YOUR GENERAL CONDITIONS

Sanitas S.A.

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

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

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

Tax ID Code A-28037042

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Your general conditions

Preliminary clause

This Policy is governed, by Ley 50/1980, de 8 de octubre de Contrato de Seguro ("the Insurance Contract Act'), by Royal Legislative Decree 6/2004 of 29 October 2004 enacting the consolidated text of Ley de Ordenación y Supervisión de Seguros Privados ("the Private Insurance Ordination and Supervision Act'), the implementing Regulations of that Act (Royal Decree 2486/98 of 20November 1998), by Law 22/2007 of 11th of July, sobre comercialización a distancia de servicios financieros destinados a los consumidores ("Distance Marketing of Financial Services destined to Consumers"), by Ley 26/2006, de 17 de julio, de mediación de seguros y reaseguros privados ("the private insurance and reinsurance mediation Act) and these General Terms and Conditions and the 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 **Profesionales** 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 by 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 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 centers providing it and to be paid directly to SANITAS.

HEALTH QUESTIONNAIRE
Declaration made and signed by the Policyholder or Insured before formalization of 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.

INSURER OR INSURANCE COMPANY
Sanitas, Sociedad Anónima de Seguros, the legal person 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. 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 CONDITIONS
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.

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.

POLICYHOLDER
The physical or legal person who, 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 hospitalization.

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 ('ATS', 'DUE')
Registered nurse or Technical Healthcare Assistant legally qualified and authorized 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 centers 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 centers forming the medical network of this policy available to the insured in 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 in-patients.

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.

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

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

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 HOME SERVICES
Care provided at the Insured’s address appearing in the Policy in cases of emergency, provided by a general practitioner 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 clinic situation that does not suppose a vital commitment or irreparable damage to the physical integrity of the patient, that requires immediate medical care

VITAL 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.

Clause I: Purpose of the Insurance

Within the limits and conditions stipulated in the Policy and following payment by the Policyholder of the corresponding premium, co-payments and deductibles that may correspond, SANITAS provides its insured with a wide range of professionals, clinics and hospitals for medical, surgical and hospital care, according to normal medical practice, in the specialties and modalities included in the cover of this Policy, their cost being assumed through direct payment to the professionals or centers providing the insured provision.

Any diagnostic and therapeutic advances arising in medical science after the effective date of this contract may become part of the cover of this policy provided that they are safe, effective and universalized and consolidated. Whenever this policy is renewed, SANITAS shall inform of the techniques or treatments to be included in the cover of the policy for the following period.

Clause II: Benefits

PRINCIPAL BENEFITS

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

1. Primary care

1.1. General Medicine

This includes medical care in a healthcare center, indication andprescription of basic diagnosis tests and procedures (analysis and general radiology) during thedays and times established for this purpose by the doctor. It includes also home services when, for reasons attributable only to the Insurer's illness, he/she is prevented to attend the consultancy.

In emergencies the Insured shall go to the permanent emergency services or else contact the SANITAS telephone service.

1.2. Pediatrics and Childcare

This includes the care of children **until they are 15 years old** in consultancy and at home, the indication and prescription of tests and basic diagnosis procedures (analysis and general radiology), being applicable all other regulations mentioned for the benefit of General Medicine.

1.3. Nurse Care Service

Includes healthcare at the healthcare center and at home.

2. Emergencies

These include emergency healthcare provided in permanent emergency centers.

In justified circumstances, the service shall be provided at the home of the Insured, by the permanent services on call, **only in those towns in which SANITAS has contracted the performance of such service.**

Sanitas 24 Hours

Telephonic service that comprises the informative attention performed by a medical team, who shall advice 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

3.1. Allergology

3.2. Clinical Analysis

3.2.1. Genetic Studies

Comprises only those necessary for diagnosis and/or prescription oftreatment of affected and symptomatic patients.

3.3. Anatomic Pathology

Includes the performance of therapeutic targets prior to the administration of certain pharmaceutical products, provided that the technical summary ofcharacteristicsof the product as established by the Spanish Agency of Medicinal Products and Medical Devices requires that such targets be determined.

3.4. Anesthesiology

3.5. Angiology and Vascular Surgery

Varicose vein treatments with foam or microfoam are excluded.

3.6. Digestive System

3.7. Cardiology

3.8. Cardiovascular Surgery

The cryoablation technique and percutaneous techniques forthe replacement of heart valves are excluded.

3.9. General and Gastrointestinal Surgery

Includes laparoscopic surgery.

3.10. Maxillofacial Surgery

Includes the diagnosis and surgical treatment of diseases andtrauma involving only the jawbone, maxilla and facial bones.

Dentistry treatments are excluded, as are cosmetic treatments and/or treatments targeting functional issues of the patient's mouth or teeth, such as orthognatic, pre-implant and pre-prosthesis surgery.

3.11. Traumatology and Orthopedic Surgery

Includes arthroscopic surgery.

3.12. Pediatrics Surgery

In the same terms and conditions as those mentioned for adult surgery.

3.13. Reconstructive Surgery

3.14. Chest Surgery

3.15. Dermatology

3.16. Endocrinology and Nutrition

3.17. Geriatrics

3.18. Hematology and Hemotherapy

Comprises autologous bone marrow and parentperipheral blood cell transplants **solely for treatment of hematological tumors.**

3.19. Internal Medicine

3.20. Nuclear Medicine

Contrast agents are paid for by SANITAS.

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

A)Oncology Diagnosis:

- Characterization of the sole lung nodule.
- Detection of the unknown origin tumor evidenced, for example by cervical gland illness, liver or bone metastasis.
- Characterization of a pancreatic mass.

B) Staging:

- Head and neck tumors, including assisted guided biopsy.
- Primary lung cancer.
- Breast cancer locally advanced
- Esophagus cancer
- Pancreas carcinoid
- 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.

C)Monitoring of treatment response:

- Malignant lymphoma

- Head and neck tumors

D) Detection in case of reasonable suspicion of recurrence:

- Gliomas with high degree of malignity
- Head and neck tumors
- 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 carcinoid
- Colorectal cancer
- Ovary cancer
- Malignant lymphoma
- Malignant melanoma

E)Neurology:

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

3.21. Nephrology

Includes dialysis techniques only for the treatment of acute processes. **Chronic treatments of dialysis and hemodialysis are excluded.**

3.22. Pneumology

3.23. Neurosurgery

Includes surgery with surgical navigation assistance and Intraoperative Electro-physiological Monitoring.

3.24. Clinical Neurophysiology

3.25. Neurology

3.26. Obstetrics and Gynecology

Includes laparoscopic gynecological surgery and studyand basic diagnosis of infertility and sterility.

It also includes family planning, tubal ligation, IUD implantation **(the IUD has to be paid by the Insured)**, and follow up of treatment with anovulatories.

The following genetic tests are included: karyotype, factor V Leiden and prothrombingenemutation 20210. **Any other genetic test other than those mentioned shall be excluded.**

3.26.1. Neonatology Care

It comprises the medical check, vaccine administration and performance of all those tests that systematically are performed to newborns during his/her first 48 hours of life, according to the care delivery protocol applicable in each autonomous regions, **excluding all medical service that is a consequence of a pathology or complication appearing at the moment of birth.**

3.26.2. Newborn care

It comprises the expenses derived from care performed to newborns, **providing he/she is enrolled as Insured in SANITAS and has contracted the corresponding coverage.**

3.27. Ophthalmology

Includes laser photocoagulation and cornea transplant surgery. Thetransplantable cornea must be paid for by the Insured.

3.28. Medical Oncology

Treatment must always be prescribed by the Medical Oncology consultant in charge of the patient's care. The treatments shall be paid by SANITAS if they are conducted at ahealthcare site, both as Oncologic day-patient treatment and as inpatient treatment if such was necessary.

SANITAS, shall only pay for expenses corresponding to specifically cytostatic drug products, the sale of which is authorized in the Spanish market and only if these products are used according to the instructions of the summary of product characteristics and administered parenterally, in as many cycles as required.

3.29. Ear, Nose and Throat

Includes laser surgery and radiofrequency surgery.

3.30. Psychiatry

The admission as psychiatric in-patient **only includes the treatment of acute outbreaks. It is limited to a maximum period of 50 days per Insured/year.**

3.31. Radio Diagnosis/Imaging Diagnosis

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

It also includes:

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

- Screening of colon cancer and colon polyposis in patients without a known clinical history of colon cancer, polyposis or inflammatory 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 colon polyposis in patients in which the conventional colonoscopy is contraindicated due to their clinical situation or supposes a higher risk.

- As complement to conventional colonoscopy when this has not achieved the complete length of the colon.

To access to the insured coverage of this diagnosis test the Insured must participate in the cost of the service in the amount expressly indicated in the particular conditions of his/her policy.

B) Includes CT coronary angiography: covered **only for patients with symptoms of coronarydisease with non-conclusive ischemia test results, valve replacement surgery, post-operative coronary stenosis bypass assessment and malformations of the coronary tree.**

Assessment of the stenosis after implantation of a coronary stent and the calcium score are excluded.

3.32. Radiotherapy

3.33. Rehabilitation

It comprises the consultations which have the purpose of diagnosis, evaluation and prescription of the physiotherapy treatments included in the cover of Physiotherapy.

3.34. Rheumatology

3.35. Urology

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

Prostate interventions by any laser technique are excluded.

4. Other care services

4.1. Ambulance

This service shall be performed by land. The present benefit only includes transfers from the place where the Insured is to the hospital where the care covered by this policy will be provided and from this hospital to the Insured's home. It includes also intra-hospital transfers when the hospitals are located in different provinces when the care resources in the province of residence of the Insured are not enough to attend him/her.

This benefit does not include any transfer required for physiotherapy treatments, forconducting diagnostic tests or for outpatient attendance to consultancies.

4.2. Special Care in the Home of the Insured

This shall be performed by the care teams designated by SANITAS, providing there is

the possibility of contracting the service, when the conditionof the patient requires special care but does not require hospital admission.

4.3. Obstetric-Gynaecological Nursing (Midwifery)

Care provided by a midwife will be available only for hospital-based child delivery.

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 onlycovered until the patient has achieved the greatest functional recovery possible in the opinion ofhis/her rehabilitating physician.

It also includes the musculoskeletal physiotherapy as inpatient, **secondary to orthopedic surgery and heart rehabilitation under a hospital admission system following surgery withextra-corporeal circulation.** Also includes lymphatic drainage after a mastectomy arising from cancer.

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

4.5. Speech and Language Therapy

It is included only when related with organic processes, **to a maximum of 6 months a year per Insured.**

Language therapy in non organic processes is excluded.

4.6. Podiatry (Chiropody exclusively)

Limited to a maximum of 6 sessions per Insured and insurance annuity.

4.7. Prostheses

Only includes the internal prostheses and internally implantable materials expressly indicated below and **up to the insured capital limits established, if such is the case, in the Particular Conditions of the policy.** In those cases that SANITAS requires so, the Insured shall have to provide with reports and/or budgets.

1. Ophthalmology: monofocal intraocular lens for cataract surgery.

2. Traumatology and Orthopedic Surgery: Hip, knee and other joint prostheses; necessary material for backbone fixing; intervertebral disc; interbodyor interspinal intervertebral material; vertebroplasty/ kyphoplasty material; biological bone ligament material obtained from tissuebanks in Spain; osteosynthesis material; bone substitutes **exclusively for backbone surgeryand bone grafts after tumor surgery.**

3. Cardiovascular Area: The following vascular prostheses: stent, peripheral or coronary by-pass, medicalised or non-medicalised, **with exclusion of those used in aorta in any of its stages and the aortic valved ducts, heart valves with exclusion of aortic valved ducts and any other that require implantation via percutaneous or transapical; pacers with exclusion of any type of defibrillator and the artificial heart;** coils and/or embolization materials.

4. Chemotherapy or Pain Treatment: reservoirs.

5. Other surgical materials: abdominal meshes **except those used as closing in laparoscopic surgery;** urological suspension systems; spinal tapsystems (hydrocephalus); breast implants and expanders, exclusively for the breast affected by prior tumor surgery.

6. Bone fixing materials in cranial and/or maxillofacial surgery

4.8. Maternal Infant Program

Includes theoretical and practice classes for child delivery preparation, child health examinations, as well as telephonic assessment by nursing professionals during the first six months of life of the child.

4.9. Psychology

Includes individual psychological care prescribed by Psychiatrists, General Practitioners or MedicalOncologists. Also includes simple psychological diagnosis and psychometric tests, t**he 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 andpsychosocial and neuropsychiatric rehabilitation services.

4.10. Home-based respiratory therapy

Exclusively comprises the following treatments:

a) Oxygen therapy: liquid, concentrator-based and gaseous.**Liquid oxygen therapy must be prescribed for administration for at least 15 hours a day SANITAS shall only pay for one type of oxygen therapy treatment.**

b) Generation of positive airway pressure to treat sleep disorders.

c) Aerosol therapy and Ventilation therapy.

5. Hospital admission

Includes any type of hospitalization (medical, psychiatric, in ICU, surgery, obstetrical) in a clinic or hospital.

The patient shall occupy a conventional, individual room with a bed for relatives, except inpsychiatric hospitalization, in ICU and in incubator and SANITAS shall pay for any expensesarising from the performing of the diagnosis and therapeutic methods, surgical treatments(including surgery and drug costs, **except cytostatic drugs that are not authorized for sale in Spain)** and accommodation with the upkeep of the patient, included in the cover of the policy.

6. Early detection of disease

This includes the medical consultation, physical examination and basic diagnostic testsprescribed by the corresponding consultant for the early diagnosis of the following diseases:

6.1. Digestive System: early diagnosis of cancer of the esophagus, stomach and colon-rectum.

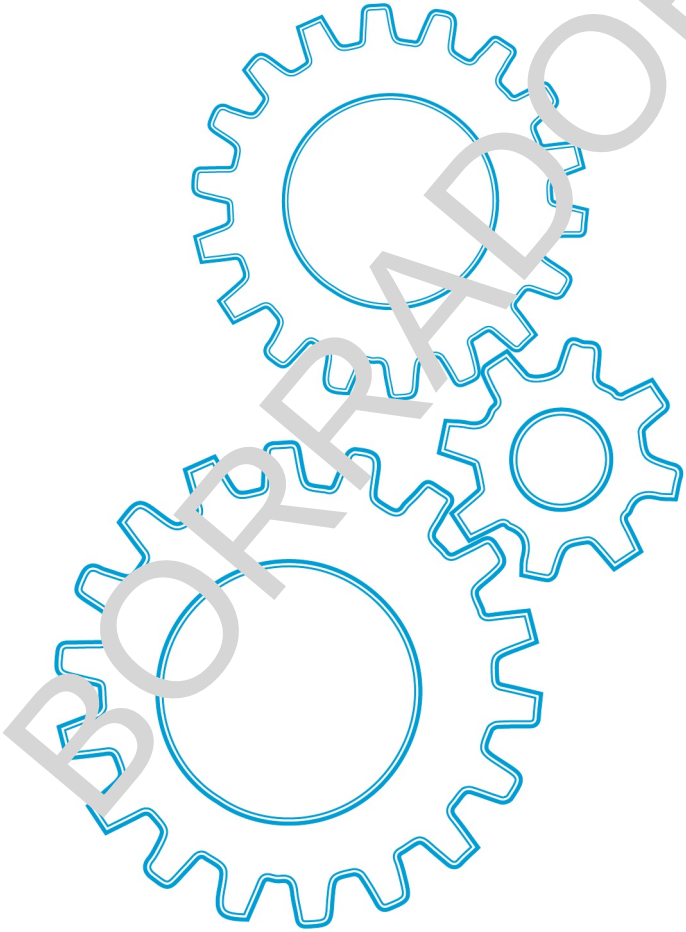
6.2. Cardiology: early diagnosis of heart risk.

6.3. Pneumology: early diagnosis of lung cancer.

6.4. Obstetrics and Gynecology: early diagnosis of breast cancer, cervical cancer and ovariancancer.

6.5. Urology: early diagnosis of prostate and bladder cancer.

ADITIONAL COVERAGES OF YOUR INSURANCE



Second medical opinion

This cover includes a second opinion on medical diagnosis or treatment in the event of seriouschronic diseases, requiring scheduled care, which course requires exceptional diagnostic or therapeutic measures and/or whereof the life prognosis is seriously compromised. Such a second opinion shall be issued by leading consultants, healthcare centers,physicians oracademics in any country in the world, designated by SANITAS

To use this service, the Insured shall send the clinical dossier comprising written medicalinformation, X-rays or other image diagnoses performed, excluding dispatch of any biological or syntheticmaterials. SANITAS shall confidentially send this dossier to the corresponding specialist or center, accordingto the disease in question.

When the process finishes, a report about the second medical opinion shall be sent to the Insured, including:

- Summary of his/her clinical history
- Opinion of the leading experts consulted
- Curriculum de of these leading experts.

All along this process, the Insured shall be accompanied by a consultant physician, responsible for the management of the case and for assessing the patient at all times.

Traffic and Occupational Accidents Cover

Sanitas will cover, under the terms and conditions set down in the policy hereunder, healthcare required by the insured as a result of traffic accidents, occupational accident or occupational illness, considered as such by the relevant Administrative Authorities.

Healthcare requiring treatment for illness, injury, malformation or defects derived from sporting completions is excluded.

Family Care Cover

1. PURPOSE OF THE COVER

Family Care is a complementary cover to the healthcare policy with guarantees that are covered when the insured needs to be hospitalised for more than 48 hours or is immobilised at home for more than 5 days for convalescence with medical leave or an equivalent certified document, or when the insured dies as a result of an accident or illness.

2. TERRITORY COVERED

The Family Care guarantees will apply throughout Spain for insured parties domiciled in Spain, even if the accident or illness is produced outside of Spain.

3. USE OF THE SERVICES

To use the services the insured must be up to date with his or her premium payment obligations. The services will be provided via a provider appointed by SANITAS. The insured must contact the provider by calling 902 747 767 as soon as possible after learning of the hospitalisation, immobilisation or death.

4. GUARANTEES INCLUDED

Through the provider that SANITAS appoints, SANITAS will provide the following guarantees:

1. Home help

The provider will send a person to the insured's home to help with basic household tasks (cleaning, washing, ironing, meal preparation, etc.) for a maximum of 30 hours at a ratio of 2 continuous hours per day starting from the first day. These hours will be distributed throughout a maximum period of 1 month.

The number of hours of service provision will be assigned on the basis of an objective

assessment of the applicant's degree of autonomy, considering aspects such as the effective time of immobilisation or invalidity to perform basic tasks, the seriousness of the insured's injuries and the number of dependent family members.

The provider reserves the right to ask the insured for the medical report and tests that have been performed, which will be assessed by a medical team who will determine and evaluate the insured's degree of invalidity and subsequently the hours ofhome help needed.

The home help guarantee cannot be accumulated if various members of the same family are injured or immobilised in the home.

2. Transfer of a relative to care for children under 16 years of age or disabled children

Transfer of a relative of the insured or the person designated by the insured to the insured's home to care for his or her children. The transfer will be aboard a scheduled airline flight (economy class), train (1st class) or taxi. Return ticket included.

This guarantee excludes guarantees 3, 4 and 8.

3. Home help to care for children under 16 years of age or disabled children

A person will be sent to the insured's home to care for children under 16 years of age or disabled children and the number of hours will be established on the basis of the effective time of immobilisation or the severity of the insured's injuries, with a minimum of 2 continuous hours a day from the first day and up to a total maximum of 30 hours distributed throughout the maximum period of 1 month.

This guarantee excludes guarantees 2 and 4.

4. Transfer of children under 16 years of age or disabled children

Transfer of children under 16 years of age in a scheduled airline flight (economy class), train (1st class) or taxi to the home of the relative appointed by the insured in Spain.

This guarantee excludes guarantees 2 and 3.

5. Escort transferring children under 16 years of age or disabled children

A person will be appointed to escort underage or disabled children to the home of the relative appointed by the insured in Spain. The escort will be appointed by the provider, so long as there is no possibility of the insured appointing an adult escort.

6. Escort to take children under 16 years of age or disabled children to school and back

An escort will be appointed by the provider for a maximum of two journeys a day for up to 5 days, if no relative is available, and for a maximum period of 1 month.

7. Home help to care for elderly parents

A person will be sent to the insured's home to care for elderly parents who live in the same home as the insured and who are dependent upon him or her, according to the laws in force. Up to a maximum of 30 hours at a ratio of a minimum of 2 continuous hours per day starting from the first day.

The number of hours of service provision will be assigned on the basis of an objective assessment of the applicant's degree of autonomy, considering aspects such as the effective time of invalidity to perform basic tasks, the seriousness of the insured's injuries and the number of dependent family members.

The provider reserves the right to ask the insured for the medical report and tests that have been performed.

This guarantee excludes guarantees 8 and 9.

8. Transfer of a relative to care for elderly parents

Transfer of the relative appointed by the insured to the insured's home in a scheduled airline flight (economy class), train (1st class) or taxi to care for elderly parents who live in the same home as the insured and who are dependent upon him or her, according to the laws in force. Return ticket included.

This guarantee excludes guarantees 2, 7 and 9.

9. Transfer of elderly parents

Transfer in a scheduled airline flight (economy class), train (1st class) or taxi to the home of the relative appointed by the insured in Spain of the elderly parents who live in the same home as the insured and who are dependent upon him or her, according to the laws in force.Return ticket included.

This guarantee excludes guarantees 7 and 8.

10. Care of pets (dogs and cats)

Transport and accommodation for pets (dogs and cats) from the first day and for a maximum of 1 month.

11. Dispatch of medication

Dispatch of medication to the place where the insured is located in Spain, for a maximum of 3 times in 1 month.

The cost of the medication is excluded and must be paid for by the insured upon delivery. The provider takes no responsibility regarding delays in delivery or state of medication for causes not imputable to it.

5. GENERAL EXCLUSIONS

Damage, situations, expenses and consequences deriving from the following are excluded from the insured guarantees:

5.1. Wilful misconduct on the part of the insured

5.2. Nuclear reactions or radiation or radioactive, chemical or biological contamination, either directly or indirectly.

5.3. Events whose size or seriousness qualify them as catastrophic.

5.4. Armed conflict, even if it hadn't been preceded by an official declaration of war.

5.5. Extraordinary risks, even when the disaster has ended, as well as extraordinary situations such as natural phenomena (flood, earthquake, volcanic eruption, atypical cyclone, falling astral bodies and meteorites).

6. GRACE PERIODS

For the provision of the guarantees described above, it will be necessary for two months to have passed from the date of the present supplementary cover taking effect in relation to the insured who requests a service covered herein.

All of the guarantees described above will be provided to the Insured by the provider that Sanitas appoints from the date of the present supplementary cover taking effect in relation to the insured who requests a service covered herein.

Sanitas Dental 21

1. Services included in your policy

For this type of service the Insured does not need to pay the dentist any amount.

The services covered shall only be provided by the medical professionals included in the list of dentists in the medical network corresponding to this policy.

This care shall only be provided at the dentist’s surgery, specifically excluding care outside of it.

The services and treatments listed below are covered:

GENERAL AND PREVENTIVE DENTISTRY

- General dentistry consultation: examination and diagnosis
- Oral cleansing/tartar removal
- Priority consultation in case of emergency

SURGICAL PROCEDURES

- Simple extraction
- Extraction of non-impacted third molars
- Extraction of impacted third molar plus dental cysts
- Extraction of impacted tooth (not third molar) plus dental cysts
- Extraction of root remains
- Extraction by odontosection
- Postoperatory check-up (includes removal of stitches)

COSMETIC DENTISTRY

- Photoactivation whitening brace (for treatments performed at the same clinic)

CHILDREN'S DENTISTRY (patients aged under 15 years)

- Consultation
- Buccodental education
- Intraoral X-rays
- Oral cleansing/tartar removal
- Extraction of deciduous teeth

PROSTHESIS

- Occlusal analysis

PERIODONTICS

- Periodontal X-ray series

ORTHODONTICS

- Consultation
- X-ray study for orthodontics
- Extraction of deciduous teeth
- Simple extraction
- 1st replacement metal brackets
- 1st replacement ceramic brackets
- 1st replacement self-binding brackets
- 1st replacement sapphire brackets
- 1st replacement of cosmetic self-binding brackets
- Orthodontics box (for treatments performed at the same clinic)
- Oral protector for orthodontics (for treatments performed at the same clinic)

IMAGING DIAGNOSIS: RADIOLOGY/OTHERS

- Periapical/bite-wing/occlusal
- Periodontal X-ray series
- Lateral skull X-rays
- Orthopantomogram (panoramic)
- Cephalometry
- Photographs or slides
- Computed axial tomography (dental CT scan)

TEMPOROMANDIBULAR JOINT PATHOLOGY

- Occlusal analysis

EMERGENCIES

In case of emergency, the Insured must go to the permanent emergency centres indicated in the Practical Guide.

2. Services with a deductible payable by the Insured

The Insurer must agree to the relevant prescription and deductible given by the dentist, and the Insured shall pay directly this deductible to the dentist corresponding to the cost of the service requested.

The Insured shall bear the cost of services in accordance with the scale of deductible amounts in force at the time of service provision.

If there is any change to the deductibles to be paid by the Insured, Sanitas shall notify the new amounts to the Insured two months in advance of the date of effect. Payment of the premium shall imply acceptance of such changes.

The deductible amounts of these services are indicated in the Particular Conditions of the Policy, such deductible amounts shall be charged to the Insured. These services are:

GENERAL AND PREVENTIVE DENTISTRY

- Topical fluoride treatments
- Treatment for dental sensitivity
- Fissure sealer

SURGICAL PROCEDURES

Minor surgery

- Frenectomy (upper or lower)
- Removal of epulis/small mucosal cysts
- Drainage of gingival/parodontal abscesses
- Apicoectomiy
- Dental cyst

Preprosthetic surgery

- Vestibuloplasty (per quadrant)
- Alveolar regularization (per quadrant)
- Removal of torus (per quadrant)

Orthodontic surgery

- Orthodontic fenestration (per tooth)

CONSERVATIVE DENTISTRY

- Fillings / obturation
- Reconstruction
- Direct pulp coating
- Indirect pulp coating
- Provisional obturation

ENDODONTICS

- Consultation for symptom treatment (opening, instrumentation and drainage)
- Root-end filling material (MTA)
- Fiberglass or carbon post
- Monoradicular endodontics
- Biradicular endodontics
- Polyradicular endodontics
- Monoradicular re-endodontics
- Biradicular re-endodontics
- Polyradicular re-endodontics

COSMETIC DENTISTRY

Whitening

- Custom tray tooth whitening (per treatment)
- Dental bleaching by photoactivation (per treatment)
- Dental bleaching by photoactivation (per tooth and session)
- Combined dental bleaching photoactivation plus brace)

Dental reconstruction

- Reconstruction of aesthetic composite front (per tooth)
- Intraoral repair of porcelain (per tooth)
- Porcelain facing
- Injected facing
- Zirconia facing
- Composite facing
- Cosmetic bridge crown or unit over tooth

CHILDREN'S DENTISTRY (patients aged under 15 years)

- Topical fluoride treatments
- Fissure sealer
- Obturation of deciduous teeth
- Pulpotomy without reconstruction
- Pulpectomy without reconstruction
- Preformed metallic crown
- Apical formation (full treatment)
- Fixed space maintainer
- Removable space maintainer
- Bridge/crown/space maintainer removal, (per tooth)
- Guided occlusion or occlusal pad (per tooth)
- Oral screen
- Tooth reimplantation

PROSTHESIS

- Assembly and study of semi-adjustable articulator
- Selective carving
- Diagnostic polishing (per tooth)

Fixed prosthesis

- Bridge/crown/space maintainer removal (per tooth)
- Recementation
- Inlay
- Provisional resin crown
- Bridge crown or unit on tooth
- Cosmetic bridge crown or unit over tooth
- Supplement for precious metal
- Monoradicular cast stump
- Multiradicular cast stump
- Maryland support (unit)
- Attaches

Removable prosthesis

- Removable acrylic (1 to 3 teeth)
- Removable acrylic (4 to 6 teeth)
- Removable acrylic (more than 6 teeth)
- Hypoallergenic resin supplement (per arch)
- Repair
- Repair (rebase)(per appliance)
- Repair (addition of retainer)
- Metal reinforcement
- Repair (add piece to acrylic removable)
- Provisional complete (one arch, upper or lower)
- Definitive complete with metal reinforcement
- Skeletal (per tooth)
- Skeletal (base structure)
- Flexible removable (from 1 to 3 teeth) (Flexite, Valplast, others)

- Flexible removable (from 4 to 6 teeth) (Flexite, Valplast, others)
- Flexible removable (more than 6 teeth) (Flexite, Valplast, others)
- Ceramic shoulder or neck (per tooth)

PERIODONTICS

Non-surgical treatmens

- Periodontal examination (periodontal X-rays) (per arch)
- Periodontal maintenance
- Radicular scraping and smoothing (per quadrant) (curettage)
- Periodontal bracing (per tooth)
- Radicular scraping and smoothing (per tooth) (curettage)

Surgical Treatmens

- Gingivectomy (per quadrant)
- Flap surgery (per tooth)
- Regeneration with biomaterials (lyophilised bone, etc.)(per unit 0.5g)
- Membrane (unit)
- Crown lengthening
- Apical replacement flap (per quadrant)
- Graft free gum
- Mucogingival surgery

ORTHODONTICS

Supplementary treatments

- Study and diagnosis for orthodontics
- Retention appliance with brace (end of treatment)(per arch)
- Retention appliance with lingual bar (end of treatment)(per arch)
- Revisions (in latency or resting periods)
- Renewal mobile device, replacement or loss
- Appliance repairs (due to appliance breakage)
- Orthodontic microscrews (per unit)
- 2nd replacement metal brackets (unit)
- 2nd replacement ceramic brackets (unit)
- 2nd replacement self-binding brackets (unit)
- 2nd replacement sapphire brackets (unit)
- 2nd replacement of cosmetic self-binding brackets (unit)

Treatment with fixed appliances with metal brackets

- Start of one arch; upper or lower (including first appliance)
- Start of both arches (including first appliances)

Treatment with fixed appliances with ceramic brackets

- Start of one arch; upper or lower (including first appliance)
- Start of both arches (including first appliances)

Treatment with fixed appliances with sapphire brackets

- Start of one arch; upper or lower (including first appliance)
- Start of both arches (including first appliances)

Treatment with fixed appliances with self-binding brackets

- Start of one arch; upper or lower (including first appliance)
- Start of both arches (including first appliances)

Treatment with fixed appliances with aesthetic self-binding brackets

- Start of one arch; upper or lower (including first appliance)
- Start of both arches (including first appliances)

Treatment with fixed appliances with invisible technique

- Start treatment under 12 months of age
- Start treatment over 12 months of age

Interceptive treatment with fixed appliances

- Start of one arch; upper or lower (including first appliance - quad helix)
- Start of both arches (including first appliances)

Interceptive treatment with removable appliances

- Start of one arch; upper or lower (including first appliance)
- Start of both arches (including first appliances)

Mixed treatments: orthopaedic force with fixed appliances

- Start of one arch; upper or lower (including first appliance)
- Start of both arches (including first appliances)

Mixed treatments: orthopaedic force with removable appliances

- Start of one arch; upper or lower (including first appliance)
- Start of both arches (including first appliances)

DENTAL IMPLANTS

- Implantology study
- Implantology maintenance

Dental implant surgery

- Osteointegrated implant (unit)
- Closed maxillary sinus lift
- Open maxillary sinus lift
- Regeneration with biomaterials (lyophilised bone, etc.)(per unit 0.5g)
- Biomaterial regeneration (block bone)
- Membrane (unit)

Guided surgery

- Study guided implantological surgery
- Supplement per implant in guided surgery (unit)
- Radiological guide
- Surgical brace (for guided surgery)

Prosthesis over implants

- Crown over implant
- Cosmetic crown over implant
- Provisional crown over implant
- Provisional crown for immediate charge
- Titanium stump (per tooth)
- Zirconia stump over implant (per tooth)
- Overdenture on implants (per appliance)
- Hybrid prosthesis (per arch)
- Metal termination: supra or mesostructure (unit)
- Supplement for precious metal in implants
- Prosthetic additament (intermediate pieces)
- Prosthetic additament for immediate charge
- Locator (unit)
- Micromilled Bar (on 5 implants or fewer)
- Micromilled Bar (on 6 implants or more)
- Ackerman-type clip (per implant)
- Attachment over implant (includes riders)

TEMPOROMANDIBULAR JOINT PATHOLOGY

- Assembly and study of semi-adjustable articulator
- Revisions, brace adjustments
- Selective carving
- Neuromyorelaxation brace (Michigan type)
- Stabilisation splint (single)

Europe Assistance

What is this?

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

Wich services am I entitled to?

1. Medical Costs

By virtue of the contract signed with EUROP ASSISTANCE, the company Sanitas, S.A. de Seguros 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 12.000€ per person and year 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

12.000€ per person and year.

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 **EUROP ASSISTANCE** medical service, **EUROP ASSISTANCE** 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, **EUROP ASSISTANCE** 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 in the discretion of the **EUROP ASSISTANCE** medical team

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, **EUROP ASSISTANCE** shall provide a family member resident in Spain with a return economy-class air fare with a regular airline or first-class rail ticket. **EUROP ASSISTANCE** 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, **EUROP ASSISTANCE** 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. **EUROP ASSISTANCE shall not pay the funeral and burial costs.** On application from the beneficiaries, **EUROP ASSISTANCE** 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. **EUROP ASSISTANCE shall not pay the funeral and burial costs.**

6. Early return of insured accompanying relatives

If t 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, **EUROP ASSISTANCE** 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, **EUROP ASSISTANCE** 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 an **EUROP ASSISTANCE** 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, **EUROP ASSISTANCE** shall help in its search and retrieval, advising on how to file the corresponding formal complaint. If the luggage is retrieved, **EUROP ASSISTANCE** 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

EUROP ASSISTANCE 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.

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

10. Advance of funds

EUROP ASSISTANCE shall advance funds of up **to €1,500 to the Insured, when required. EUROP ASSISTANCE 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 EUROP ASSISTANCE within a maximum period of 30 days.**

11. Legal advice

If the Insured is incarcerated or prosecuted as a result of a traffic accident, **EUROP ASSISTANCE 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 EUROP ASSISTANCE 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, **EUROP ASSISTANCE** shall issue an advance equal to the amount of bail demanded by the local authorities **to a maximum of €10,000.**

Europ Assistance 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 **EUROP ASSISTANCE** 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, **EUROP ASSISTANCE** 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 EUROP ASSISTANCE for the price of the medication against presentation of invoice

14. Transmission of urgent messages (relating to covers)

EUROP ASSISTANCE 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 Europ Assistance; 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 Europ Assistance within a period of 7 days of the date of admission.

Coverage rent

1. OBJECT OF THE INSURANCE OF THE COMPLEMENTARY COVERAGE RENT

Within the limits and conditions established in the Policy, and following payment by the policyholder of the corresponding Premium, SANITAS assumes the payment of an indemnification for each day of internment of the Insured in hospital or clinic if as a consequence of an acquired illness or accident suffered during the validity of this benefit and covered by it, the Insured had to be necessarily interned in a hospital for his/her due medical or chirurgic treatment, a minimum of 24 hours, due to:

a) Illness of the Insured that needs hospital care.

b) Chirurgic intervention of the Insured

c) Accident of the Insured.

The daily indemnification shall be as established in the particular conditions and shall be earned from the first day of hospital internment and during all the time that the Insured is registered as interned in ah hospital or clinic until his/her documented hospital discharge and with a maximum of 365 days. If within the period of the twelve months following a hospitalization of the Insured, due to which he/she has earned an indemnification, the Insured hat to be hospitalized again for the same or a consequent or related cause, the new internment shall be considered as a prolongation of the previous, to the effect of the calculation of the above established limit of 365 days.

For the cases in which the Insured suffered several illnesses at the same time, or a new illness ensued the daily indemnification to be paid by SANITAS shall be that indicated in the corresponding Particular Conditions.

In this last case, SANITAS shall be informed in writing of this circumstance. If this new

illness had no relation with the previous process, a new term shall start to count from the date that the new illness has started.

2. EXCLUDED RISKS

The following risks shall be excluded from the present coverage:

2.1. The direct provision by SANITAS of medical, hospital or surgery services.

2.2. The indemnification for hospitalization due to problems of social type.Also the indemnification for hospital internment is excluded when a consequence of:

2.3. All types of preexisting and/or congenital illnesses, defects or deformities occurred before the date of enrollment of each Insured in the Policy, as well as those that can derive from those, providing they were known by SANITAS or Insured and not declared.

The Policyholder, in his/her name and in the name of the beneficiaries and/or each of them, is obliged to manifest in the moment of subscription of the insurance proposal/application, if they suffer or have suffered any type of injuries or illnesses, especially those of a recurrent character, congenital or that need or have needed studies, diagnosis tests or any type of treatments; or if at the time of subscription of the policy they suffered symptoms or signs that could be considered as the beginning of any pathology.

Manifesting in such form, the condition shall be considered as preexisting and/or congenital and, as a consequence, excluded from the coverages agreed in the insurance contract. If there were preexisting and/or congenital illnesses, SANITAS preserves the right to accept or refuse the enrollment of the applicant or applicants, and in case of accepting, the corresponding clause of exclusion shall be included in the Particular Conditions of the Policy in what refers to the indemnification as a consequence of preexisting and/or congenital illnesses, defects or deformities present before the date of enrollment of each Insured in the Policy; as well as those that can derive of those.

2.4. All illnesses or injuries produced as a consequence of civil, international or colonial wars, invasions, insurrections, rebellions, acts of a terrorist character in any of its forms (chemical, biological, nuclear, etc.), revolutions, mutinies, uprisings, repressions and military maneuvers, even in time of peace, and officially declared epidemics.

2.5. Illnesses, accidents, injuries, malformations or defects that have a director indirect elation with nuclear radiation or radioactive contamination, as well as those arising from cataclysms such as earth quakes, floods, volcanicer uptions and other sysmic or meteorological phenomena.

2.6. The illnesses, injuries, malformations or defects derived from working, professional and sport competition accidents, those derived from the use of motor vehicles covered by the Compulsory Subscription of Automobile Insurance.

2.7. The illnesses or injuries derived from chronic alcoholism, drug addiction, intoxication due to alcohol, psychotropics, narcotics or hallucinogens abuse, suicide attempt and self injuries, as well as Health care due to illnesses or accidents suffered due to dolo of the Insured.

2.8. The illnesses or injuries derived of the infection of the Human Immunodeficiency Virus, AIDS, and the illnesses related with this.

2.9 The illnesses or injuries produced practicing as amateur risky sports, such as aerial activities, speed or endurance tests with motor vehicles, bobsleigh, water diving, climbing, boxing, bull fighting,

martial arts, rugby or any other activity with a similar risk.

2.10. Illnesses or processes of a chronic character.

2.11. All those diagnostic, surgical or therapeutic processes whose clinic security and efficacy are not duly scientifically contrasted or that are of new appearance, not expressly included in the present policy. Those procedures non consolidated in the habitual clinical practice and those that have manifestly been overcome by others available. Equally those procedures of an experimental character or that their effective contribution to the prevention, treatment or healing of illnesses is not sufficiently proved.

2.12. The indemnification for services or technics that consist in mere activities of leisure, rest, comfort, or sport, as well as treatments in spas and rest cures.

2.13. The interventions, infiltrations and treatments, as well as any other intervention that has a purely cosmetic or esthetic character.Also, the treatment of any type of pathology or complication that may arise at a later stage and that are directly and/or principally caused due to the submission of the insured to an intervention, infiltration or treatment of the above mentioned of a purely esthetic or cosmetic nature are excluded.

2.14. Treatments and interventions directed to solve the sterility or infertility in both sexes (in vitro fertilization, artificial insemination, etc.) and the voluntary interruption of pregnancy. The study, diagnosis and treatment of impotency is also excluded.

2.15. Any process that requires for its treatment the use of psychology, psychoanalysis, hypnosis, psychotherapy, narcolepsy, sleep cure and educative therapy, such as speech education or special education in sick persons with psychic affectations.

2.16. The indemnification for hospitalization as a consequence of chirurgic technics or therapeutic treatments that use laser, except photocoagulation technics in Ophtalmology.

2.17. General medical examinations of a preventive character.

2.18. Determinations of the genetic map, that have the finality of knowing the predisposition of the Insured or of his/her current of future offspring to suffer certain illnesses related with genetic alterations

2.19. The indemnification for hospital internment as a consequence of pregnancy, child delivery and caesarean, together with their possible complications, unless otherwise agreement included in the Particular Conditions of the Policy.

3. WAITING PERIODS

All coverages shall enter into force once it has taken effect on the date expressly indicated in the corresponding Particular Conditions, and once the following waiting periods have elapsed:

- **For the rent for illness that requires surgical intervention:** 8 months
- **For the rent for hospitalization without intervention:** 8 months
- **For the rent for the additional guarantee for child delivery:** 8 months

4. LIMITATIONS DUE TO PATHOLOGY

The maximum indemnification for the following cases shall be:

- Mental or nervous illnesses: an indemnification shall be paid to the Insured corresponding to the days he/she stays

admitted in hospital, **with a maximum of 20 days per Insured and annuity**.

- Disease of backbone: an indemnification shall be paid to the Insured corresponding to the days he/she stays admitted in hospital, **with a maximum of 30 days per Insured and annuity**.

- Indemnification for child delivery or caesarean: the Insured shall have the right to the indemnification **with a maximum of 6 days per Insured and annuity**, if she had to stay admitted in hospital or sanatorium.

5. SPECIAL CASES

- **Stay in I.V.U..or I.C.U.:** In case that the Insured needs to be admitted in I.V.U. or I.C.U., he/she will receive double of the contracted insured daily amount while he/she stays in one of these units..

- **Admittance of the Insured in other province:** Fort he admittance of the Insured in a hospital facility situated in a province different from that of his/her habitual address indicated in the policy, he/she shall receive fifty per cent (50%) more tan the contracted insured daily amount while he/she stays admitted in such facility.

- Convalescence: Fort he admittance of the Insured due to a surgical intervention he/she will receive fifty per cent (50%) more of the contracted insured daily amount while he/she stays admitted in such facility.

- Whenever a hospital admittance is produced, without Sanitas having to pay, under the insured guarantee of the Health care policy the expenses related with such admittance, the insured shall receive double of the contracted insured daily amount expressly indicated in the particular conditions for this coverage.

6. TRANSACTION IN CASE OF SINISTER

For the transaction of a covered sinister the following rules have to be fulfilled:

6.1. The Insured or any person in his/her name must communicate the hospital admittance, surgical intervention and in general any insured medical service within the maximum term of seven (7) days since the date of acknowledgement, unless a longer term has been fixed.

In the case of surgical intervention or programmed hospital admittance, he/she must communicate such circumstance to the Insurer from the moment that he/she has the knowledge of the date in which such surgical intervention or hospital admittance will take place and in any case within the maximum term of seven (7) days from which he/she has known it.

6.2. Together with the communication of illness or accident, the Policyholder or the Insured shall send to SANITAS a medical report in which the diagnosis and nature of the illnesses shall be specified, as well as the medical center, date of admittance, probable duration of the hospitalization, being it indispensable that the part related with the illness is written and signed by the physician that treats the patient.

6.3. Once the hospitalization has finished, the Policyholder or, in its case, the Insured, must submit to SANITAS the following documentation:

6.3.1. Application for indemnification form, duly completed and broken down, where the following is shown:

a) The person to whom the hospital care has been delivered.

b) The nature of the performed medical act or acts and their dates..

c) Identification of the individual or legal person that has delivered the care (clinic, hospital, etc.), recording, if such is the case,

the surname, name or company name customer, address, corporation number and tax identification number (N.I.F.).

If the mentioned form is not available, the notice of the sinister can also be sent to SANITAS by written notice where the above mentioned data are recorded.

6.3.2 Original medical prescriptions of the hospital care delivered to the Insured.

6.3.3 Hospital discharge report where the date of admittance and the date of discharge are recorded, as well as information about the illness's process and its evolution.

6.4. When care continuity is required, the Policyholder or in its case, the Insured, must submit to SANITAS, besides the form of indemnification application and the medical prescription, as it is described in the former points of the present clause, a medical report where the need for such care continuity is indicated.

6.5. The Insured must also follow faithfully all prescriptions of the physician in charge of his/her healing and must provide SANITAS with all types of information about the circumstances or consequences of the sinister.

6.6. The Policyholder or the Insured or their relatives must allow that physicians designated by SANITAS visit the Insured as many times as SANITAS considers it necessary, as well as any enquiry or ascertainment about his/her state of health that SANITAS considers necessary.

The nonfulfillment of the rules established in the six previous points shall be considered as express waiver to the indemnification collection, unless it has not been possible to fulfill them for reasons not attributable to the Policyholder's, Insured's or their relatives' wills.

If such is the case, the expenses attributable to the translation into Spanish of the corresponding documents (invoices, reports, etc.) written in other languages shall be on the account of the Insured.

7. FORM OF PAYMENT OF THE SINISTERS

The amounts due by SANITAS by virtue of this coverage shall be made affective to the Beneficiary once all the required documentation has been received and all appropriate ascertainments have been made by SANITAS, to establish the existence of the sinister.

SANITAS shall make, on the next 40 days following the reception of the sinister declaration, the payment of the minimum amount of those that SANITAS may owe according to the circumstances by it known (article 18 of the Insurance Contract Law).

SANITAS shall pay the indemnification according to what is established in the previous conditions.If in the term of three months since the occurrence of the sinister SANITAS has not paid the amount due to a non justified cause of that was attributable to it, the indemnification shall be increased in the money legal rate valid on the moment it was earned, increased by 50 per 100. These rates shall be considered as produced by days, without the need of judicial claim. Nevertheless, once 2 years have elapsed since the occurrence of the sinister, the annual rate cannot be less than 20 per 100 (article 20 of the Insurance Contract Law).

In the case that due to delay of SANITAS in the payment of the amount of the indemnification turned uncontestable, the Insured was forced to claim it judicially, the corresponding indemnification shall be increased by the rate established in paragraph above this, together with the expenses of the process, according to article 38, paragraph 9 of the Insurance Contract Law.

After the communication of each sinister, causing or not the payment of an indemnification, the parts can terminate the agreement, The part deciding the termination, must notify the other in

writing within the term of 30 days since the date of communication of the sinister, if there was no cause for the indemnification, or since the settlement, if there was cause to it, being it compulsory to make the notification at least with a minimum of 15 days' notice to the date of effectiveness of the termination.

If the decision of terminating the contract is taken by the Policyholder, SANITAS will keep the premiums corresponding to the period in course, and if it was taken by SANITAS, it must reimburse to the Policyholder the part of Premium corresponding to the time between the date of effect of the termination and the date of expiration of the period of insurance covered by the paid Premium.

8. DURATION

8.1. Only persons that, on the date of enrollment have an age comprised between 0 and 75 years, can be included as Insured in the present coverage.

8.2. The contracted coverages shall not be effective until the first Premium receipt has been paid.

Geographical scope

The coverages of the present guarantee shall be effective WORLDWIDE, providing the Insured has his/her habitual address established in Spain, not with standing the previous, the indemnifications shall be made effective in Spain and in euros.

Accidents or illnesses acquired in countries and/or unexplored regions shall be excluded.

9. CONTROVERSIES

9.1. In case of disagreement about the nature of an illness and/or the amount of the indemnification, each party shall appoint an expert, whose acceptance must be expressed in writing. If one of the parties has not made its designation, it is obliged to make it in the next eight days following the date on which it has been required by the party that has made its designation, and if it does not make it in this last term, it is understood that it accepts the opinion issued by the other party's expert, being bound by it.

9.2. In case the Experts come to an agreement, it shall be recorded in a joint act, in which the causes of the sinister, the assessment of the damages and other circumstances that affect the determination of the amount of the sinister shall be recorded.

9.3. When there is no agreement between the experts, both parties shall jointly appoint a third expert and, if there is no agreement, the designation shall be made by the First Instance Judge, in voluntary jurisdiction act and following the procedure established for the choice of Expert of the Civil Prosecution Law. In this case, the expert report shall be issued in the term established by the parties or, in its defect, in the term of thirty days counted from the acceptance of its designation by the third Expert.

9.4. The opinion of the experts, by unanimity or by majority, shall be notified to the parties immediately and in undoubtedly form, being it binding for them, unless it is judicially contested by any of the parties within the term of thirty days, in case of SANITAS and of one hundred and eighty days in case of the Insured, counted both from the date of its notification,.If the corresponding contestation was not made in such terms the opinion shall become uncontestable.

9.5. If the opinion of the Experts was not contested, SANITAS must pay the amount of the indemnification indicated by the Experts in the term of five days.

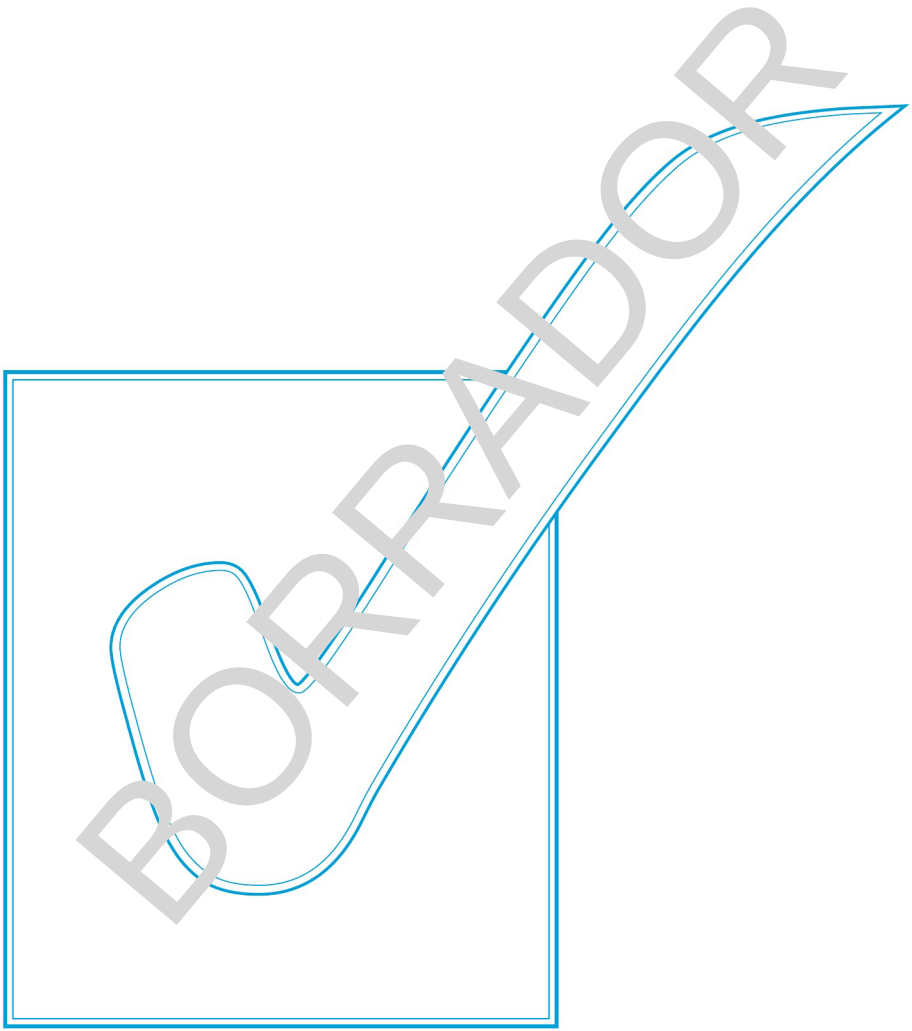
9.6. In the case that due to delay of SANITAS in the payment of the amount of the indemnification that has become uncontestable the Insured was forced to claim it judicially, the corresponding indemnification shall be increased with the annual rate legally established that in this case shall start to accrue since the opinion turned uncontestable for SANITAS and, in any case, with the amount of the expenses caused to the Insured by the process to which indemnification shall make express

condemnation the sentence of any judicial procedure that was applicable.

Each party shall pay the fees of its expert. The fees of the third expert and rest of the expenses caused by the expert assessment shall be borne by half by the Insured and by SANITAS.

Nevertheless, if any of the parties had made the assessment necessary by maintaining an assessment manifestly disproportionate, it shall be the only responsible of such expenses.

COMPLEMENTARY COVERAGES OF YOUR INSURANCE



Accidents Cover

1. PURPOSE OF THE INSURANCE

Within the limits and conditions established in the policy and following payment by the Policyholder of the corresponding Premium, SANITAS covers the payment of the indemnifications that are mentioned in this policy, as a compensation for bodily injuries caused by accidents that can occur to the insured in the performance of the profession or occupation that is indicated in this policyor in the performance of any other activity of his/her ordinary life that does not have a professional character. Accident is defined as the bodily injury stemming from an external, sudden, violent cause, external and beyond the Insured's intention that produces death or permanent disability and that causes the payment of the Policy's benefits. Accidents also include the injuries caused while the Insured is practicing any sport as amateur, except those expressly excluded from this policy.

SANITAS guarantees the payment of the corresponding capital, whenever such Complementary Guarantee has been contracted and this is recorded expressly in the Particular Conditions of the policy.

2. COVERED RISKS

a) Death due to Accident of the Insured:

Death due to accident of the Insured is defined as that produced by any bodily injury stemming from thhe direct action of an external, sudden violent cause, beyond the Insured will that is covered by the Policy and that causes his/her death within the next two years counted from the date he/she suffered the accident, providing the death occurs during the validity of the present policy and the Beneficiary proves to SANITAS that the death of the Insured is a direct consequence of the accident he/she suffered.

b) Permanent Disability:

If as a consequence of an accident covered by the policy the disability of the Insured was caused, immediately or within the period of one year since the date of its occurrence, SANITAS shall pay the Insured the indemnification specified in the present conditions, according to the coefficient of such disability.

It is expressly recorded that the permanent disability coefficients that are included in the guarantees are those indicated below:

- Total permanent disability, being that, the situation due to which the Insured remains completely disabled to perform any remunerated profession or occupation, as a consequence of an accident.

- Partial permanent disability, when the disability, although being permanent, does not reach the level of total for any profession or occupation, shall turn into a partial permanent disability and in this case the company shall pay the percentages indicated in the scale established in the clause indicated after Guarantees and Insured Capital.

This complementary cover will not be available to be contracted separately from the principal illness insurance.

3. EXCLUDED RISKS

Together with the risks excluded from the General Conditions of the policy, the following accidents are also excluded from the cover of the present Complementary Guarantee:

3.1. Those occurred in doings notoriously dangerous or criminal committed by the Insured, including the attempted, frustrated or consummated suicide, as well as his/her participation in bets, challenges or quarrels, except in proven cases of legitimate self-defense and attempt to save persons or goods.

3.2. Those occurred as a consequence of civil, international or colonial wars, invasions, insurrections, rebellions, acts with a terrorist character in any of their forms (chemical, biological, nuclear, etc.)

revolutions, mutiny, uprisings, repressions and military maneuvers, even in time of peace and officially declared epidemics.

3.3. Those occurred whilst practicing boxing, rugby, bull fighting and bull running, martial arts, in endurance or speed contests with motor vehicles, including training, fencing, other notoriously dangerous sports and those suffered whilst practicing any sport as a professional.

3.4. Those occurred in state of somnambulism, manifested intoxication (alcoholic or toxic) mental alienation or drugaddiction. The state of intoxication shall be determined according to the Law of Road Safety in force.

3.5. Those ensued as a consequence of pregnancy or child delivery.

3.6. Those occurred due to sunstroke, freezing, burnings and other effects of the atmospheric temperature, unless they are the consequence of an accident.

3.7. Those suffered as member of aerial crew, or as passenger of helicopters or planes of less than two engines.

3.8. Those occurred in unexplored regions and/or travels that have the character of an exploration.

3.9. Those caused intentionally by the Insured, as well as any self-harm.

3.10. The intoxications, poisoning and hipersensitivity reactions due to the ingestion of foodstuff or medicaments, and infections of a general character, such as malaria, exanthematic typhus, sleep disease, yellow fever and similar.

3.11. Diseases of any kind or nature, as well as injuries and other sequels due to surgical interventions or medical treatments not originated by an accident covered by the Policy.

3.12. Bodily injuries or complications related with an illness or morbid state (syncope, loss of conscience or similar) and hernias of any kind or nature as well as their exacerbations, be them or not of a traumatic origin.

3.13. The rescue of persons in mountains, see or desert. In no case, SANITAS shall substitute the emergency aid organisms or pay for the costs of these services.

3.14. Those whose cover corresponds to the Insurance Compensation Corporation as it is detailed in the Extraordinary Risks Clause. Unless the contrary is expressly established in the Particular conditions corresponding to this guarantee and the corresponding over Premium is paid, the following shall not be covered:

a) Intervention in high tensión electric currents.

b) The practice as amateur of:

- **Motocycles or moped driving.**
- **Sailing or motor boats driving in high seas.**
- **Equestrian, polo, sky, alpinism and caving.**
- **Big gamehunting.**
- **Under water diving.**

4.DESIGNATION OF BENEFICIARY

The Policyholder can designate beneficiary or modify the designation previously made, without SANITAS' consent.

The designation of beneficiary can be made in the Policy, in a later written declaration communicated to SANITAS or in a will.

In case of death, the lack of express designation by the Insured by written communication sent to SANITAS, shall mean that the beneficiaries of this guarantee in preferred and exclusion order are the following persons:

- Spouse and children of the Insured in equal parts.**it**

- Parents of the Insured in equal parts.
- Brethren of the Insured in equal parts.
- Legal heirs.

In case of disability the insured sum shall be paid to the Insured his/herself.

5. NON INSURABLE PERSONS

Persons under 14 years of age will not be able to appear as insured, according to what is established in article 83 of the Insurance Contract Act. Also, this guarantee shall not be available for:

5.1. Persons over 65 years of age.

5.2. Persons affected by dementia, mental alienation, blindness or strong myopia (more than 10 diopters in one eye), deafness, paralysis, sequels of neurologic injuries, epilepsy, diabetes, alcoholism, drug addition, SIDA and/or positive HIV, spinal bone marrow illnesses, sleeping sickness and, in general, by any injury, illness or physical or psychological disability that according to SANITAS' criteria, diminishes their capacity in comparison with a person physically whole and with normal health.

If any of these illnesses arise, the present guarantee shall be considered as extinguished from that moment, reimbursing SANITAS the part of the Premium not earned from the date SANITAS receives the notification of such state.

6. GUARANTEES AND INSURED CAPITAL

6.1. **Death:**

The amount of the indemnification shall be the insured capital established in the Particular Conditions.

The payments that SANITAS may have made under the concept of permanent disability as a consequence of the accident that causes the death of the Insured, shall be deducted of the indemnification due in case of death.

6.2. **Total permanent disability:**

The amount of the indemnification shall be the insured capital established in the Particular Conditions for these cases:

- Loss or disablement of both arms or both hands; of an arm and a leg; of an arm and a foot; of both legs or both feet
- Incurable mental alienation that disables for the performance of a remunerated job
- Complete and permanent paralysis (tetraplegia)
- Absoluteblindness, incurable and permanent

6.3 Partial permanent disability:

The amount of the indemnification shall be the result of applying, on the Insured Capital established in the Particular Conditions, the following percentages:

	Right	Left
Removal of the lower jaw	30%	30%
Shortening of a lower limb by at least 5 cm	15%	15%
Amputation of 4 fingers on one hand	10%	10%
Partial amputation of a foot and all its toes	40%	40%
Unhealed fracture of a leg or a foot	25%	25%
Unhealed fracture of lower jaw	16,66%	16,66%
Unhealed fracture of a kneecap	20%	20%
Complete functional impairment of a knee	16,66%	16,66%

Complete functional impairment of the elbow	16,66%	16,66%
Complete functional impairment of the instep of the foot and ankle	16,66%	16,66%
Complete loss of movement of the shoulder joints	25%	20%
Total loss of wrist movement	20%	15%
Loss of a leg or a foot	50%	50%
Loss of index finger and other nonthumb finger of hand	25%	20%
Loss of the middle finger, ring or little finger of hand	10%	8%
Loss of the middle finger, ring or little finger (two fingers) of hand	15%	12%
Loss of thumb and another than the index of hand	30%	25%
Total loss of arm or hand	60%	50%
Total loss of thumb	22%	18%
Total loss of index finger	15%	12%
Total loss of the thumb and index finger of hand	30%	25%
Total loss of three digits including thumb or index finger of hand	30%	25%
Total loss of three digits that are not thumb or index infer of hand	25%	20%
Total loss of another toe of a foot	5%	5%
Total loss of an eye or sight reduced by half	30%	30%
Total loss of movement of a hip or knee	20%	20%
Total loss of movement of the right elbow	20%	15%
Complete rigidity of the spinal column	40%	40%
Complete deafness in both ears	60%	60%
Complete deafness in one ear	15%	15%

If the Insured is left-handed, that must be conveniently declared in the Insurance Application, the percentage established for the right upper limb shall be applied to the left upper limb and inversely.

Forthe injuries not established, the coefficient of disability shall be established by analogy with the indicated coefficients, according to the medical reports with respect to the strict physical injury, without any consideration of personal or professional type.

The disability coefficient to consider when the same accident causes several anatomic or functional losses is calculated by adding the percentages corresponding to each of them not being possible that such coefficient can exceed of 100%. The sum of indemnification percentages, for several types of partial disability, in the same limb or organ, cannot be higher than the percentage established for the total loss of such limb or organ.

If an organ or limb affected by an accident already suffered, before such accident, a physic or functional defect since the sinister's

occurrence, the coefficient of disability shall be determined by the difference between the preexisting and the defect resulting after the accident.

The complete and irreversible loss of the functionality of one limb or one organ or the absolute functional impotence of it, shall be interpreted, regarding the effect of the insurance, as equivalent to the anatomic loss of such limbor organ.

7. PROCEDURE TO FOLLOW IN CASE OF SINISTER

7.1.Death:

In case of accident, the Beneficiary has the following duties and obligations:

7.1.1. Communicate SANITAS the occurrence of the accident in the maximum term of 7 days and the circumstances and consequences of it. The communication shall be formulated in the file of declaration of the sinister established for it, together with the following documents, common for all guarantees contracted that are the object of these conditions:

a) Certificate of the physician that has assisted the Insured in which the circumstances and causes of the death shall be detailed.

b) "Literal" certificate of the death registration in the Civil Register.

c) Autopsy report where the results of the toxicological report shall be recorded.

d) Documents that credit the personality and in case the condition of Beneficiary (unless expressly indicated in the particular conditions of the policy).

e) Letter of exemption of the Inheritance Tax of the settlement if corresponding, duly completed by the Taxes Authorities.

The nonfulfillment of this obligation shall cause that SANITAS may claim any damages occasioned unless dolo or serious fault in which case the right of indemnification shall be lost according to the point Contract nullity and loss of rights.

7.1.2.Once the documents are received and confirmed by SANITAS, the insured capital must be paid in the maximum term of 40 days or, at least, the minimum amount that SANITAS can owe according to the circumstances known to SANITAS.

7.1.3. Not with standing the above mentioned, SANITAS remains authorized to retain the part of insured capital in which, according to the known circumstances, the tax debt resulting from the settlement of the Inheritance Tax can be estimated.

7.1.4. If in the term of three months from the occurrence of the sinister, SANITAS has not reimbursed its amount without a justified cause or a cause attributable to it, the amount SANITAS may owe shall be increased in the legal rate of money valid n the date of earning, increased in 50%. This interest shall be produced on a daily basis, without the need of a court claim. Nevertheless, once 2 years have elapsed since the sinister's occurrence, the yearly interest will not be lower than 20 per 100 (article 20 of the Insurance Contract Act).

7.2. **Permanent disability due to accident:**

The determination of the coefficient of disability shall be made, according to the article 104 of the Insurance Contract Act, after the submission by the Insured, of the official medical report in which the sequels object of evaluation are diagnosed, according to what is established in the policy. SANITAS, if it considers it convenient, shall require the Insured in writing to be submitted to the checkup of a physician designated by SANITAS, and after such checkup is performed, and in the term of 15 days, shall notify in writing to the Insured the amount of the indemnification that to SANITAS' criteria corresponds to him/her. If the Insured does not accept SANITAS's proposal the parts shall submit to the expert opinion procedure established in the point Determination of the indemnification in case of disconformity between the parts.

To receive the indemnification the Insured must **communicate SANITAS the occurrence of the accident** in the maximum term of 7 days, handing in all types of information about its circumstances. The communication shall be accompanied by the following documentation:

a) Documentation of the social security where the coefficient of disability is specified.

b) Official medical report where the circumstances and causes of the disability shall be detailed.

c) Documents that credit the personality and, in such case, the condition of Beneficiary.

d) Date of determination of the disability, that shall be that indicated by the commission of assessment of Disabling.

As a complement to the benefits corresponding for permanent disability, SANITAS shall bear the cost of the first orthopedic prosthesis that the Insured needs to be performed as a result of the guaranteed accident not exceeding the amount of 10% of the base Insured capital for the case of permanent disability and up to the maximum amount of 601,01 euros.If in the coverage of his/her healthcare policy were there an economic limit less restrictive for such prosthesis, the limit established in this Complementary Guarantee shall not be applicable.

8. GEOGRAPHICAL SCOPE

The covers included in this guarantee are valid worldwide. The present guarantee will be extinguished if the Insured transfers his/her residence abroad orif he/she does not live a minimum of six months per year in Spain.

9. CONCLUSION AND EFFECTS OF THE GUARANTEE OF ACCIDENTS

9.1. This guarantee is concluded by the consent, manifested by the subscription of the corresponding Particular Conditions or of the temporary document of coverage by the contracting parties. The contracted coverage and its modifications or additions shall not be effective until the first premium receipt has been paid, unless the contrary is agreed in the Particular Conditions.

9.2. In case of delay in the fulfilment of any of these two requirements, SANITAS duties shall begin at 24 hours of the date in which they have been completed.

9.3. The guarantees object of these General Conditions enter into force at the time and date established in the corresponding Particular Conditions.

10. DURATION OF THE INSURANCE

10.1. The duration of the present complementary Guarantee of accidents shall coincide with the policy of which it is a part.

10.2. Notwithstanding the above, those Insured that come to 70 years of age, will be excluded from this guarantee on the date of expiry of the annuity in which they have come to such age.

11. CANCELLATION IN CASE OF SINISTER

11.1. After the communication of each sinister, causing it or not the payment of an indemnification, the parties shall be able to cancel the present guarantee. The party that decides the cancellation, shall notify the other party in writing in the term of 30 days counted from the date of notification of the sinister, if there was no indemnification to be paid or counted from the settlement if there was an indemnification to be paid, being it compulsory to make the notification with a minimum of 15 days' notice to the date in which the cancellation has to be effective.

SANITAS, once it knows the existence of a sinister, shall check the causes and form of occurrence of it.

If the parties agree on the amount and form of indemnification, SANITAS shall pay the agreed amount in the term established in the

point Procedure to follow in case of sinister of these conditions.

If the decision to cancel the present guarantee is taken by the Policyholder, SANITAS shall keep the premiums of the current period and if the decision was taken by SANITAS, it must reimburse the Policyholder the part of the Premium corresponding to the period between the date of effect of the cancellation and the date of expiry of the period of insurance covered by the paid premium.

12. NULLITY AND LOSS OF RIGHTS

The guarantees object of these conditions shall be null except in the cases established by the law, if at the moment of their conclusion, there was no risk or the sinister had already occurred. The right for indemnification is lost:

12.1. In case of nondisclosure or inexactness when completing the questionnaire, if there was dolo or serious fault.

12.2. In case of aggravation of the risk, if the Policyholder or the Insured do not communicate to SANITAS or have proceeded with bad faith.

12.3. If the sinister occurs before the first Premium has been paid, unless otherwise agreed

12.4. If the Policyholder or the Insured do not hand in to SANITAS the information about the circumstances and consequences of the sinister and dolo or serious fault have occurred.

12.5. Of the Policyholder or the Insured do not fulfill their duty to lessen the consequences of the sinister and they do son with the clear intention of damaging or deceiving SANITAS.

12.6 When the sinister has been caused due to bad faith of the Insured.

13. COVERAGE OF EXTRAORDINARY RISKS

Indemnification by the Insurance Compensation Corporation clause of the losses caused by extraordinary events in personal insurances.

According to what is established in the consolidated text of the legal Statute of the Insurance Compensation Corporation, approved by the Real Decreto Legislativo 7/2004, of 29 of October and modified by the Ley 12/2006, of 16of May, the policyholder of those that must compulsory include the surcharge in favour of the mentioned public enterprise entity has the faculty to agree the coverage of extraordinary risks with any insurance company that meets the requirements established by the regulations in force.

The indemnifications caused by sinisters produced by extraordinary events occurred in Spain and that affect risks there located, and also occurred abroad when the insured has his/her habitual residence in Spain, shall be paid by the Insurance Compensation Corporation when the policyholder has paid the corresponding surcharges on its favor and any of the following circumstances occur:

a) That the extraordinary risk covered by the Insurance Compensation Corporation is not covered by the insurance policy contracted with the insurance entity.

b) That, being covered by such insurance policy, the obligations of the insurance entity can not be fulfilled because the entity has been declared judicially in bankruptcy or because it is submitted to a settlement procedure intervened or assumed by the Insurance Compensation Corporation

The Insurance Compensation Corporation shall adapt its proceedings to what is established in the mentioned Legal Statute, in Law 50/1980,of 8 of October, of Insurance Contract, in the Regulation of extraordinary risks insurance, approved by Real

Decreto300/2004, of 20 of February, and in complementary regulations.

SUMMARY OF LEGAL REGULATIONS

1. Covered extraordinary events

a) The following nature phenomena: earthquakes and seaquakes, extraordinary floods (including sea attacks), volcanic eruptions, atypical cyclonic storm (including extraordinary winds of gusts higher than 120km/h, and tornados) and meteorites.

b) Those violently caused as a consequence of terrorism, rebellion, sedition, mutiny and popular tumult.

c) Events or proceedings of the Army or of the Security Forces in times of peace.

2. Excluded risks

a) Those that do not produce the right to an indemnification according to the Law of Insurance Contract.

b) Those caused in goods insured in an insurance contract different than those in which the surcharge in favor of the Insurance Compensation Corporation is compulsory.

c) Those due to vice or own defect of the insured object or to its manifest lack of maintenance.

d) Those produced by armed conflicts, even if the official war declaration does not precede.

e) Those produced by nuclear energy, notwithstanding what is established in Law 25/1964, of 29 of April, about nuclear energy.Notwithstanding the above mentioned, direct damages caused in an insured nuclear facility are included when they are consequence of an extraordinary event that affects the facility.

f) Those produced by the mere lapse of time and, in case of goods totally or partially submerged permanently, those attributable to the mere action of surf or ordinary currents.

g) Those produced in nature phenomena different from those indicated in article 1 of the Regulation of extraordinary risk insurance and in particular, those produced by the elevation of the phreatic level, slope movement, land glissade or settlement, rock detachment and similar phenomena, unless those were caused manifestly by the action of rain water that, on its turn, had caused in its zone a situation of extraordinary flood and were produced simultaneously to such flood.

h) Those caused by tumultuous actions produced in the course of meetings and demonstrations performed according to what is established in Organic Law 9/1983, of 15of July, regulating the right to meet as well as during the course of legal strikes unless such actions could be qualified as extraordinary events according to article 1 of the extraordinary risks insurance Regulation.

i) Those caused by bad faith of the Insured.

j) Those derivative of sinisters which occurrence has taken place during the waiting period established in article 8 of the extraordinary risk insurance Regulation.

k) Those corresponding to sinisters produced before the payment of the first Premium or when, according to what is established in the Insurance Contract Act, the coverage of the Insurance Compensation Corporation is suspended or the insurance becomes extinguished due to lack of Premium payment.

l) Indirect risks or losses derivative of direct or indirect damages, different from benefit loss established in the extraordinary risks insurance Regulation. Particularly, this coverage does not include damages or losses suffered as a consequence of cut or alteration in the

external supply of electric energy, combustible gases, fuel-oil, gasoil or other fluids, or any other indirect damages or losses different of those mentioned in paragraph above this, even if theses alterations derive from a cause included in the coverage of extraordinary risks.

m) Sinisters that due to their magnitude or seriousness are qualified by the Nation's Governement as a "national catastrophe or calamity".

3. Deductible:

In case of direct damages (except automobiles and dwellings and their communities), the deductible on the account of the Insured shall be of a 7 per cent of the amount of the compensable damages produced by the sinister. In case of the coverage of loss of benefits, the deductible on the account of the Insured shall be that established in the policy for the loss of benefits in ordinary sinisters.

4. Extension of coverage

The coverage of extraordinary risks shall reach the same persons and insured sum that have been established in the policy regarding the ordinary risks. Nevertheless the policies that cover own damages in motor vehicles, the Corporation guarantees the total insured rate even if the policy only guarantees a part of it.

PROCEDURE TO FOLLOW IN CASE OF COMPENSABLE SINISTER BY THE INSURANCE COMPENSATION CORPORATION

In case of sinister, the Insured, policyholder, beneficiary or their respective legal representative, directly through the insurance company or the insurance mediator, shall communicate, withn the term of seven days counted from the date of acknowledgement, the occurrence of the sinister, in the corresponding regional office of the Corporation, depending on the place where the sinister took place.The communication shall be made in the form established, which is available in the web page of the Corporation (www.consorseguros.es), or in its offices or in the insurance company's offices, to which the documents that, according to the nature of the injuries, is required, must be enclosed.

Also, rests and vestiges of the sinister must be preserved for the expert examinations and, in case of absolute impossibility, submit the probation documents of the damages, such as photographs, notary affidavits, videos or official certificates. Equally, the invoices corresponding to the wrecked goods whose destruction cannot be delayed shall be preserved.

All necessary measures to lessen the damages shall be adopted.

The assessment of the losses derivated from the extraordinary events shall be made by the Insurance Compensation Corporation, not being this Corporation bound by the assessment made, if such was the case, by the Insurance Company covering the ordinary risks.

To clarify any doubt that may arise about the procedure to follow, the Insurance Compensation Corporation has made available the following number of insured attention:902 222 665.

Cover 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 limit in the United States: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 UnitedHealthCare (UHC), and will be without effect if that agreement terminates.

1. QUALIFYING PERIODS

All coverages shall enter into force once it has taken effect on the date expressly indicated in the corresponding Particular Conditions, and once the following waiting periods have elapsed:

- **Psychology:** 6 Months
- **High complexity diagnosis tests:** 6 Months
- **Outpatient surgical operations:** 3 Months
- **Hospitalization and surgical operations different from outpatient care and those performed as inpatient, vasectomy and tubular ligation included:** 10 Months
- **The following Complex Therapeutical Methods: interventional cardiology/ hemodynamics; interventional radiology, radiotherapy and chemotherapy; and lithotripsy:** 10 Months
- **Child delivery or caesarean:** 8 Months

Sanitas Dental Cover

1. Services included in your policy:

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 dentistry consultation: examination and diagnosis
- Topical fluoride treatments
- Oral cleansing/tartar removal
- Treatment for dental sensitivity
- Fissure sealer
- Priority consultation in case of emergency

SURGICAL PROCEDURES

Extractions

- Simple extraction
- Extraction of non-impacted third molars
- Extraction of impacted third molar plus dental cysts
- Extraction of impacted tooth (not third molar) plus dental cysts
- Extraction of root remains
- Extraction by odontosection
- Postoperatory check-up (includes removal of stitches)

Minor surgery

- Removal of epulis/small mucosal cysts
- Drainage of gingival/paradontal abscesses
- Apicoectomy
- Dental cyst

Orthodontic surgery

- Orthodontic fenestration (per tooth)

CONSERVATIVE DENTISTRY

- Provisional obturation

COSMETIC DENTISTRY

Whitening

- Photoactivation whitening brace (for treatments performed at the same clinic)

CHILDREN'S DENTISTRY (patients aged under 15 years)

- Consultation
- Buccodental education
- Intraoral X-rays

- Topical fluoride treatments
- Fissure sealer
- Oral cleansing/tartar removal
- Extraction of deciduous teeth

PROSTHESIS
- Occlusal analysis
- Selective carving

Fixed prosthesis
- Recementation

PERIODONTICS
Non-surgical treatments
- Periodontal examination (periodontal X-rays) (per arch)
- Periodontal X-ray series

Surgical treatments
- Gingivectomy (per quadrant)

ORTHODONTICS
Supplementary treatments
- Consultation
- X-ray study for orthodontics
- Extraction of deciduous teeth
- Simple extraction
- Revisions (in latency or resting periods)
- 1st replacement metal brackets
- 1st replacement ceramic brackets
- 1st replacement self-binding brackets
- 1st repositioning sapphire brackets
- 1st replacement of cosmetic self-binding brackets
- Orthodontics box (for treatments performed at the same clinic)
- Oral protector for orthodontics (for treatments performed at the same clinic)

DENTAL IMPLANTS
- Implantology study
- Implantology maintenance for treatments covered under Milenium

IMAGING DIAGNOSIS: RADIOLOGY/OTHERS
- Periapical/bite-wing/occlusal
- Periodontal X-ray series
- Lateral skull X-ray
- Orthopantomography (panoramic)
- Cephalometry
- Photographs or slides
- Computed axial tomography (dental CT scan)

TEMPOROMANDIBULAR JOINT PATHOLOGY
- Occlusal analysis
- Selective carving

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

2. Services with a deductible payable by the Insured

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
- Frenectomy (upper or lower)

Preprosthetic surgery
- Vestibuloplasty (per quadrant)
- Alveolar regularization (per quadrant)
- Removal of torus (per quadrant)

CONSERVATIVE DENTISTRY
- Filling / obturation
- Reconstruction
- Direct pulp coating
- Indirect pulp coating

ENDODONTICS
- Consultation for symptom treatment (opening, instrumentation, and drainage)

- Root-end filling material (MTA)
- Fibreglass or carbon post
- Monoradicular endodontics
- Biradicular endodontics
- Polyradicular endodontics
- Monoradicular re-endodontics
- Biradicular re-endodontics
- Polyradicular re-endodontics

COSMETIC DENTISTRY

Whitening

- Custom tray tooth whitening (per treatment)
- Dental bleaching by photoactivation (per treatment)
- Dental bleaching by photoactivation (per tooth and session)
- Combined dental bleaching photoactivation plus brace)

Dental reconstruction

- Reconstruction of aesthetic composite front (per tooth)
- Intraoral repair of porcelain (per tooth)
- Porcelain facing
- Injected facing
- Zirconia facing
- Composite facing
- Cosmetic bridge crown or unit over tooth

CHILDREN'S DENTISTRY (patients aged under 15 years)

- Obturation of deciduous teeth
- Pulpotomy without reconstruction
- Pulpectomy without reconstruction
- Preformed metallic crown
- Apical formation (full treatment)
- Fixed space maintainer
- Removable space maintainer
- Bridge/crown/space maintainer removal (per tooth)
- Guided occlusion or occlusal pad (per tooth)
- Oral screen
- Tooth reimplantation

PROSTHESIS

- Assembly and study of semi-adjustable articulator
- Diagnostic polishing (per tooth)

Fixed prothesis

- Bridge/crown/space maintainer removal (per tooth)
- Inlay
- Provisional resin crown
- Bridge crown or unit on tooth
- Cosmetic bridge crown or unit over tooth
- Precious metal supplement
- Monoradicular cast stump
- Multiradicular cast stump
- Maryland support (unit)
- Attaches

Removable prothesis

- Removable acrylic (1 to 3 teeth)
- Removable acrylic (4 to 6 teeth)
- Removable acrylic (more than 6 teeth)
- Hypoallergenic resin supplement (per arch)
- Repair
- Repair (rebase) (per appliance)
- Repair (addition of retainer)
- Metal reinforcement
- Repair (add piece to acrylic removable)
- Provisional complete (one arch, upper or lower)
- Definitive complete with metal reinforcement
- Skeletal (per tooth)
- Skeletal (base structure)
- Flexible removable (from 1 to 3 teeth)(Flexite, Valplast, others)
- Flexible removable (from 4 to 6 teeth) (Flexite, Valplast, others)
- Flexible removable (more than 6 teeth) (Flexite, Valplast, others)
- Ceramic shoulder or neck (per tooth)

PERIODONTICS

Non-surgical treatments

- Periodontal maintenance
- Radicular scraping and smoothing (perquadrant) (curettage)
- Periodontal bracing (per tooth)
- Radicular scraping and smoothing (per tooth) (curettage)
- Mucogingival surgery

Surgical treatments

- Flap surgery (per tooth)
- Regeneration with biomaterials (lyophilised bone, etc.) (per unit 0.5g)
- Membrane (unit)
- Crown lengthening
- Apical replacement flap (per quadrant)
- Graft free gum

ORTHODONTICS

Supplementary treatments

- Study and diagnosis for orthodontics
- Retention appliance with brace (end of treatment)(per arch)

- Retention appliance with lingual bar (end of treatment)(per arch)
- Renewal mobile device, replacement or loss
- Appliance repairs (due to appliance breakage)
- Orthodontic microscrews (per unit)
- 2nd replacement metal brackets (unit)
- 2nd replacement ceramic brackets (unit)
- 2nd replacement self-binding brackets (unit)
- 2nd replacement sapphire brackets (unit)
- 2nd replacement of cosmetic self-binding brackets (unit)

Treatment with fixed appliances with metal brackets
- Start of one arch; upper or lower (includes first device)
- Start of both arches (includes first devices)

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

Treatment with fixed appliances with sapphire brackets
- Start of one arch; upper or lower (includes first device)
- Start of both arches (includes first devices)

Treatment using fixed appliances with self-binding brackets
- Start of one arch; upper or lower (includes first device)
- Start of both arches (includes first devices)

Treatment with fixed appliances with aesthetic self-binding brackets
- Start of one arch; upper or lower (includes first device)
- Start of both arches (includes first devices)

Treatment with fixed appliances with invisible technique
- Start of treatment under 12 months of age
- Start of treatment over 12 months of age

Interceptive treatment with fixed appliances
- Start of one arch; upper or lower (includes irst device - quad helix)
- Start of both arches (includes first devices)

Interceptive treatment with removable appliances
- Start of one arch; upper or lower (includes first device)
- Start of both arches (includes first devices)

Mixed treatments: orthopaedic force with fixed appliances
- Start of one arch; upper or lower (includes first device)
- Start of both arches (includes first devices)

Mixed treatments: orthopaedic force with removable appliances
- Start of one arch; upper or lower (includes first device)
- Start of both arches (includes first devices)

DENTAL IMPLANTS

Dental Implant surgery
- Osteointegrated implant (unit)
- Closed maxillary sinus lift
- Open maxillary sinus lift
- Regeneration with biomaterials (lyophilized bone, etc.)(per unit 0.5g)
- Biomaterial regeneration (block bone)
- Membrane (unit)

Guided surgery
- Study for guided implantological surgery
- Supplement per implant in guided surgery(unit)
- Radiological guide
- Surgical brace (for guided surgery)

Prosthesis over implants
- Crown over implant
- Cosmetic crown over implant
- Provisional crown over implant
- Provisional crown for immediate charge
- Titanium stump (per tooth)
- Zirconia stump over implant (per tooth)
- Overdenture on implants (per appliance)
- Hybrid prosthesis (per arch)
- Metal termination: supra or mesostructure (unit)
- Supplement for precious metal in implants
- Prosthetic additament (intermediate pieces)
- Prosthetic additament for immediate charge
- Locator (unit)
- Micromilled Bar (on 5 implants or fewer)
- Micromilled Bar (on 6 implants or more)
- Ackerman-type clip
- Attachment over implant (includes riders)

TEMPOROMANDIBULAR JOINT PATHOLOGY

- Assembly and study in semi-adjustable articulator
- Revisions, brace adjustments
- Neuromyorelaxation brace (Michigan type)
- Stabilisation splint (single)

Pharmacy Cover

This consists of reimbursing the amount for drugs whose marketing is authorized by the relevant public body, provided that they are required for the treatment of conditions suffered by the insured and which are covered by the policy hereunder.

The reimbursement of this amount shall be performed in the percentage set in the Particular Terms and Conditions and up to the limit of the capital insured as specified in the above Terms and Conditions, once the insured submits the invoice in proof of payment of the drug and the doctor's prescription.

1. QUALIFYING PERIODS

All coverages shall enter into force once it has taken effect on the date expressly indicated in the corresponding Particular Conditions, and once the following waiting periods have elapsed:

- **Reimbursement application for the above mentioned medicaments** : 4 Months

Temporary Disability Cover

THE POLICYHOLDER OF THIS INSURANCE IS:

SANITAS, S.A. DE SEGUROS with legal address in 28042 MADRID, Ribera del Loira, 52, con CIF A-28037042.

THE INSURER COMPANY IS:

LA PREVISIÓN MALLORQUINA DE SEGUROS, S.A., with legal address in 08036 BARCELONA, Aribau, 168-170, entresuelo 1ª, with CIF A08169013.

INSURED AN BENEFICIARIES:

The Policyholders, individuals, that, appearing in the list of Insured in the present collective policy, are holders of insurance policies commercially named as Profesionales, if their age is between 16 and 65 years at the moment of contracting as such policyholder Profesionales, and providing they are enrolled in the Social Security, Mutuality or analogue Institution that the applicable regulations determine.

In any case, the Insured shall cease to be insured on the date of expiry of the annuity of insurance in which he/she becomes 70 years of age.

INSURED AMOUNT:

Those indicated in the particular conditions of this policy .

COVERED RISKS

The Insurer is committed to guarantee the earning of the daily subsidy indicated in the Particular Conditions of this policy for a term extending from the 7º to the 365º day maximum, according to what is regulated in the present coverage, when the Insured is affected by an alteration of his/her state of Health attributable **EXCLUSIVELY** to an illness (no accident, risk not object of coverage) that is not excluded in this coverage and that supposes the TOTAL interruption of his/her working or professional activity temporarily.

The definition and scope of the claim to the effects of this contract is alien and does not follow the same definition and qualification criteria than the public system and, therefore, the qualification of this is defined by the contents of the present insurance contract.

APPLICABLE RULES FOR THE EARNING OF THE DAILY SUBSIDY.

a) In all illnesses or accidents, the Insured must receive consultant Health care and follow in a continuous manner the medical treatment necessary for the process' healing.

b) The illness must prevent temporarily the Insured, in a clinical explicable manner, the performance of his/her working or professional activity in a TOTAL manner. The right to earn the subsidy will cease on the moment on which the Insured can restart his/her habitual professional or working activities, EVEN IN A PARTIAL MANNER, and even if he/she has not reached total healing.

Also, the earning of the daily subsidies shall cease from the moment in which it can be medically diagnosed that the illness that has caused the claim suffered by the Insured has turned into a permanent disability for the performance of the working or professional activity indicated in the policy.

c) The sum of days in which the daily subsidy for illnesses of the Insured had been earned, that for any cause affect and/or are originated by the same process, cannot be higher than the maximum term of 361 days, once the contracted deductible of 7 days has been applied.

In the case that the Insured has not consumed the maximum period of coverage, in a consecutive way or in different periods with health intervals, and a new claim started for the same process or related causes, it will be considered, to all effects, as an extension of the previous claim. In these cases, the sum of all consumed periods cannot be higher than the maximum term of coverage. The above mentioned shall not be applicable if 12 months have elapsed between the discharge date of the last claim and the leave of the consecutive.

d) The daily subsidy to be paid by the Insurer shall be of the amount indicated in the insurance certificate, even in the case that the Insured suffered several illnesses at the same time or a new illness overcame as a consequence of the clinical course of that or those initially declared.

In this last case, the Policyholder, Insured or Beneficiary are obliged to provide the Insurer with a medical report informing of such circumstance. If the new overcome illness had as cause a different process to that or those declared previously, a new term shall start to count since the date in which the last illness or accident has occurred.

QUALIFYING PERIODS

The contracted guarantees have a waiting period of 38 months without prejudice of the waiting period established hereunder for the case of pregnancy.

SPECIAL CASES WITH LIMITED COVERAGE PERIODS WITH RESPECT TO THE MAXIMUM TERM DESCRIBED IN THE PARAGRAPH "COVERED RISKS"

a) When the primary cause or causes of the illness suffered by the Insured are pregnancy, the maximum term of coverage that the Insurer guarantees is LIMITED to 45 days for the same annuity of contract, once the contracted deductible days are applied if such is the case.In any case, the right to earn the subsidy shall cease on the same date on which the delivery or cesarean of one or several newborns occurs, even if the Insured has not reached her total healing.Such subsidy shall have a waiting or lack of coverage period of 12 months counted from the date of inclusion of the Insured in the policy.

b) The mental and behavioral illnesses and/or disorders that force the Insured to stay in an interrupted manner admitted in a psychiatric hospitalization area in hospitals and/or care residences, the maximum term of coverage that the Insurer guarantees is LIMITED to 90 days for the same annuity of contract, applying if such is the case, the contracted deductible days.

EXCLUDED RISKS

The following risks are not object of coverage in the present contract:

a) The direct performance by the Insurer of the medical, surgical services and the payment of the expenses of the medical and pharmaceutical care, or any other alteration of Health attributable directly or indirectly to an accident.

b) All alterations of a state of Health, chronic or not, injuries or defects with an origin previous to the date of inclusion of the Insured in this policy.

c) All alterations of the state of Health which cause is originated by civil or international war, those derived of nuclear or atomic energy unless it is a sequel or a medical treatment, the officially declared epidemics and all risks officially declared as catastrophic.

d) The illnesses produced in any case of sport practiced with a professional character.

e) The illnesses which cause was originated by the ingestion of alcoholic drinks, drug addiction and suicide intents. As well as all alterations of the state of health produced by medical acts or treatments which the Insured has undergone voluntarily and which primary cause or causes are not an illness or an accident.

f) The abortion and child delivery.

g) The Immunodeficiency Syndrome (IDAS) and/or illnesses caused by the Human Immunodeficiency Virus (HIV). The fibromyalgia and the Chronic Fatigue Syndrome.

h) Mental and behavioral illnesses and/or disorders that do not force the Insured to stay in an uninterrupted manner admitted in a psychiatric hospitalization area of a hospital and /or care residence. All illnesses and/or disorders caused or triggered by stress are also excluded.

Also, all exacerbations, sequels, consequences and/or complications and their specific treatments related to all described excluded risks, shall be also considered as EXCLUDED RISKS.

AGE LIMIT

The coverage of the present collective policy **shall be applied exclusively to persons with an age below 70 years.**

INSTRUCIONS IN CASE OF CLAIM

In order to have the right to earn the contracted daily subsidies, the Insured must, within the term of 7 days counted from the date of the claim, provide the Insurer, duly completed, with the following documents:
Sinister Declaration, form that shall be provided upon his/her application by the Insurer and that has to be completed in all its parts, being it indispensable that the part related with the illness is extended and signed by the physician in charge of the patient. If the mentioned form is not available, the notice of the claim can be provided to the Insurer in writting where the following must be stated:

1. Number of policy
2. Name of Policyholder
3. Name, surname, age and address of the Insured.

To the mentioned writing notice, a report issued by the physician assisting the patient must be enclosed, indicating the illness, its causes, if he/she must keep absolute home repose or relative repose, if he/she has suffered the illness before and on what date, if his/her illness prevents him/her from performing his/her working or professional activities in a total or partial manner, probable date of initiation of the process, date on which he/she started to perform the assistance, prognosis in what refers to the illness's duration and, last of all, date on which the report is issued.

Once the Sinister Declaration is received, The Insurer can dispose the inspection visits that it considers convenient to check the Insured's state of Health, whenever none of the consultants that assist the patient oppose to these, remaining the Insured with the obligation to provide the Insurer with the medical reports required by the latter for the correct assessment of the claim.

The date on which the Insured is discharged shall not earn any daily subsidy.

APPLICABLE REGULATIONS AND CONTROL AUTHORITY

The collective policy subscribed between SANITAS, S.A. DESEGUROS, as Policyholder, and LA PREVISIÓN MALLORQUINA DE SEGUROS, S.A.,as Insurance Company, shall be regulated by Law 50/1980, of 8th of October, of the Insurance Contract, Real Decreto Legislativo 6/2004, of 29 of October, by which the consolidated text of the Law de Ordenación y Supervisión de Seguros Privados, and its Reglamento de Desarrollo (Real Decreto nº2486/98 de 20 de noviembre) and by what is agreed in the Collective Policy subscribed between the Policyholder and the Insurance Company. The Dirección General de Seguros y Fondos de Pensiones is the organ dependant of the Ministerio de Economía that, with headquarters in Madrid(Spain) performs the control of the activity of the Insurance Company.

GRIEVANCE AND COMPLAINTS STAGES

Grievances and complaints can be addressed to the Customer Attention Service of LA PREVISIÓN MALLORQUINA DE SEGUROS, S.A. with headquarters in the legal address of the Insurer. If the resolution of these was not favourable to the customer, he/she can reproduce it by written means addressed to the Commisioner for the Defense of the Insured in 28046 MADRID, Paseo de la Castellana, nº 44. In any case, the concerned person can use the judicial way. The contract is submitted to the Spanish jurisdiction and, within it, the competent judge for the acknowledgement of the actions derived from it shall be that corresponding to the Insured's address, to which effect he/she shall appoint an address in Spain if his/hers was abroad.

VALIDITY OF THE INSURANCE

The present coverage will remain valid while the conditions of the collective policy subscribed between Sanitas as Policyholder and Previsión Mallorquina as Insurer Company are valid and the Insured is a Policyholder of the present policy.

Also, the condition of Insured shall be extinguished retroactively at the same moment in which the following events occur, even if there is no previous communication to the Insurer:

a) When the Insured ceases in all habitual professional activity or turns into the situation of unemployment or retirement.

b) Since the date on which it can be medically diagnosed that the illness that has caused the sinister suffered by the Insured has turned into a permanent disability for the performance of his/her workingor professional activity indicated in the policy.

TREATMENT OF PERSONAL CHARACTER DATA

The enrollment as Insured in the collective policy that causes this informative extract requires for its development, fulfillment, control and execution by LA PREVISION MALLORQUINA DE SEGUROS, S.A. the inclusión in files and the treatment of data of the Insured, including their Health data, as well as the communication of those data that are adequate, pertinent and non excessive for the fulfillment ofthe indicated finality between the services performed and the insurance company.

The application for any insured benefit that he/she needs on the basis of the insurance contract, supposes the express conformity of the Insured to the fact that LA PREVISION MALLORQUINA DE SEGUROS, S.A.

To be able to benefit from the cover insured by this supplementary cover, the insured must reside in Spain at least six months in each contractual annuity.

This supplementary cover is not applicable in the United States of America.

A)Insured capital limits

1. Hospital health care

With the same extent of insured coverage as that mentioned under the modality of contracted medical network, SANITAS shall pay up to the limits and sublimits of insured capital established in the Particular Conditions of the policy, the expenses caused by inpatient treatment, surgical operations, child delivery or cesarean, surgeons' and their assistants' fees, midwifes, anesthetists, operating theaters use, materials and medicaments, ICU care, as well as inpatient expenses that include upkeep and conventional room whit companion bed.

Surgical operations performed to the same Insured on the same day, by the same professional, shall be considered a sole operation in what refers to the application of the corresponding limit of insured capital.

The amounts indicated in the invoices for the use of specific surgical technics (robotic, laser, etc.) shall be included in the limit corresponding to surgeons' and assistants' fees.

The Insured shall be able to use simultaneously the modalities of medical network and reimbursement in relation to the same inpatient treatment, being committed to fulfill in any case with the regulations applicable to each of those care modalities and providing that Sanitas has authorized previously such simultaneous use.

2. Outpatient care

With the same extent of insured coverage as that mentioned under the modality of contracted medical network, SANITAS shall pay up to the limits and sublimits of insured capital established in the Particular Conditions of the policy, the expenses corresponding to:

- **Consultations.**
- **Emergency Home Services.**
- **Diagnosis Tests.**
- **Therapeutic Methods.**
- **Outpatient or Daypatient surgery.**
- **Land ambulance service.**

B)Reimbursement percentage

As a general rule, Sanitas will only reimburse the percentage indicated in the Particular Conditions of the policy, of the amount of medical and/or hospital expenses in which the Insured really incurs as a consequence of the care received for the contracted benefits included in the coverage of this policy, being the rest of the percentage difference on the account of the Insured.

In case the Insured uses the contracted medical network in Spain or the worldwide network of participating centers with the prior authorization, the Policyholder or Insured will not have to attend the payments for such services, being all medical and hospital expenses on the account of Sanitas. The Insured shall have to proceed as established in this clause.

C)Procedure for the reimbursement of expenses.

For the management of reimbursement of expenses included in the insured coverage of this policy, the following must be complied with:

C.1. The Insured or any person in his/her name, must communicate the inpatient treatment, surgical operation and in general any medical service insured in the maximum term of seven (7) days since he/she knew it, unless a larger term has been agreed.

In case of surgical operation or programmed inpatient treatment, he/she must communicate such circumstance to Sanitas since the moment in which he/she has knowledge of the date in which such surgical operation or inpatient treatment is going to take place and, in any case, within the

- **For the reimbursement of acupuncture consultations and acupuncture materials:** 6 months
- **For the reimbursement of homeopathy consultations and homeopathic products:** 6 months

3. ARRANGING REIMBURSEMENT

To arrange reimbursement the insured needs to present the following documentation within a period not exceeding 7 days:

a) A duly completed reimbursement application form.

b) Original invoices broken down by date, amount and item.
These documents must be originals.

Once all the necessary documentation has been received and verified, the corresponding amount will be reimbursed within ten working days.

4. DISCLAIMER

The insured may freely choose which professional provides the services covered hereunder. Sanitas will not intervene in any way in this choice, nor shall it participate in or supervise how these services are provided. This means Sanitas is exempt from the direct, joint and several, and secondary liability of the acts of these providers.

Vision Cover

This supplement exclusively includes reimbursement for the following optical materials: prescription contact lenses and prescription eyeglass lenses, provided they are prescribed by an ophthalmologist pertaining to the network of the policy contracted, unless said policy includes a reimbursement modality, in which case the ophthalmologist would not necessarily have to pertain to said network of physicians. Limit one invoice per year.

The reimbursement of this amount shall be performed in the percentage set in the Particular Terms and Conditions and up to the limit of the capital insured as specified in those Terms and Conditions, once the insured party submits the invoice in proof of payment of the covered optical materials together with the ophthalmologist's prescription.

1. QUALIFICATION PERIODS

All coverages shall enter into force once it has taken effect on the date expressly indicated in the corresponding Particular Conditions, and once the following waiting periods have elapsed:

- **Request for the reimbursement of optical material**: 6 months

Reimbursement of Expenses Cover

The medical benefits object of coverage by this policy under the modality of contracted medical network in Spain and the network of participating centers and within the same limits and exclusions can also be covered under the modality of reimbursement of expenses. The reimbursement by SANITAS of the expenses corresponding to the insured medical benefits already mentioned, will be performed according to the reimbursement percentages and specific insured capital limits for each contracted benefit, according to which is specified in the Particular Conditions of this policy and following the regulations for reimbursement management established in this General Conditions.

In case of using the modality of reimbursement of expenses, it will not be necessary that the prescription and performance of care services is made by a professional belonging to the medical network contracted by Sanitas.

To able to benefit from the cover insured by this supplementary cover, the insured must reside in Spain at least six months in each contractual annuity.

This supplementary cover is not applicable in the United States of America.

A)Insured capital limits

1. Hospital health care

With the same extent of insured coverage as that mentioned under the modality of contracted medical network, SANITAS shall pay up to the limits and sublimits of insured capital established in the Particular Conditions of the policy, the expenses caused by inpatient treatment, surgical operations, child delivery or cesarean, surgeons' and their assistants' fees, midwifes, anesthetists, operating theaters use, materials and medicaments, ICU care, as well as inpatient expenses that include upkeep and conventional room whit companion bed.

Surgical operations performed to the same Insured on the same day, by the same professional, shall be considered a sole operation in what refers to the application of the corresponding limit of insured capital.

The amounts indicated in the invoices for the use of specific surgical technics (robotic, laser, etc.) shall be included in the limit corresponding to surgeons' and assistants' fees.

The Insured shall be able to use simultaneously the modalities of medical network and reimbursement in relation to the same inpatient treatment, being committed to fulfill in any case with the regulations applicable to each of those care modalities and providing that Sanitas has authorized previously such simultaneous use.

2. Outpatient care

With the same extent of insured coverage as that mentioned under the modality of contracted medical network, SANITAS shall pay up to the limits and sublimits of insured capital established in the Particular Conditions of the policy, the expenses corresponding to:

- **Consultations.**
- **Emergency Home Services.**
- **Diagnosis Tests.**
- **Therapeutic Methods.**
- **Outpatient or Daypatient surgery.**
- **Land ambulance service.**

B)Reimbursement percentage

As a general rule, Sanitas will only reimburse the percentage indicated in the Particular Conditions of the policy, of the amount of medical and/or hospital expenses in which the Insured really incurs as a consequence of the care received for the contracted benefits included in the coverage of this policy, being the rest of the percentage difference on the account of the Insured.

In case the Insured uses the contracted medical network in Spain or the worldwide network of participating centers with the prior authorization, the Policyholder or Insured will not have to attend the payments for such services, being all medical and hospital expenses on the account of Sanitas. The Insured shall have to proceed as established in this clause.

C)Procedure for the reimbursement of expenses.

For the management of reimbursement of expenses included in the insured coverage of this policy, the following must be complied with:

C.1. The Insured or any person in his/her name, must communicate the inpatient treatment, surgical operation and in general any medical service insured in the maximum term of seven (7) days since he/she knew it, unless a larger term has been agreed.

In case of surgical operation or programmed inpatient treatment, he/she must communicate such circumstance to Sanitas since the moment in which he/she has knowledge of the date in which such surgical operation or inpatient treatment is going to take place and, in any case, within the

maximum term of seven (7) days counted from the date from which he/she knew this.

C.2. In case of surgical operations, inpatient treatment, child deliver or cesarean, diagnosis tests and therapeutic methods, together with the communication of the illness or accident, the Policyholder or Insured shall send to Sanitas the medical report in which it is specified the diagnosis and nature of the illness, as well as, if such is the case, the care center, date of entry, probable duration and type of treatment.

C.3. The Insured shall also faithfully follow all prescriptions of the doctor in charge of his/her treatment and shall give SANITAS all type of informations about the circumstances and consequences of the claim.

C.4. The Policyholder or the Insured or their relatives must allow that professionals designated by Sanitas visit the Insured as many times as SANITAS considers it necessary, as well as any enquiry or check SANITAS may deem necessary about his/her state of health.

C.5. In case of inpatient treatment, once it is finished, the Policyholder or the Insured shall communicate such circumstance to SANITAS, indicating the duration of the treatment.

C.6. The Policyholder or the Insured shall hand in to Sanitas the following documents:

- Application of reimbursement, duly completed.

- Documents or invoices of the expenses really incurred in by the Insured, duly broken down in any of the concepts included in the invoices where it is showed:

  a) The person receiving the medical and/or hospital care.

  b) The nature of the medical services performed (consultation, diagnosis tests, therapeutic methods, surgical operations, etc.), their dates and amounts.

  c) Identification of the individual or legal person that has performed the care (physician, registered nurse, clinic or hospital, etc.), indicating expressly the surname, name or legal denomination, address, corporation number and tax identification number.

- Documents accrediting the payment of the invoice made by the Insured.

- Medical prescription of the medical and/or hospital services received by the Insured, except in the case of consultations and podiatry in respect of which it will not be necessary to submit such prescriptions.

- Medical report specifying medical and/or hospital services received by the Insured, the illness' process and its evolution, as well as the medical or hospital discharge, with indication, if such is the case, of the necessity of continuous care.

The unfulfilment of the regulations established in the five previous points will be considered as express waiver to receive the reimbursement amount, unless such fulfillment is impossible due to force majeure causes.

The Policyholder or Insured will keep the originals of the documents mentioned in this point during the term of five years counted from the date of payment by Sanitas of the applied for reimbursement and will make them available to Sanitas upon Sanitas' request with the purpose of fulfilling Sanitas' obligations.

D)Payment of the amounts due to be reimbursed.

The Policyholder or the Insured must apply for the reimbursement of the medical and/or hospital expenses to which they are entitled according to the present policy in the term of 90 days counted from the date on which they have received the corresponding care.

Once all the required documents are received and all corresponding checks are made, to

establish the existence of a claim, Sanitas will reimburse or consign the guaranteed amount.

In case the medical and/or hospital care is performed abroad, the assessment of the expenses or of the amount to be reimbursed by Sanitas will be made in euros according to the buyer's official foreign exchange rate that, on the day of payment made by the Policyholder or the Insured of the invoice of the medical and/or hospital care expenses being reimbursed, the foreign currency has in which the Policyholder or Insured have made the payment for the received assistance. The expenses corresponding to the translation to Spanish language of the corresponding documents (invoices, reports, etc.) written in other languages, shall be on account of the Insured.

1. QUALIFYING PERIODS

All coverages shall enter into force once it has taken effect on the date expressly indicated in the corresponding Particular Conditions, and once the following waiting periods have elapsed:

- **Vasectomy and tubular ligation:** 10 month
- **Psychology:** 6 month
- **High complexity diagnosis tests:** 6 month
- **The following Complex Therapeutical Methods: interventional cardiology/ hemodynamics; interventional radiology, radiotherapy and chemotherapy; and lithotripsy:** 10 month
- **Outpatient surgical operations:** 3 month
- **Child delivery or caesarean:** 8 month
- **Hospitalization and surgical operations different from outpatient care and those performed as inpatient:** 10 month

Reimbursement of Pediatric, Gynecological and Obstetric Consultations Cover

In the event that the Insured arranges this specific cover, the Insurer assumes, under the terms set down in the corresponding supplement to the policy hereunder, the reimbursement of 60% of reasonable and normal costs incurred by the Insured derived from medical consultations, exclusively in the specialities of Paediatrics and of Gynaecology and Obstetrics, that the Insured has had as a result of an illness or accident covered by the policy. For this method of cost reimbursement, the limits of capital insured per consultation and per insured and annuity shall be those set down in the Particular Terms and Conditions of the policy hereunder. To process the reimbursements, the Policyholder or, as applicable, the Insured, should submit to SANITAS the reimbursement request form duly completed, original receipt or invoice of the costs actually incurred by the Insured, which specify the person who received the medical care and the full identification of the physical or legal person that provided the medical care, and original receipt or accreditation of the payment of the invoices by the Insured.

1. TERM OF THE INSURANCE

For the speciality of Paediatrics, the insured in this supplementary cover shall cancel it upon expiry of the annuity in which they turn 15 years' old.

Repatriation cover

Transfer to the country of origin of the insured and an escort in the event of the insured's death

If the insured dies in Spain, SANITAS will, via the provider it appoints, organise and take charge of the transfer of the coffin or ashes, in the case of cremation, from the place of death to the international airport closest to the place of interment in the deceased's country of

origin expressly designated in the particular conditions, when the insured's beneficiaries report on the undertaker's that will take charge of the mortal remains at the airport.

SANITAS will furthermore assume the costs of the transfer from the international airport to the place of interment in the deceased's country of origin, with a $1,000 limit and always so long as the burial is more than 30 km from the international airport.

In the event of the insured's death, the provider appointed by SANITAS will also take charge of the transfer from the place of the insured's death in Spain to the international airport closest to the place of interment in the deceased's country of origin of a direct family member of the deceased whose habitual place of residence is in Spain (hereafter the escort).

SANITAS will also assume the cost of transferring the escort from the international airport to the place of interment in the deceased's country of origin with a $1,000 limit so long as the burial is more than 30 km from the international airport.

The policy also covers the escort's return trip from the place of interment to his or her place of habitual residence in Spain (first-class train, economy-class scheduled airline or any other suitable form of transport). This guarantee will be provided so long as the return trip takes place within a maximum of fifteen days from the date of death.

TERRITORIAL SPHERE

The services apply in Spain.

USE OF THE SERVICES

To use the services under this supplementary cover, the insured must be up to date with his/her obligations, especially with regards premium payment, and the information must be included in a file which will be supplied to the provider at the start of the cover.

The Sanitas card clearly indicates a hotline number to make reverse-charge calls if needed, pursuant to the conditions of the present supplementary cover, and if any additional information is needed.

RISKS EXCLUDED

- **Interment and ceremonial expenses are excluded from this cover.**

- **Transfers not previously communicated to the provider and for which the corresponding prior authorisation has not been obtained are generally excluded. The service provision will not proceed if this communication is not produced under the indicated terms. The transportation of organs, tissue, cells and by-products, embryos and fetuses is expressly excluded.**

- **Transfer is excluded if the insured's death occurs in a state of war, insurrection or similar conflict of any type or nature, even when not officially declared; and those cases where the transfer is to a country under the same conditions.**

Clause III: Exclusions from cover

Healthcare arising from the risks indicated below is excluded from the cover of this policy, regardless of any other exclusion duly highlighted in the terms and conditions of this policy:

A. All types of disease, injury, pain, constitutional or congenital defect, deformity, medical condition or situation (such as pregnancy or gestation) existing prior to the registration date of each Insured party in the policy and/or those as a result of accidents or diseases and their consequences arising prior to the date of inclusion of each insured party in the policy.

The Policyholder, on his/her behalf or that of the insured, must include any type of injury, congenital condition, disease, diagnostic test, treatment and symptoms that may be considered the start of a condition in the health questionnaire included in the request for insurance. Where not indicated, any insured cover directly or indirectly relating to the declaration not made shall be excluded. SANITAS shall assess the information provided by the Policyholder as a basis to accept or reject the request for insured or to accept it excluding certain insured cover.

B. Healthcare relating to diseases, accidents, injuries, deformities or defects:

- **Arising as a result of civil wars, international wars, terrorist action in any form (chemical, biological, nuclear, etc.), revolutions and military manoeuvres, even during peacetime, and officially declared epidemics.**

- **Directly or indirectly related to nuclear radiation or radioactive contamination and those resulting from natural phenomena such as earthquakes, flooding, volcanic eruptions and other seismic or meteorological phenomena.**

- **Arising from working or professional accidents.**

- **Arising from the use of motor vehicles that are the purpose of the Automobile Compulsory Subscription Insurance.**

- **Arising while the Insured is involved, as an amateur, in sports of risk, such as flying activities, speed trials in a motor vehicle, scuba diving, climbing, boxing, bull fighting, martial arts, rugby or any other similar activity of risk, as well as those resulting from sporting competitions.**

C. Healthcare provided at Social Security clinics or services or those integrated in the National Health System. Cross-border healthcare is also excluded.

D. Hospitalisation for problems of a social nature.

E. Health care and/or inpatient treatment provided to the Insured by persons that are related with the Policyholder or with the Insured by conjugal relationship or kinship until the fourth grade of consanguinity or affinity, inclusive.

F. Healthcare derived from chronic alcoholism, drug addiction, intoxication due to the abuse of alcohol, psychotropic drugs, narcotics or hallucinogens, attempted suicide and self-harm, diseases or accidents due to negligence or gross negligence of the Insured, infection by Human Immunodeficiency Virus, AIDS and related diseases.

G. All diagnostic, surgical or therapeutic procedures for which their clinical **safety and effectiveness** are not duly proven scientifically or **that are new to appear after this policy has been signed; non-universal** procedures **and those not consolidated in normal clinical practice,** those proven to have been overtaken by other available procedures and **experimental**

procedures or those **not sufficiently proven for their effective contribution** towards the prevention, treatment or cure of disease.

For the purposes of this policy, a diagnostic, surgical or therapeutic procedure is considered safe and effective when it is approved by the European Drug Agency and/or the Spanish Agency for Medicinal Products and Medical Devices. A procedure is also considered universal and consolidated when it is performed in normal clinical practice in at least nine Autonomous Communities of Spain in a generalized manner in their public hospitals, not only in Flagship Hospitals.

H. Any type of service relating to:

• Conditions or treatments not covered, as well as any complications arising from them.

• Specific diagnosis and treatments, including surgery, aimed at remedying sterility or infertility in either sex (in vitro fertilization), artificial insemination, etc. or involving impotence and erectile dysfunction, including sex-change surgery.

• Voluntary interruption of pregnancy.

• Organ, tissues, cells or cells components, except autologous transplant of both bone marrow and progenitor cells of peripheral blood due to hematologic lineage tumors and cornea transplant. In this latter case, SANITAS does not pay for the economic cost of the cornea to be transplanted.

• Any surgical procedure on unborn babies.

• Any surgical technique using robotic surgery equipment.

• Genetic map determinations to ascertain the predisposition of the Insured or his ancestors or present or future offspring to certain diseases related to genetic disorders. Genetic mapping of tumors and pharmacogenetics are also expressly excluded.

• Prosthesis and implantable materials except those mentioned in the corresponding paragraph of the present General Conditions. Among others, any external prosthesis, any orthopaedic material, external fixing materials, synthetic or biological materials, grafts, aortic endoprosthesis, valved ducts, implantable pumps for the infusion of medicaments, medullary stimulating electrodes, defibrillators and the artificial heart.

• Operations, infiltrations and treatments, as well as any other action that is purely for questions of appearance or of a cosmetic nature. Breast surgery is only covered in the case of tumours. Surgical interventions of a prophylactic nature or for breast hypertrophy or breast reduction in men are expressly excluded. Any kind of disorder or complication which may occur subsequently and which is directly and/or mainly caused by the Insured's undergoing an operation, infiltration or treatment of a purely aesthetic or cosmetic nature are also expressly excluded.

• Treatment with platelet- or growth-factor-rich plasma.

• Educational therapy in all its forms, such as language education in processes unrelated to organic disease or special education in patients with mental illness.

• General medical examinations for preventive purposes, except the cover mentioned in these General Terms and Conditions.

• Alternative medicine, naturopathy, homeopathy, acupuncture, mesotherapy, hydrotherapy, magnetotherapy, pressotherapy, ozone therapy, etc.

• Services or techniques that merely consist of leisure, rest, comfort or sporting activities, similarly treatments at spas and health farms.

I. All surgical techniques or therapeutic procedures using laser, except:

• Ophthalmic photocoagulation.

• Haemorrhoid treatments.

• Clinical (not cosmetic) peripheral vascular surgery.

• Ear, nose and throat.

• In musculoskeletal physiotherapy.

J. Travelling expenses except those included in the ambulance section of these General Terms and Conditions.

K. The following pharmaceutical products:

• Those administered to the patient outside hospitalization or in day care hospital, except chemotherapy administered parenterally by a healthcare professional in partner centers. Vaccinations and autovaccinations of all types; drugs in ventilation therapy and aerosol therapy and parapharmacy products.

• Medicinal products not on the market in Spain.

• Advanced therapies (human medicinal parts based on genes, cells and cell therapy and including autologous, allogenic or xenogenic products).

L. Water birth, homebirth and alternative childbirth techniques are expressly excluded.

M. Bariatric surgery in morbid obesity is excluded.

N. Radiosurgery is excluded

Ñ Parkinson surgery is excluded

O Epilepsy surgery is excluded

Clause IV: 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:

Qualitification Periods for the modality of Contracted Medical Network:

- **Vasectomy and tubular ligation:** 10 Months
- **Psychology:** 6 Months
- **High complexity diagnosis tests:** 6 Months
- **The following Complex Therapeutical Methods: interventional cardiology/ hemodynamics; interventional radiology, radiotherapy and chemotherapy; and lithotripsy:** 10 Months
- **Outpatient surgical operations:** 3 Months
- **Child delivery or caesarean:** 8 Months
- **Hospitalization and surgical operations different from outpatient care and those performed as inpatient:** 10 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 V: Form of service provision

1. Through the contracted medical network

Care shall be provided according to healthcare regulations applicable, by professionals with sufficient qualifications for each specific service and belonging to the contracted medical network corresponding to this insurance product. Where one of the services included in the cover of this policy does not exist in the town where the Insured is located, it shall be provided in another region through the healthcare provider that the Insured choses in each case.

On receiving applicable services, the Insured must present his/her SANITAS card. Also de Insured must show his/her Identity National Document, if such was required. Each time the Insured receives a service covered by this policy, he/she must pay, in the concept of participation in the cost of such service, the amount that is established in the Particular Conditions.

SANITAS must provide insured cover under the terms established in the policy and is not bound by the decisions that professionals may make, whether or not they belong to its medical network or are included in this insured cover.

The care may be provided in different ways, depending on the service to be given:

1.1. Free access.

The Insured shall be able to attend freely in Spain to the consultancies of consultants, general physicians and pediatrics, as well as the emergency centers that belong to the contracted medical network by Sanitas for this product. Please check your User Guide to Doctors and Services for those consultants for which you will need prescription/authorization.

1.2. Prior prescription for the performance of the service

Diagnosis tests, therapeutic methods, and certain care services will require, for their performance, written prescription by a physician belonging to SANITAS medical network.

Particularly, Psychology consultations must be prescribed by a Psychiatrist, General Practitioner, Oncologist or Pediatric.

1.3. Prior prescription and authorization for the performance of the service.

As a general rule, for surgical operations, inpatient treatment and counselor professionals, prior express authorization by Sanitas shall be needed, after the written prescription of the professionals belonging to Sanitas network. Such authorization shall be also needed for certain therapeutic methods, diagnosis tests and other care services, whenever such is said in the general conditions of the policy. The authorization voucher shall not be valid if at the moment of receiving the service, the Insured is not fulfilling all the requirements established in the General Conditions of his/her policy to access to the full insured coverage relating to the service indicated in such authorization voucher (i.e. no being current on payments of the premium, preexisting condition not declared, etc.).

1.4. Prior authorization for the service to be performed by expressly accredited professionals

Any laparoscopic or arthroscopic surgical procedures and those involving radiofrequency or laser techniques must be performed by professionals specifically arranged and accredited by SANITAS to perform this type of specific surgical technique.

1.5. Prior authorization and express designation of the physician

More particularly, for surgical procedures of great complexity, as indicated below: neurosurgery, heart surgery, bariatric surgery and backbone surgery, surgery requiring robotic equipment, assisted navigation equipment or any other restricted

implementation technology, that are covered by this policy, SANITAS shall appoint the healthcare center and the professionals to perform the surgery in each individual case and prior to the specific surgical procedure.

1.6. Home Services.

Sanitas is bound to perform home services in those cities where SANITAS has contracted the performance of these services and only **in the address that is established in the policy. Any change of such address must be reliably communicated** with a minimum notice of eight days prior to the requirement of any service.

The services performed at home are those related with the specialties of General Practitioner, Pediatrics, Emergencies, Nurse Care, Special Care at Home, Ambulance and home-based respiratory therapies. All of them require prescription by a physician except General Practitioner and Pediatrics. Sanitas keeps the right to not perform such service when, following medical criteria, does not consider it necessary.

Particularly, treatments involving home-based respiratory therapies, must be prescribed by a pneumologist belonging to SANITAS network. In all chronic treatments, the Insured has to renew the pneumologist's prescription and the service authorization by SANITAS **each month.**

1.7. Care in case of temporary displacement to Cantabria and Navarra.

In case of temporary displacement of the Insured to the mentioned Autonomous Regions the service included in the coverage shall be performed through the medical network of the Entities expressly contracted by Sanitas for such performance. The Insured must present his/her Sanitas card in the Offices of the contracted Entities, accepting the administrative steps of these Entities.

1.8. Emergencies

As specified in article 103 of the Insurance Contract Act, SANITAS assumes the necessary care of an **emergency** nature in accordance with the Policy Terms and Conditions and that in all cases shall be provided through the resources designated by SANITAS, expressly indicated in the User Guide to Doctors and Services for this product.

In cases of **vital emergency, wherever the Insured must be admitted to a center not included in the medical network, SANITAS must be reliably informed** of this admission as soon as possible so that it can transfer the insured to a partner center, provided his/her medical condition allows as such.

1.9. Care in providers not recognized by SANITAS.

Notwithstanding what is mentioned in the above paragraph for cases of vital emergency, SANITAS shall not pay for the fees of professionals not belonging to its medical network, nor for the expenses of internment or services that such professionals could order. Also, SANITAS shall not pay, under the contracted medical network modality that is the object of insurance of this policy, for the expenses originated in private or public centers not contracted for this product, no matter who the prescribing or performing professional is.

Clause VI: Other features of your 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 when, even sometiéndoselo, 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 make the statement to which the preceding paragraph, the provision will be reduced proportionally to the difference between the agreed premium and it has been applied to the true risk they met . If he mediated malice or gross negligence of the policyholder will SANITAS 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:

a) In accordance with the provisions of clause rights and duties of the general conditions in the event of an increase in risk if the Policyholder or the Insured not communicate SANITAS and have acted in bad faith (Art. 12 of the Insurance Contract Act).

b) If the incident occurs before the premium has been paid (or, if 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 formalized. 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.

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 de date in 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, SANITAS shall 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 authorize the bank to pay them.

3.7. SANITAS is only bound by the receipts issued by the Management or by its legally authorized 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.

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 receipt in return.

4. Newborn children inclusions

Newborn children can be included in the policy with all its rights since their date of birth if the care provided to the biological mother whilst the child delivery has been provided by SANITAS within the coverage of the biological mother's policy and if the inclusion of the biological mother in the policy has taken place at least 365 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 hi/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. **The SANITAS Complaints Management Department** - by means of a letter addressed to **calle Ribera del Loira n° 52 (28042 Madrid) or to fax no. 91 585 2468 - or to the email** address: departamentocalidad@sanitas.es, which will acknowledge receipt in writing and issue a reasoned written decision, **within the statutory deadline of two (2) months** from the date of filing of the complaint.

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

a) In the case of complaints whose amount does not exceed €21,000 and which concern the interpretation of the General and Particular Terms and Conditions of the Policy. Claims 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 SANITAS so agrees, even though the foregoing requirements are not met. To file a complaint 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 complaint. The Ombudsman shall issue a written acknowledgement of receipt and declare whether or not he/she is authorized to examine the complaint. If the Ombudsman declares that he/she is authorized, he/she shall examine the complaint and within the legal deadline of two (2) months from the date the claim was filed with SANITAS shall issue a reasoned decision, written notice of which shall be served on the claimant and SANITAS, on whom the decision shall be binding.

3. The administrative complaint procedure may also be instituted before the 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 Insurance Ombudsman has expired or that the complaint has been rejected.

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

5. Legal actions originated in connection to this Insurance Agreement shall be subject to a five-year time limit (Article 23 of the Insurance Contract 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 address of the Policyholder in Spain that is included in the policy, except where a change of address has been notified to SANITAS.

7.2.3. Reliable notifications sent to the insurance agent who mediates or has mediated in the contract shall take be valid.

However, notifications sent by the Policyholder or Insured to the Insurance broker are not considered made to SANITAS until it has received them.

Notifications made by an Insurance broker to SANITAS on behalf of the Policyholder shall have the same effect as if they were sent by the Policyholder him/herself, except where otherwise indicated by him/her.

On all accounts, the express agreement of the Policyholder shall be required to sign a new contract or to modify or terminate the current insurance policy.

7.3. Protection of personal data

The Policyholder undertakes to ensure that all information provided to SANITAS 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.

Nevertheless, he/she authorizes SANITAS to ask physicians, clinics, hospitals, etc. and he/she therefore authorizes such persons to provide to SANITAS, any data on the health of the persons included under the policy that SANITAS may deem expedient for the management of the insurance, for offering comprehensive healthcare programs that SANITAS 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.

Furthermore, and in accordance with Ley 15/1999 de 13 de diciembre de Protección de Datos de carácter Personal (the Spanish Data Protection Act 1999) and Royal Decree 1720/2007 of 21 December, approving the implementing rules of the aforementioned Act, 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 programs that will allow them to improve their health, the understanding of reasons for cancelling the policy, fraud prevention and the sending, by any means, of advertising or other offers that might be of interest from the entity and third parties with which it collaborates, authorizing SANITAS to use their data to send them the information that best meets their particular needs. For the purpose of preventing fraud, the insured parties expressly consent to SANITAS 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.

In addition, the insured parties and the policyholder expressly authorize assignment

of those data to companies of the Sanitas Group identified at 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 SANITAS creates ties of cooperation, for the effectiveness of contractual relations with the insured and for sending advertising from those companies.

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 SANITAS 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.

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 delLoira 52, 28042 Madrid, Customer Relations Department.

If the policyholder and/or insured parties do not wish to receive commercial information from SANITAS 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 to the following email address: relacionesconclientes@sanitas.es.

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 the Insurer their authorization 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.

Made in duplicated in Madrid on 07 de May de 2015

For the Insured / Policyholder

For SANITAS

Sergio de Andrés Osorio
Sanitas, S.A. de Seguros