the legal deadline of two months from the date the complaint was filed with the Insurer shall issue a reasoned decision, written notice of which shall be served on the complainant and the Insurer, on whom the decision shall be binding, releasing the Insurer from any benefit arising from the loss.

3.The claimant may also initiate administrative proceedings for a complaint before the Directorate General for Insurance and Pension Funds. Accordingly, the claimant must prove that the established period for the settlement of the complaint by the Insurance Ombudsman has expired or that the complaint has been rejected.

4. Notwithstanding this, the Policyholder/Insured may seek the judgement of the Courts and Tribunals.

OTHER IMPORTANT LEGAL POINTS

1. Subrogation

The Insured shall grant subrogation to the Insurer so that it may exercise the rights and actions that might pertain to the Insured by virtue of the claim in respect of the persons responsible therefor.

The Insurer shall not be entitled to subrogation against any of the persons whose acts or omissions may give rise to the Insured's liability, in accordance with the law, nor against the

originator of the claim who is a relative of the Insured in direct or collateral line in the third civil degree of kinship or an adopting parent or adoptive child living with the Insured.

This rule shall not take effect, however, if the liability is a result of fraudulent intent or if the liability is covered by an insurance contract. In the latter case, the subrogation shall be limited in its extent in accordance with the terms of said contract.

If the Insurer and the Insured both act jointly against a third responsible party, the redress obtained shall be divided between the two in proportion to their respective interest.

2. Duplicate policy

If the Policy is mislaid, at the request of the Policyholder or, as the case may be, of the Beneficiary, the Insurer **shall be under the obligation to issue a copy or duplicate of same,** which shall have the same effectiveness as the original.

The request shall be made in writing explaining the circumstances of the case, evidence shall be supplied of having notified whoever may be holders of any right by virtue of the Policy, and the applicant shall undertake to return the original Policy should it eventually turn up and compensate the Insurer for any damages occasioned by a third party claim.

3. Notices

3.1. Notices to the Insurer on the part of the Policyholder, the Insured or Beneficiary **shall be sent to the Insurer's registered office as stated in the Policy.**

3.2. Communications to the Policyholder, the Insured or Beneficiary on the part of the Insurer shall be remitted to their address as stated in the Policy, unless the Insurer has been notified of a change of address.

3.3. Notices remitted by the Policyholder to the insurance agent or broker who mediates or has mediated in the contract shall take the same effect as if they had been remitted directly to the Insurer.

3.4. Payment of the amount of the premium made by the Policyholder to the insurance agent or broker shall not be considered as made to the Insurer, unless **the agent or broker issues the Policyholder the aforesaid Insurer's premium receipt in return.**

OTHER

The Policyholder and/or the Insured grant the Insurer 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 the Insurer for a copy or written transcription of the contents of the conversations recorded between both.

JURISDICTION

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

Made in Madrid on 06 February 2012

For the Insured/Policyholder **For the Insurer**

Beatriz López
Executive Director of
Customer Service
Sanitas, S.A de Seguros