GENERAL TERMS AND CONDITIONS

Sabadell Health Protection

Sabadell Seguros Generales | Sanitas

BanSabadell Seguros Generales, Sociedad Anónima de Seguros y Reaseguros.

With registered offices at C/ Isabel Colbrand, 22, 28050 Madrid.

Registered under entry C-0767 in the Special Register of the Directorate-General of Insurance and Pension Funds.

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General terms and conditions

Preliminary clause

The present contract is bound by the matters set out in its general aspects, Act 50/1980 of 8 October on Insurance Contracts (Official State Bulletin of 17 October 1980), Act 20/2015 of 14 July on the Management, Supervision and Solvency of Insurers and Reinsurers and its implementing regulation (Royal Decree 1060/2015 of 20 November on the Management, Supervision and Solvency of Insurers and Reinsurers), Act 22/2007 of 11 July on the Distance Marketing of Financial Services for Consumers by the insurance distribution directive and the matters agreed upon in the General and Particular Terms and Conditions. For particular aspects this Policy is governed by what is specifically established about coinsurance in article 33 of the above mentioned Insurance Contract Act.

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 **Sabadell Over 60 Health Protection** insurance product, the following definitions apply:

INSURANCE TERMS

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

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

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

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

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

HEALTH QUESTIONNAIRE
Declaration that must be truthfully and fully completed and signed by the Policyholder or Insured before formalisation of the policy and used by the Insurer to assess the risk subject to insurance.

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

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

INSURER OR INSURANCE COMPANY
SANITAS Sociedad Anónima de Seguros and BanSabadell Seguros Generales, bodies corporate taking on the risk as agreed under this Agreement in a coinsurance regime of 50% each.

DEDUCTIBLE
Sum of medical and/or hospital expenses not 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 the Insurer, which is specified according to the degree of difficulty of the cover.

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

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

PRE-EXISTING PATHOLOGIES
State or condition of health (illness, injury or defect), not necessarily pathological, suffered

by the Insured prior to the date of signing the health questionnaire.

BENEFIT
Acceptance of payment of the care service by the Insurer of the guarantees committed to in the policy.

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

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

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

POLICYHOLDER
The physical person or body corporate that, together with the Insurer, 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/WITH ADMISSION TO HOSPITAL
This is the care provided in a medical centre or hospital under admission to hospital, recording admission and the insured being admitted as a patient for at least one night in order to undergo medical treatment, diagnosis, surgery or therapeutic treatment.

HEALTHCARE IN A DAY HOSPITAL
This is the medical, diagnostic, surgical or therapeutic care provided in a medical centre or hospital that requires non-intensive, short-duration care that does not require an overnight stay.

In the case of surgical treatment at a day hospital, it will be performed in the operating room under general, local or regional anaesthesia or sedation and requires non-intensive, short-duration care that does not require an overnight stay.

HEALTHCARE WITHOUT HOSPITALISATION / OUTPATIENT HEALTHCARE
This is the medical, diagnostic, surgical or therapeutic care provided in the hospital that does not involve admission or a day hospital.

In the case of an outpatient surgical treatment, it is performed in the consulting room on surface tissues and generally requires local anaesthesia.

SOCIAL CARE
Medical admission becomes social admission when a patient with functional deterioration or affected by age-related chronic processes and/or disorders have surpassed the acute phase of the disease and require healthcare but not under admission to hospital.

CYTOSTATIC MEDICINES
Cytotoxic medicine, which is used in oncological chemotherapy and can stop the proliferation of cancer by acting directly on the integrity of deoxyribonucleic acid chains (DNA) and cell division, inhibiting normal cell multiplication, of both healthy and cancer cells. They are a mixture of heterogeneous substances used in antineoplastic treatment.

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
Graduate in Nursing legally qualified and authorised to perform nursing activities.

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.

MAGISTRAL FORMULA
A magistral formula is the medicine intended for an individual patient, prepared by a pharmacist or under their direction and which is dispensed both in pharmacy offices and in hospital pharmaceutical services. This type of medicine must be prescribed by a healthcare professional, who must list all of the active ingredients, which include.

USER GUIDE TO DOCTORS AND SERVICES
Healthcare professionals and centres belonging to the medical network of this policy and recommended by the Insurer for the provision of the services included in the insurance. The Guide may undergo modifications during the validity period of the policy. There is a full, up-to-date list of the doctors and centres forming the medical network of this policy available to the insured at the the Insurer offices.

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

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

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

The centres, services and establishments, regardless of ownership, authorised by the health authorities of the autonomous communities and cities with a Statute of Autonomy are listed in the **Registro General de centros, servicios y establecimientos sanitarios**, of the Ministry of Health. Centres, services and establishments, regardless of ownership, not within the national territory must appear accredited as healthcare establishments according to the law applicable in each country.

PROCEDURE
The action of subjecting a person with a disease to the necessary control or examination, carrying out the corresponding tests, for either diagnostic or therapeutic purposes, for the symptoms or alterations reported during the consultation with the healthcare professional. There are different types of procedures: surgical, therapeutic and diagnostic. In all cases, they must be carried out by a competent specialist doctor in an authorised centre (hospital or outpatient centre) that usually requires a specific room with the necessary equipment.

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
External anatomical parts of any kind used to prevent or correct body deformities such as, for example, a back brace, harness or crutches.

MEDICINE
Any substance or combination of substances presented as having properties of treating or preventing disease in human beings or that may be used by or administered to human beings with a view to restoring, correcting or modifying a physiological function by exerting a pharmacological, immunological or metabolic action or making a medical diagnosis.

Coverage by the insurer will be contingent upon the prescription of the most efficient therapy available at the time, by active ingredient and always using the generic drug or biosimilar if authorised by the Spanish Agency of Medicinal Products and Medical Devices and marketed in Spain.

RADIOPHARMACEUTICALS: These are medicines that contain a small amount of active substance, known as a tracer, which is tagged with a radionuclide, causing them to emit a dose of radiation and which is used for both diagnostic and therapeutic purposes.

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

COMPLEX THERAPEUTIC PROCEDURES
A complex therapeutic method is any method requiring a healthcare or hospital setting with technical equipment, a room and/or specialised health professionals.

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

Indicate as an example that all lithotripsy, radiotherapy, chemotherapy, interventional radiology, haemodynamic, speech rehabilitation and endoscopy procedures and procedures covered that require laser, shockwaves will be included.

SIMPLE THERAPEUTIC PROCEDURE
A simple therapeutic procedure is defined as a therapeutic procedure prescribed by a doctor on the medical chart during the consultation for which highly complex equipment and medical staff are not required, as it is carried out by non-medical healthcare staff. This header also includes wound treatment, injectable drugs, some types of physiotherapy, etc.

NEWBORN
Person in the life stage of the first four weeks after birth.

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

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

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

BASIC DIAGNOSIS TEST

This test is essential for diagnosing a disease, regardless of whether the test is simple or complex (e.g. blood in faeces, cervical cytology, colonoscopy, etc.).

COMPLEX DIAGNOSIS TEST

A complex diagnostic test is defined as any test that requires a healthcare facility or hospital with technical equipment and specialised health professionals in order to perform it and/or to interpret the results due to their complexity. Similarly, the healthcare facility where it is performed must have appropriate staff and resources to address any complications that the patient might experience as a direct or indirect consequence of the test. For example, this includes all tests: CAT scan, MRI, ultrasound scan, neurophysiology, nuclear medicine, genetic, molecular biology, endoscopy, haemodynamics, interventional radiology, etc.

SIMPLE DIAGNOSTIC TEST

A simple diagnostic test is defined as a test prescribed by a doctor on the medical chart during the consultation for which highly complex equipment and specific interpretation by a specialist are not required. This header will include simple blood and urine tests and simple radiology.

PSYCHOLOGY

Psychology is the science of practical application of knowledge, skills and techniques to diagnose, prevent and resolve individual or social problems, especially as regards the individual's interaction with his/her physical and social environment.

HOME SERVICES

Visit to the insured's home at the Insured's request of a general practitioner, paediatrician or registered nurse, when the insured is unable to travel to attend the consultation due to their illness, provided that the Insurer has an arrangement for providing the service in this place.

EMERGENCY CARE SERVICES

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

TREATMENT

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

EMERGENCY

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

LIFE-THREATENING EMERGENCY / MEDICAL EMERGENCY

A life-threatening emergency is a situation that requires immediate medical care as a delay could prove life-threatening or lead to irreparable harm to the patient's physical integrity which could involve the loss or significant deterioration of a function, member or body organ.

Clause I: Purpose of the Insurance

The Insurer has designed an insurance product designed especially for people over 60 years old, which includes benefits that suit their specific needs.

Within the limits and terms and conditions set out in the policy and provided that the Policyholder has previously paid the corresponding premium, co-payments and deductibles, the Insurer offers its insureds an extensive appointed chart of professionals for your basic medical consultations, diagnostic tests and simple therapeutic methods, according to standard medical practice, in the specialities and modules included in the cover of this policy, assuming the cost via direct payment to the appointed professionals or centres that provided the insured service. The insured cover also includes certain home services and digital benefits. **In all cases, these services are carried out by professionals and medical centres and hospitals that meet the legal requirements for doing their job in the country and within their respective specialty, defined according to the accepted training plan according to the corresponding body of the activity in question.** However, the insured cover included on this policy shall be provided in Spain only.

Clause II: Benefits

The benefits covered by this policy are conditional on compliance with the qualifying periods indicated below.

PRINCIPAL BENEFITS

Accreditation of the procedures and services corresponding to a medical speciality, that is, the services that a healthcare professional from this speciality can perform, are based on the Clasificación Terminológica y Codificación de Actos y Técnicas Médicas (Nomenclátor) of the Spanish Medical Colleges Organisation.

In general, and with the limits and exclusions set out in the terms and conditions of this policy, the healthcare services covered are consultations, diagnostic tests and simple therapeutic methods corresponding to the following specialities:

1. Primary care

Consultations, diagnostic tests and simple therapeutic methods in the following specialities are covered:

1.1. General Medicine

This includes medical care in a healthcare centre, indication and prescription of basic diagnosis tests and procedures (analysis and general radiology)during the days 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 from attending the consulting room.

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

1.2. Paediatrics and Childcare

This includes the care of children **until they are 15 years old** in consulting room 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. Nursing Service

Includes healthcare at the healthcare centre and at home.

2. Emergencies

It includes the healthcare associated to the consultations, diagnostic tests and simple therapeutic methods that the insured may require in the event of emergency. It will be

provided in the permanent emergency centres agreed with the Insurer and listed in the User Guide to Doctors and Services corresponding to this product.

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

Sanitas 24 Hours

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

3. Medical specialities

Consultations, diagnostic tests and simple therapeutic methods in the following specialities are covered:

3.1. Allergology

Includes determination of complete allergen-specific IgE (natural extracts) including recombinant allergens. **The IgE antibody qualitative test and molecular diagnosis of the allergy (microarrays) are excluded.**

3.2. Clinical Analysis

3.3. Anatomic Pathology

Protein targeting is excluded.

3.4. Anaesthesiology

3.5. Angiology and Vascular Surgery

3.6. Digestive System

3.7. Cardiology

3.8. Cardiovascular surgery

3.9. General and gastrointestinal surgery

3.10. Maxillofacial Surgery

Includes the diagnosis and surgical treatment of diseases and trauma 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 Orthopaedic Surgery

3.12. Paediatric surgery

3.13. Reconstructive Surgery

3.14. Thoracic surgery

3.15. Dermatology

3.16. Endocrinology

3.17. Geriatrics

3.18. Gynecology and Obstetrics

It includes for diagnosing fertility **the following tests only: analytical basal hormone determinations (except the anti-müllerian hormone), ultrasound scan, hysterosalpingography and hysteroscopy, only up until diagnosis, that is, once treatment starts no other related services will be covered.**

The following genetic tests are included:

- Karyotype
- Factor V Leiden and mutation 20210 of the prothrombin gene, with these two determinations requiring prior authorisation from the Insurer following assessment of the medical report, being covered when there is a personal history of recurrent miscarriage and/or thromboembolic processes.

Any other genetic test other than those mentioned shall be excluded.

Includes breast tomosynthesis.

Includes the study of circulating foetal DNA in maternal plasma (non-invasive pre-natal screening) for foetal trisomy screening (13, 18, 21 and sex chromosomes) when the risk ratio from combined screening in the first quarter is between 1:50 and 1:250 and the pregnant woman is in her 10th to 18th week of pregnancy. Requires prior authorisation from the Insurer after assessing the medical report.

The Insured can access the pelvic floor recovery plan via the phone programme (917 522 904), provided by our specialised phone platform Sanitas Responde, which comprises a multidisciplinary team, to recover muscle tone and prevent and treat secondary dysfunctions or conditions.

3.19. Haematology and haemotherapy

3.20. Internal medicine

3.21. Nuclear Medicine

Contrast agents are paid for by the Insurer.

PET and PET/ CT scans exclusively with 18-fludeoxyglucose (18 FDG) are covered for:

A) **the diagnosis, staging, monitoring of treatment response and detection in reasonable case of relapse in cancer processes and**

B) **the following non-cancer indications (authorised by the Spanish Agency of Medicinal Products and Medical Devices on the 18-fludeoxyglucose (18 FDG) fact sheet):**

b.1- Cardiology
- Evaluation of myocardial viability in patients with serious left ventricle dysfunction and who are candidates for revascularization, only when conventional imaging techniques are not conclusive.

b.2- Neurology
- Localisation of epileptogenic foci in the pre-surgical assessment of partial temporary epilepsy.

b.3- Infectious or inflammatory diseases
Localisation of abnormal foci to guide etiological diagnosis in the case of idiopathic fever.

Infection diagnosis in the case of:
- Suspected chronic infection of bones or adjacent structures: osteomyelitis, spondylitis, discitis or osteitis, including when there are metallic implants
- Diabetic patients with a foot indicative of Charcot foot and ankle, osteomyelitis or a soft tissue infection
- Painful hip prosthesis
- Vascular graft
- Detection of septic metastatic foci in the case of bacteraemia or endocarditis (also see section 4.4)

Detection of extension of inflammation in the case of:
- Sarcoidosis
- Inflammatory bowel disease
- Large vessel vasculitis
- Treatment monitoring:

Unresectable alveolar echinococcosis in the detection of active outbreaks of the parasite during medical treatment and following treatment suspension.

Includes PET-MRI **exclusively for oncological processes.**

Prior authorisation from the Insurer is required after assessment of the medical report.

Any radiotracer other than 18FDG is excluded.

3.22. Nephrology

3.23. Pneumology

3.24. Neurosurgery

3.25. Clinical neurophysiology

3.26. Neurology

3.27. Ophthalmology

3.28. Medical Oncology

3.29. Ear, Nose and Throat

3.30. Psychiatry

3.31. Radiodiagnosis/Imaging Diagnosis

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

3.32. Rehabilitation

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

3.33. Rheumatology

3.34. Urology

Includes Multiparametric Magnetic Resonance of the prostate.

- Local, regional or distance staging
- Detection or guide for diagnostic biopsy where there is a suspicion of clinical risk in the following cases:
  - PSA 4-10 (grey area) with a ratio (free/total) lower than 0.13. It will be necessary if it continues to increase after 3 months of monitoring/treatment.
  - PSA>10 and/or ratio lower than 0.13. Involves Multi-parametric MRI.
- Therapeutic monitoring.

Requires prior authorisation from the Insurer after assessment of the medical report.

It includes Fusion-guided prostate biopsy but only when **the result of the multi-parametric MRI is PIRADS 3, PIRADS 4 or PIRADS 5.**

Prior authorisation from the Insurer is required after assessment of the medical report.

It includes for diagnosing fertility **the following tests only: basal hormone determinations, basic semen analysis and bacteriological cultures of semen, only up until diagnosis, that is, once treatment starts no other related services will be covered.**

4. Other care services

Consultations, diagnostic tests and simple therapeutic methods in the following specialities are covered:

4.1. Ambulance

Ambulance services are not covered under any circumstances.

4.2. Physiotherapy

It is provided solely on an outpatient basis and **exclusively for conditions originating in the musculoskeletal system**, considering as such exclusively those structures of the human body that perform the locomotive or movement function and therefore not those such as the temporomandibular or the abdominal wall/muscles, which do not perform this function and always provided it is not a chronic (more than 6 months of evolution) or degenerative process, through to the greatest possible functional recovery of the patient, determined by the rehabilitation doctor and provided by qualified and registered physiotherapists.

Includes pelvic floor rehabilitation **exclusively under the criteria set out in the Gynaecology section.**

Neurologic rehabilitation, early care, occupational therapy, heart rehabilitation as an outpatient, respiratory rehabilitation, temporomandibular joint rehabilitation, vestibular rehabilitation, water-based rehabilitation, ophthalmological rehabilitation and those performed using robotic equipment are excluded.

Physiotherapy and rehabilitation are excluded when functional recovery has been achieved, or as close as possible to it, or when it becomes maintenance therapy, in addition to neuropsychological rehabilitation and cognitive stimulation.

4.3. Speech and Phoniatric Therapy

Requires prior authorisation from the Insurer after assessment of the medical report and must be prescribed by an ear, nose and throat specialist (in the case of organic processes of the larynx and vocal cords) or by a neurologist (in the case of acute cerebrovascular accident).

It covers **up to 80 sessions per year and insured.**

Only the following are covered:

Organic processes associated to the larynx and vocal cords:

1. Inflammation: oedemas
2. Tumours:
   a) Benign: modules, polyps.
   b) Malignant: cancer of the larynx (partial or total)
3. Changes to the vocal cords:
   a) Paresis (reduction of cord movement because either the muscle or nerve are injured)
   b) Paralysis (reduction of cord movement because either the muscle or nerve are injured)
4. Congenital malformations

The insured cover includes **only speech therapy and language therapy for processes derived from acute cerebrovascular accident.**

4.4. Nutrition

Access to this speciality **must be prescribed by specialists in endocrinology, oncology, internal medicine, geriatrics, paediatrics, digestion or gynaecology authorised by the Insurer**. It is covered **when a medical condition exists (cancer patients, diabetes, obesity with BMI >30 or a severe eating disorder).**

4.5. Odontology

This only includes consultations, simple extractions of dental pieces (simple teeth, third molars, impacted teeth and root remains), stomatological treatment derived from the latter and scale and polish, **performed in consultation only and prescribed by a dentist appointed by the Insurer.**

This does not include treatments, fillings and obturations, dental prostheses, orthodontic treatments, periodontics treatments, implants or any other dental treatment not listed above as included.

4.6. Podiatry (Chiropody exclusively)

It covers **only chiropody, which is understood as treatment for removing calluses and alterations to the toe nails performed by a chiropodist.**

Limited to a maximum of 12 sessions per Insured and insurance annuity.

4.7. Psychology

This comprises individual psychological care prescribed by Psychiatrists, Family Health Advisors, Paediatricians or Medical Oncologists the purpose of which is to treat disorders which could be treated via psychological intervention.

Psychometric tests will be covered by the insured.

It includes a maximum of 15 sessions per Insured and insurance annuity.

Psychoanalysis, psychoanalytical therapy, hypnosis, narcolepsy treatment, animal-assisted therapy and psychosocial and neuropsychiatry rehabilitation services are excluded.

4.8. 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. The Insurer shall only pay for one type of oxygen therapy treatment.

Portable oxygen concentrator is excluded.

b) Generation of positive airway pressure with CPAP to treat obstructive sleep apnoea. **Auto-CPAP machines for this treatment are excluded.**

c) Partial BiPAP ventilation therapy and aerosol therapy.

4.9. Pain treatment

Only diagnostic tests are covered. **Therapeutic methods are not covered under any circumstances.**

ADDITIONAL COVERAGES OF YOUR INSURANCE

Sabadell Seguros Generales | Sanitas

Seniors' Programme

1. PURPOSE OF THE COVER

The purpose of this service is to provide the Insured member who arranges it with the information, guidance and professional and personal assistance in terms of health by way of telematic channels (primarily by phone, email, ordinary post and the website), in order to provide health advice on aspects relevant to their age group.

Description of the service:

- Service provided by personal health advisors.
- The objectives and action plans with each Insured shall be individual and agreed jointly with the Insured member.
- Service provided by way of telematic channels, with no call limits.
- The service is personal and non-transferable.
- The helpline is available from 9 am to 10 pm Mondays to Friday and 9 am to 4 pm Saturdays.
- The purpose of the service (or guarantee) is to provide a personalised health programme, undertaken by healthcare professionals, so the Insured member understands, anticipates and improves their health by way of follow-up calls.
- The service will be provided by Sanitas Emisión, S.L., a company in the SANITAS Group.

Procedure:

- The Insured member needs to call the special phone number to sign up to the service (900 906 211).
- A personal health advisor will assess the Insured member's health and design an action plan.
- The frequency of calls will be scheduled with the Insured member. These follow-up calls will be made by the personal health adviser.
- The Insured member can call whenever they wish within the hours of service established.

2. EXCLUDED RISKS

The following risks are not covered:

- **Face-to-face consultations or attention.**
- **The purpose of this guarantee does not entail the diagnosis of illness or the prescription of diagnostic tests or medical treatment.**

Second medical opinion cover

Includes a second opinion on medical diagnosis or treatment in the event of serious chronic diseases requiring scheduled care of which the course may require new diagnostic tests or therapeutic measures and whereof the life prognosis is seriously compromised. This second opinion shall be issued by a medical report by leading specialists, healthcare centres, physicians or academics in any country in the world, designated by the Insurer.

To use this service, the Insured can call 93 25 40 538 for an explanation of the procedure to follow and the documentation to supply, which shall include written medical information, X-rays or other image diagnoses, excluding dispatch of any biological or synthetic materials. The dossier shall be sent, with due confidentiality, to the specialist or centre concerned, according to the disease being treated.

When the process ends, the Insured will be sent a second medical opinion report which will include:

- Summary of their clinical history.
- Opinion of the experts consulted.
- Curriculum vitae of these experts.

During the whole of this process the Insured shall be accompanied by a consultant physician responsible for managing the case and advising the patient at all times.

Acute diseases or those requiring an urgent answer are excluded from this service.

Consultations, tests or treatments not performed in accordance with the rules or covers of the healthcare policy will not be covered.

Sabadell Over 60S Home Services

1. PURPOSE OF THE COVER

Sabadell Over 60S Home Services is supplementary cover to the healthcare policy. The benefits shall be covered when the Insured requires hospitalisation for more than 48 hours or is housebound for convalescence, a medical certificate, doctor's report or equivalent certified document of more than 5 days having been issued.

If another Accident or Illness should arise during the same year, the Insured will be entitled to access the services specified in this Annex, up to the annual limit specified for each case.

2. TERRITORY

The Sabadell Over 60S Home Services benefits shall be applicable in Spain for Insureds with their permanent residence in Spain, even if the accident or illness occurs outside Spain. However, the services covered in the benefits described below shall only be provided in Spain.

3. USING THE SERVICES

In order to use the services, the Insured must be up to date with their premium payment obligations. The services will be provided by the provider designated by the Insurance Entity. The Insured must contact that provider on 91 353 63 48 in the shortest possible time after becoming aware of the hospitalisation, immobility or death.

4. BENEFITS INCLUDED

The Insurer shall provide the following benefits to the insured:

Home assistant

Dispatch of auxiliary personnel to the Insured member's home to help with basic household tasks (cleaning, washing, ironing, meal preparation, etc.) **up to a maximum of 30 hours at a ratio of a minimum 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 incapacity to perform basic tasks, the seriousness of the Insured member's injuries and the number of dependent family members.

In any case, but particularly where the Insured member is dissatisfied with the number of hours of home help, or for the purpose of preventing fraud, the provider reserves the right to ask the Insured member for the medical report and tests that have been performed, which will be assessed by a medical team, which will determine and evaluate the Insured member's degree of invalidity and subsequently the hours of home help needed.

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

Personal assistance

Dispatch of personal assistance auxiliary personnel to care for the Insured member, other than domestic tasks, when the Insured member requires personal care, **up to a maximum of 30 hours at a ratio of a minimum of 2 continuous hours per day, starting from the first day.**

- By way of example, the provision of this guarantee includes:
- Assistance with hygiene, personal grooming, showering and/or bathing
- Personal assistance with dressing, putting on footwear and meals
- Movements and mobilisation within the home
- Assistance when eating
- Assistance when taking medication prescribed by the health centre
- Basic care for people who are incontinent
- Assistance with cleanliness and tidiness

Under no circumstances may this guarantee be considered as provision of healthcare personnel to the home, such as nursing, medical specialities, physiotherapy, rehabilitation, occupational therapy, etc.

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 incapacity to perform basic tasks, the seriousness of the Insured member's injuries and the number of dependent family members.

In any case the provider reserves the right to ask the Insured member for the medical report and tests that have been performed.

These hours will be distributed throughout a maximum period of 1 month.

This guarantee should be considered a supplementary guarantee for number 1. The hours of provision for each guarantee cannot be accumulated.

Pet care (cats and dogs) in boarding kennels

When the Insured is housebound or hospitalised, depending on the general event resulting in the claim, and cannot take care of their pets, Sanitas shall arrange and cover the cost of taking care of pets (cats and dogs) at boarding kennels for a maximum of 30 days per claim and a maximum cost of €2000/year. These two limits are global for all claims submitted during the year and for all animals:

- Transport to the boarding kennels and return to permanent residence.
- Board
- Food
- Bath before leaving the boarding kennels
- Veterinary expenses with a separate limit from the aforementioned of up to €300 in case of medical emergency (for cats and dogs)

The deadline for processing the service request will be 72 hours from Monday to Friday (excluding bank holidays): Sanitas shall notify the Insured of the service start date within this deadline

Accompaniment to medical appointments

An assistant will be sent to accompany the Insured to their medical appointments within a 20 km radius of their home. To do this, the provider will arrange a return taxi service. This service will be distributed up to a maximum of **5** times per year. The deadline for processing the service request will be 48 hours from Monday to Friday (excluding bank holidays), starting when the notification is received.

Delivery of medicines

The Insurer will find and send the medicines to the Insured's location. The insured can request this service in the customer area called MI SANITAS, which is accessible via the website www.sanitas.es, and send the prescription prescribed by the SANITAS doctor via electronic means. The service can also be requested by calling 91 353 63 48. In this case, the provider appointed by the Insurer to provide this service will collect the original prescription at the Insured’s home. The cost of the medicines is excluded from

the service and must be paid by the insured on delivery.

The Insurer is not liable for the delay in delivery or the condition of the medicine due to causes not attributable to it. Neither does it guarantee the effectiveness of the service when it cannot be provided for any reason or when it is executed differently than expected. Neither is it liable for cases of delivery delays or defects in the condition of the medicines that cannot be directly attributable to the company that the Insurer has contracted to provide the service. The delivery of thermolabile drugs is not included. The insured has 6 services per year available when required. The deadline for providing the service on receiving notification will be 3 hours.

Hairdresser at home

We will send and cover the cost of a hairdresser to your home up to 3 times a year in the event you are housebound due to illness or accident. To request this benefit, the customer must prove the need to be housebound specified in the event resulting in the claim described in "Insurance Cover".

Professionals at Home

We will send and cover the cost of one of the following professionals, if the therapies have been prescribed by a doctor as a result of an accident or condition that has resulted in the insured being hospitalised for more than 48 hours or housebound for more than 5 days. **The joint limit for all services is 10 sessions/year.**

1. Physiotherapy at home

We will send and cover the cost of a general physiotherapist to come to your home for the therapies prescribed by a doctor as a result of accident or condition **up to the maximum set out in the Professionals at Home section.** At all events, the Insurer reserves the right to ask the Insured for the prescription, report and medical tests performed. This prescription is valid for up to 3 months. Treatment must be continuous, with no less than one month between one session and another. Sessions must be cancelled 24 hours in advance.

2. Home nursing care

We will send a nursing professional to your home to provide the treatment you need as a result of accident or illness that means you must be immobilized at home for more than 5 days. You must submit a prescription for the treatment prescribed by a doctor, describing the services to be performed. The service shall be provided within 48/72 hours, as this is not an emergency service.

The scope of this cover is limited to the professional nursing service described below and does not include medication or any material required in order to provide the service, which must be provided by the insured.
The services provided by the Nursing Professional are the following:

- Injectable drugs (insulin, intramuscular injections, vaccines, etc.)
- Measurement and monitoring of vital signs
- Administration of medication
- Care for bowel and urinary elimination (enemas, urinary catheters, ostomies)
- Colostomy: care and change of bag
- Wound treatment (wounds, contusions, pressure sores)
- End-of-life care
- Post-operative care
- Hypoglycaemic control
- Monitoring and control of patients with diabetes
- Monitoring and control of patients with high blood pressure

The nursing professional shall provide the services included in the cover and according to the prescriptions provided to the Insured, which they must submit. **The number of nursing services per insured**

and year is limited to those set out in the Professionals at Home section.

3. Podiatry at home

A podiatrist shall be sent to the home **up to the maximum set out in the Professionals at Home section per insurance year.** To request this benefit, the customer must prove the need to be immobilized at home specified in the event resulting in the claim described in 'Insurance Cover'.

Foot pressure studies are excluded.

5.GENERAL EXCLUSIONS

Damages, situations, expenses and consequences arising from the following are excluded from the insured cover:

5.1. Surgical procedures and medical treatments demanded by the Insured solely for aesthetic purposes, provided that they are not sequelae from an accident, and injuries or illnesses caused voluntarily by the Insured.

5.2. Those occurring when the Insured is under the influence of alcohol or intoxicated.

5.3. Those occurring due to the consumption of toxic drugs or narcotics not prescribed by a doctor.

5.4. Claims arising directly or indirectly as a consequence of a condition prior to taking out the policy, in accordance with our terms and conditions.

5.5. Those voluntarily caused by the Insured.

5.6. Attempted suicide occurring during the first year of taking out the insurance.

5.7. Those occurring when playing a sport professionally.

5.8. Those resulting from nuclear reaction or radiation or radioactive contamination.

5.9. The following claims covered by the Insurance Compensation Consortium: natural phenomena; earthquakes and tsunamis, extraordinary floods (including giant waves), volcanic eruptions; atypical cyclones (including extraordinary winds with gusts of over 135km/h, and tornadoes) and falling meteors. Violent events as a consequence of terrorism, rebellion, sedition, mutiny and revolt. Action by the armed forces or the security forces during peacetime.

5.10. Wilful misconduct by the Insured.

5.11. Events that due to their magnitude and severity are classified as catastrophic.

Digital Ecosystem

Healthcare programmes

1. PURPOSE OF THE COVER

To provide the Insured with information, guidelines and professional and personalised care via remote communication techniques (phone, chat and video consultation).

2. SCOPE OF THE COVER:

- This cover corresponds exclusively to the Insured and is personal and non-transferrable.
- The video consultation service will be provided in the cases specified by the Insurer and always with an appointment.
- The services included in this cover are provided by Sanitas Emisión S.L., a Sanitas Group company.
- If the Insured is under 18 years old, the conversation will be held with the parent or guardian of the minor.

3. PROCEDURE

- The Insured can request this service via Mi Sanitas at www.sanitas.es or via the mobile app to establish contact via chat, an appointment for a video consultation

or on 91 752 29 04 within the specified service times.
- It offers recommendations for each digital programme, in addition to an advisor to answer any questions and personalised monitoring of each Insured.
- The targets and actions plans of each Insured will be individual and agreed with the Insured.
- The frequency and form of contact to monitor the programme (via phone, chat and video consultation) will be scheduled with the Insured.
- The Insured can also request an appointment with their healthcare advisor whenever they need to hold a consultation via phone, chat or video consultation within the specified service times.
- The services included in this cover are provided if this cover and the policy of which it is part are valid and the premium is paid to date.

4. CUSTOMER SERVICE

The service times are Monday to Friday from 8:00 a.m. to 10:00 p.m., except bank holidays in Spain and local holidays in Madrid.

5. DURATION

This supplementary cover will come into effect on the date expressly specified in the individual terms and conditions of the policy and it will terminate on the expiry date; it is extended for successive 12-month periods under the terms and conditions set out for the main benefit in the general terms and conditions of this policy.

6. RISKS EXCLUDED

Notwithstanding the exclusions set out in the general terms and conditions of the policy, the following exclusions will be specifically applicable to this cover:

- **Consultations or care requiring the physical presence of the doctor.**
- **Diagnosis of illnesses or prescription of diagnostic tests or medical treatment.**
- **Treatment for any illness, congenial or acquired, which to the judgement of the specialist impedes carrying out the plan.**
- **The cover excluded in the general and individual terms and conditions of the policy.**

Below are the details of the programmes available:

Monitoring of chronic diseases

1. PURPOSE OF THE COVER

To provide the Insured with information, guidelines and professional and personalised attention on chronic diseases in order to support the Insured in treating the disease and improving their quality of life.

Service provided by nurses and doctors specialising in chronic diseases specially designated by the Insurer for each case, who work with medical protocols and specific care plans according to the Insured's profile and health.

Other digital benefits

The Insurer shall provide the insured, at not extra cost, with digital benefits associated to caring for their health in addition to or to replace those included in this policy. The scope of the insured cover of these benefits and their limits and exclusions will be available in the Mi Sanitas private area of www.sanitas.es or on the app. Insureds must accept these terms and conditions before using them.

Sabadell Over 60S Digital Add-On

Healthcare programmes

1. PURPOSE OF THE COVER

To provide the Insured with information, guidelines and professional and personalised care via remote communication techniques (phone, chat and video consultation).

2. SCOPE OF THE COVER:

- This cover corresponds exclusively to the Insured and is personal and non-transferrable.
- The video consultation service will be provided in the cases specified by the Insurer and always with an appointment.
- The services included in this cover are provided by Sanitas Emisión S.L., a Sanitas Group company.
- If the Insured is under 18 years old, the conversation will be held with the parent or guardian of the minor.

3. PROCEDURE

- The Insured can request this service via Mi Sanitas at www.sanitas.es or via the mobile app to establish contact via chat, an appointment for a video consultation or on 91 752 29 04 within the specified service times.
- It offers recommendations for each digital programme, in addition to an advisor to answer any questions and personalised monitoring of each Insured.
- The targets and actions plans of each Insured will be individual and agreed with the Insured.
- The frequency and form of contact to monitor the programme (via phone, chat and video consultation) will be scheduled with the Insured.
- The Insured can also request an appointment with their healthcare advisor whenever they need to hold a consultation via phone, chat or video consultation within the specified service times.
- The services included in this cover are provided if this cover and the policy of which it is part are valid and the premium is paid to date.

4. CUSTOMER SERVICE

The service times are Monday to Friday from 8:00 a.m. to 10:00 p.m., except bank holidays in Spain and local holidays in Madrid.

5. DURATION

This supplementary cover will come into effect on the date expressly specified in the individual terms and conditions of the policy and it will terminate on the expiry date; it is extended for successive 12-month periods under the terms and conditions set out for the main benefit in the general terms and conditions of this policy.

6. RISKS EXCLUDED

Notwithstanding the exclusions set out in the general terms and conditions of the policy, the following exclusions will be specifically applicable to this cover:

- **Consultations or care requiring the physical presence of the doctor.**
- **Diagnosis of illnesses or prescription of diagnostic tests or medical treatment.**
- **Treatment for any illness, congenial or acquired, which to the judgement of the specialist impedes carrying out the plan.**
- **The cover excluded in the general and individual terms and conditions of the policy.**

Below are the details of the programmes available:

Personal Trainer and Physiotherapy

1. PURPOSE OF THE COVER

To provide the insured with information, guidelines and professional and personalised care on physical exercise in

order to improve the insured's physical fitness.

Service offered by specialist physiotherapists and personal trainers specially designated by the Insurer for each case, who work with medical protocols and specific care programmes according to the insured's profile and health.

This programme allows more visual monitoring of the targets and the progress achieved on the Mi Sanitas app.

Nutrition

1. PURPOSE OF THE COVER

To provide the insured with information, guidelines and professional and personalised care on nutrition in order to achieve health eating habits.

Service offered by qualified specialists in nutrition and diet who work with medical protocols and specific care programmes according to the insured's profile and health.

This programme allows more visual monitoring of the targets and the progress achieved on the Mi Sanitas app.

2. SPECIFIC RISKS EXCLUDED

Notwithstanding the exclusions outlined above, the following exclusions will be specifically applicable to this cover:

- **Care for the following disorders: underweight (Body Mass Index below 17), eating disorders (anorexia, bulimia, etc.) or any serous disorder/ comorbidity the healthcare professional considers should be monitored through in-person consultations.**
- **Monitoring of morbid obesity (Body Mass Index over 40 or over 35 with associated comorbidities (diabetes, high blood pressure, heart disease, OSA, etc.) are excluded, as these should be monitored according to the protocol defined by the company, after confirming that the insured meets the requirements set out by the Insurer.**

Psychology

1. PURPOSE OF THE COVER

To provide the insured with information, guidelines and professional and personalised care on psychology in order to help the insured achieve psychological wellbeing.

Service offered by psychologists who work with medical protocols and specific care programmes according to the customer's profile and health.

2. SPECIFIC RISKS EXCLUDED

Notwithstanding the exclusions outlined above, the following exclusions will be specifically applicable to this cover:

- **Attention for the following disorders: psychotic, severe depression, eating disorders (anorexia, bulimia, etc.) personality disorders (schizoid, avoidant, dependent, histrionic, borderline, etc.); dementia and cognitive impairment; morbid obesity (this monitoring should be carried out according to the protocol defined by the company, after confirming that the insured meets the requirements set out by the Insurer**).

Healthy Child

1. PURPOSE OF THE COVER

To provide the insured with information, guidelines and professional and personalised care on the health and development of children up to 14 years old in order to complete the information

provided by the paediatrician during in-person consultations and address any queries.

Service provided by paediatric nurses specially designated by the Insurer for each case, who work with medical protocols and specific care plans according to the insured's profile and health.

This programme allows more visual monitoring of the targets and the progress achieved on the Mi Sanitas app.

Pelvic floor care

1. PURPOSE OF THE COVER

To provide the insured with information, guidelines and professional and personalised support on care and rehabilitation of the pelvic floor in order help the insured prevent or improve problems related to the pelvic floor.

Service provided by physiotherapists specially designated by the Insurer for each case, who work with medical protocols and specific care plans according to the insured's profile and health.

Quit smoking

1. PURPOSE OF THE COVER

To provide the insured with information, guidelines and professional and personalised support on giving up smoking in order to support the insured in their decision to give up or reduce their smoking habit.

Service provided by nurses and psychologists specialising in giving up smoking specially designated by the Insurer for each case, who work with medical protocols and specific care plans according to the insured's profile and health.

Digital doctor - Primary care

Primary care health provisions covered by this policy may be provided via the video consulting service under the terms indicated in the section "form of service provision" of these General Terms and Conditions.

1. Primary care video consultation service.

Insured parties seeking primary care through the video consultation service must:

- Register in the "MI SANITAS" restricted members area, which can be accessed through the www.sanitas.es website.
- The Insured party will not be able to choose the doctor they want with the video consultation service, but must speak to the one available when the consultation is requested.
- This service is not available for all the doctors in the medical network for this product. It is for those specifically designated by the Insurer only.
- A video consultation never replaces a face-to-face consultation. It is an auxiliary tool for patient diagnosis and treatment. The doctor may ask the Insured party to arrange a face-to-face consultation when he or she deems it appropriate.

Home analysis service

1. PURPOSE OF THE COVER

Reimbursement of the home analysis service and travel of laboratory staff to the home of the Insured, or the place they are staying, in order to collect a sample for analysis. Blood and urine tests prescribed by a doctor are covered, except for tests for genetic mapping and tests indicated below, which appear in these General Terms and Conditions: all diagnostic, surgical or therapeutic procedures whose

clinical safety and efficacy have not been confirmed scientifically or that **emerge after this policy has been signed**; procedures that are not **standardised or consolidated in standard clinical practice**; those which have **clearly been shown to be inferior** to others available; and procedures of an **experimental nature** or those whose **effective contribution** to disease prevention, treatment or remedy **has not been adequately confirmed**. For the purpose of this policy, a diagnostic, surgical or therapeutic procedure is considered to be safe and effective when it is approved by the European Medicines Agency and/or the Spanish Agency for Medicinal Products and Medical Devices (AEMPS). Similarly, a procedure is considered to be standardized and consolidated when it is performed as part of standard clinical practice in at least nine autonomous communities in Spain, on a general basis, at its public hospitals, not just at flagship hospitals.

Scope of the cover:

- The Insured can choose any legally approved laboratory to perform the analysis:
  - If the laboratory is engaged for provision of the "BLUA Home Analysis" service, the Insured will not have to pay anything for the provision of the service.
  - If the laboratory is not engaged for the provision of the "BLUA Home Analysis" service, the Insured will pay the corresponding amount for provision of the service and may request reimbursement from the Insurer of the travel expenses incurred by the laboratory staff
- The percentage to be reimbursed for each cover is the percentage expressly stipulated in the Particular Terms and Conditions of the policy and up to the insured capital per annuity and Insured.
- To request reimbursement, the Insured must submit an invoice showing payment, with a breakdown of the amount corresponding to the travel of laboratory staff to the place where the Insured is, in addition to any other documentation considered necessary by the Insurer to approve reimbursement under the insured cover.
- This cover takes effect on the date expressly indicated in the Particular Terms and Conditions and provided the policy is up-to-date on payments.
- The service will be provided exclusively to the Insured registered in the policy. Cover is personal and non-transferable.
- **Two services per Insured per annuity** are allowed.
- The geographical scope of this cover is Spain. So the laboratory and the Insured must be in Spain.

Procedure:

- **To request the service, the Insured must have a medical prescription for a laboratory test.**
- **If the laboratory is not engaged to provide the Home Analysis service, the Insured will cover the amount corresponding to travel in order to collect the sample.**
- **The Insured will request an invoice that specifies the amount paid to the laboratory for the tests and the travel, where necessary. These amounts are covered by this complementary home analysis service. Reimbursement by the Insurer of the percentage established in the Particular Terms and Conditions of the policy will be requested up to the insured capital, specified in said Terms and Conditions.**

2. TERM

This cover shall enter into force on the date expressly indicated in the policy's Particular Terms and Conditions and its extinction shall coincide with the date of its expiration. It may be extended for successive annual periods under the same terms and conditions established for the

main cover in the General Terms and Conditions of this policy.

3. EXCLUDED RISKS

Without prejudice to the exclusions specified in the policy's general terms and conditions, the following exclusions apply to this cover:

- **Analyses not accompanied by a medical prescription are not covered.**
- **The covers excluded under the policy's general and Particular Terms and Conditions.**

Pharmacy reimbursement

This consists of reimbursing the amount for medications whose marketing is authorised 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. Only classified magistral formula and officinal preparations listed in the National Formulary of the Spanish of Medicines and Medical Devices (AEMPS) are included.

Herbal medicine and over-the-counter products are expressly excluded.

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 insured capital per year as specified in the above Terms and 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. Any type of healthcare provided in hospital or day hospital, according to the definition of these in the glossary, in addition to any surgical operation performed under any care system.

B. Any healthcare, diagnostic tests or therapeutic methods prescribed or performed by the medical specialisations or healthcare units of radiotherapy, interventionist radiology, or hemodynamics.

C. All high-tech therapeutic methods including the following, regardless of the area of the body, the technique used or the medical speciality by which they are prescribed or performed: auricular foramen ablation administration of chemotherapy, angioplasty, cardioversion, cardiac catheterisation, stenotic dilation, urethral dilations, embolizations, electrophysiological study, fibrinolysis, haemodialysis, heparinization, lithotripsy, bone marrow transplant, valvuloplasty.

D. Any other tests or therapeutic methods, other than those already stated, that are not considered basic.

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

- **Arising as a consequence of international and civil wars, acts of terrorism in any form (chemical, biological, nuclear, etc.), revolutions and military manoeuvres, even in times of peace time, and officially declared epidemics.**
- **Directly or indirectly related to nuclear radiation or radioactive contamination and those resulting from officially declared catastrophes.**
- **Arising from working or professional accidents.**
- **Any services associated to road accidents, whether they occur in Spain or abroad are excluded from the insured cover**, except any urgent attention required or unless the road accident add-on has been taken out.
- **Those occurring whilst the insured is doing extreme sports as an amateur, for example aerial activities, high speed motor sports, scuba diving, off-piste skiing or ski jumping, bobsleigh, rock climbing, boxing, any type of wrestling, bull fighting and encierros, martial arts, rugby, quad biking, caving, sailing or rafting activities, bungee jumping, hydrospeeding, canyoning, parachuting, paragliding, hot air ballooning, free flying, gliding, hunting, horse riding and any other activity with a similar risk and those resulting from sports competitions, including training sessions.**

F. The healthcare provided in:

- **Social Security centres or services or integrated in the National Health Service. Cross-border healthcare is also excluded.**
- **Health centres or integrative medicine clinics or any center in general that is not restricted to providing conventional medicine services only, these being those provided by a profession regulated by Law 44/2003, of 21 November, on the management of medical professions and which is a service set out in Royal Decree 1030/2006, of 15 September, which defines the portfolio of common services of the National Health Service and the procedure for updating it. The aforementioned applies regardless of**

whether these services are provided by registered medical professionals and in the course of treatment are combined with services that would be included in the aforementioned law and that would not be included in the insured cover either.

Be considered alternative medicine, naturopathy, homeopathy, acupuncture, mesotherapy, hydrotherapy, deep pressure therapy, ozone therapy, chiropractic, or any other therapy not included in the services set out in Royal Decree 1030/2006, of 15 September, which defines the portfolio of common services of the National Health Service and the procedure for updating it.

G. Hospitalisation for problems of a social nature.

H. Medical and/or hospital care provided to the Insured by a doctor or a member of their professional team who is or has been the spouse or relative by consanguinity or affinity (up to the 4th degree) of the Policyholder or the Insured.

Medical and/or hospital care provided to the Insured by a doctor who has a dependency relationship with the Insured or Policyholder through a professional, work or commercial relationship, or who is associated to any of them through any partnership or stakeholder relationship.

I 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 intent or gross negligence of the Insured.

J. All means, methods, tests, techniques or diagnostic, surgical or therapeutic procedures (hereinafter the "Techniques") that arise after taking out the policy or each annual extension of the policy. This exclusion will only apply if the policy covers other alternative Techniques to the new technique, even if they are not similar, and which have not become clearly obsolete, fallen into disuse or surpassed by the new Technique in question.

Likewise, any Techniques performed within a clinical trial or that, due to their lack of safety or effectiveness, are not used in normal clinical practice are excluded; these being any techniques that are not approved by the European Medicines Agency and/or the Spanish Agency of Medicines and Medical Devices and by the Health Technology Assessment Agencies of the health services of the Autonomous Communities or the Ministry of Health.

All therapeutic methods, surgical techniques or diagnostic tests that have been clearly surpassed by others available are also excluded from the cover.

The Techniques that the Insurer informs the Policyholder are included in the policy will be included under the terms and conditions within the limits set out in said communications.

The contents of this section are understood to be without affecting the other exclusions set out in this policy.

K. Any type of service relating to:

- **Diseases or treatments not covered or any medical service that is directly associated with a treatment that has not been provided under the insured cover of the policy because it is not included in it.**

- **Specific diagnosis and treatment, including surgery, aimed at addressing infertility in both sexes, except for the tests listed in the corresponding gynaecology and urology section (in vitro fertilization, artificial insemination, etc.), or impotence and erectile dysfunction, including sex change surgery.**

- **Voluntary interruption of pregnancy.**
- **Also any assistance required by the Insured when acting as organ donor.**
- **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 present or future offspring to certain diseases related to genetic disorders. Genetic mapping of tumours and pharmacogenetics are also expressly excluded.**
- **Any type of prosthesis, osteosynthesis material, orthopaedic and implantable material (internal and external) as well as any healthcare related to its placement, review or removal from the patient.**
- **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 type of abdominoplasty. 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.**
- **Treatments with platelet-rich plasma, growth factors and stem cells.**
- **Hyaluronic acid, whether sold as a medicine or health product.**
- **Educational therapy and language education in processes unrelated to organic disease of the vocal tract and special education for 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, pressotherapy, ozone therapy, chiropractic, etc. All care provided in integrative medicine medical centres or clinics or that combine medical care and non-conventional therapies recognised as pseudo-therapies by the Spanish Ministry of Health and the Spanish Medical Association is excluded.**
- **Services or techniques that merely consist of leisure, rest, comfort or sporting activities, similarly treatments at spas and repose treatments.**
- **Orthosis, orthopaedic products, anatomical products, glasses, contact lenses, hearing devices, and others.**
- **All treatments with hyperbaric chamber are excluded.**
- **Any radiofrequency treatment at musculoskeletal level, except vertebrae.**

L. All healthcare techniques or therapeutic procedures using laser.

M. Travel expenses except those covered in the ambulance section or in the evacuation and repatriation complementary section when included on these general Terms and Conditions.

N. Administration and cost of medications under any care scheme.

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:**

Qualification Periods for the modality of Contracted Medical Network:

- **Complex diagnosis tests: 9 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 chooses in each case. **When a certain treatment or surgical or diagnostic method is not included in the insured cover, the medical care services that must be provided as a result of undergoing the aforementioned treatment or method shall not be included in the insured cover either.**

On receiving applicable services, the Insured must present his/her the Insurer card. Also the Insured must show his/her National Identity 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 Terms and Conditions.

The Insurer 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 the consulting rooms of consultants, general physicians and paediatrics, as well as the emergency centres that belong to the contracted medical network by the Insurer for this product. **Please check your User Guide to Doctors and Services for those consultants for which you will need prescription/authorisation.**

1.2 Prior prescription for the performance of the service
Diagnosis tests, simple therapeutic methods, and certain care services will require, for their performance, written prescription by a physician belonging to the Insurer medical network.

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

1.3 Prior prescription and authorisation for the performance of the service.
Generally, the express prior authorisation from the Insurer will be necessary following written prescription from the healthcare professionals of the Entity for certain therapeutic methods, diagnostic tests and other healthcare services, providing this is indicated in the terms and conditions of the policy. The authorisation 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 Terms and Conditions of his/her policy to access to the full insured coverage relating to the service indicated in such authorisation voucher (i.e. no being current on payments of the premium, preexisting condition not declared, if the policy is not in force when the service is provided, etc.).

1.4 Prior authorisation for the service to be performed by expressly accredited professionals.
Any services performed by laparoscopy or arthroscopy, in addition to those performed by radiofrequency technique and laser, will have to be undertaken by professionals who are specially engaged and accredited by the Insurer to carry out these particular techniques.

1.5 Services at the Insured's home.
The Insurer undertakes to provide home services in those localities where it has an

arrangement for the provision of this service. **Any change of the Insured's home address must be reliably notified** with a minimum of eight days' notice before requiring any service.

Services provided in the Insured's home are those relating to the specialties of Family Medicine, Paediatric Medicine, Emergency Care, Nursing, Special Home Care and Respiratory Therapies. All of these require a doctor's prescription except Family Medicine and Paediatric Medicine. The Insurer reserves the right not to provide the service when in the doctor's opinion it is not necessary.

Specifically, respiratory therapies must be prescribed by a specialist appointed by the Insurer. In all treatments, the insured must renew the service prescription and authorisation from the Insurer with a variable frequency according to the type of device and sessions authorised in each case, except for CPAP for patients already classified as chronic, who have indefinite authorisation that does not need to be renewed, except under exceptional circumstances (change of province of residence, change of policy).

1.6 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 the Insurer for such performance. The Insured must present his/her the Insurer card in the Offices of the contracted Entities, accepting the administrative steps of these Entities.

1.7 Emergencies
As specified in article 103 of the Insurance Contract Act, the Insurer provides 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 the Insurer, expressly indicated in the User Guide to Doctors and Services for this product.

1.8 Care at facilities not partnered with the Insurer.
The Insurer will only cover healthcare provided to the Insured party at facilities not partnered with it in the case of a life-threatening emergency of one of the medical provision covered by this policy.

2. Remote medical consultations

The Insured may access certain physicians and specialities from the partnered medical network to receive customised medical care via the video consultation and phone consultation services, hereinafter "Remote medical consultations".

In addition, the insured can access a 24-hour Emergencies service via video consultation.

2.1. Description:

- The service shall be provided by specialist physicians selected by the Insurer from within the the Insurer partnered medical network.
- The Insurer will provide information at all times at www.sanitas.es regarding the specialities and physicians who you can access via the remote medical consultations.
- This service shall always be provided after a previous appointment has been made and is not valid for emergency care, which shall be attended in the Insurer partner centres for due management. Subject to the availability of each specialist's schedule and opening hours. You can check these hours at Mi Sanitas. As an exception to the aforementioned, any emergency care that may be provided through the video consultation service will not require an appointment. For emergencies that, due to their nature, cannot be treated through the aforementioned services, the insured has access to the emergency services in the the Insurer partnered medical network.
- A service accompanied by the instant messaging functionality, during remote

medical consultations and afterwards if the doctor considers it appropriate.

- Remote medical consultations may involve exchanging medical documentation that can be filed in the Mi Sanitas Health File at www.sanitas.es.

- The Insurer has adopted the legally required technical resources to guarantee due confidentiality of information exchanged in this fashion.

- In order to guarantee said confidentiality, recording images and sound from remote medical consultations or attaching them to any type of capturing medium is strictly prohibited. The full or partial copying, reproduction, distribution, dissemination, making available to third parties or any other way of publicly communicating, transforming or modifying by any means, whether electronic or any other, the image or sound obtained or produced during remote medical consultations is also strictly prohibited, without the express written consent of the physician concerned or Sanitas S.A. de Hospitales. However, the physician may keep a copy of remote medical consultation for the purpose of storing it with the clinical documentation.

- The service shall be provided exclusively to those Insured who expressly appear as registered as such on the policy. Each Insured must book an appointment to receive the service, except for remote medical consultation in 24-hour emergencies. Remote medical consultation must be customised for each Insured party.

- If the Insured is under 18 years of age, remote medical consultation may only be performed with the prior authorisation of the minor's legal representative.

- The Insured must have and shall be responsible for all technical (hardware and software) and remote communication means needed to guarantee the correct performance of remote medical consultation. The Insurer shall not be held responsible for any harm that may be caused due to failure of electronic devices, connections or shortfalls of these means on the part of the Insured.

- This form of consultation is simply to aid decision-making on the part of the physician and does not replace a face-to-face consultation or make it possible to diagnose diseases or prescribe diagnostic tests or medical treatments in cases where, in the doctor's opinion, the Insured must be present in the consulting room for a personal and direct assessment, including a physical examination of the Insured by the specialist. The results of the face-to-face consultation will always prevail over any assessments and criteria performed in remote medical consultation.

- Consultations performed through remote medical consultations by professionals not expressly authorised by the Insurer to attend the Insured through remote medical consultations are not covered, regardless of whether they belong to the the Insurer partnered medical network for this product or not.

2.2. Procedure:

- The Insured must request this service via Mi Sanitas at www.sanitas.es or via the mobile app, except for the remote medical consultation in 24-hour emergencies.

- The Insured must connect to Mi Sanitas on the date and time of the appointment to establish contact with the doctor and begin the remote medical consultation and follow any other instructions provided by the Insurer at all times.

3. Home services

The Insured may request the home services included in the cover of this policy by calling 91 353 63 48. The home delivery of medicines service can also be requested via the Mi Sanitas private area on the app or website.

Clause VI: Other features of the insurance

1. Basis and loss of rights of the policy

1.1. The **present agreement** has been closed on the basis of the **declarations made by the Policyholder and the Insured in the health questionnaire included in the insurance application, where questions are made referring to the state of health of their health 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 the Insurer, 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 the Insurer did not submit questionnaire or even when the Insurer did, there are circumstances that may influence the risk assessment and that are not included in it.

The Insurer may terminate the contract by declaration addressed to the Policyholder within a month, as of knowledge or inaccuracy of the Policyholder. They correspond to the Insurer 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 the Insurer makes the statement to which the preceding paragraph refers, the provision will be reduced proportionally to the difference between the agreed premium and that which would have applied had the true risk been known. If there was fraud or gross fault on the part of the Policyholder, the Insurer will be released from payment of the benefit (Art. 10 of the Insurance Contract Act).

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

1.4. The Policyholder can terminate the agreement when the medical network is changed, providing the change affects to 50% of the consultants that are part of the national medical network of the Insurer, who will have available for the Insured, at all times, in the Insurer 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, the Insurer may only contest the policy if the Insured's true age exceeds the established limits for this when the policy comes into force.

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, except for the cost on the services, where applicable, already provided.**

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

2. Maximum age for taking out the policy

With no age limit for taking out the contract, without affecting the maximum ages that may

be defined for the different additional or complementary coverages, where applicable, included in this Policy.

3. Duration of insurance

3.1. The Insurance Contract expiry date shall be established in its particular terms and conditions and, at its expiry, in accordance with Article 22 of the Insurance Contract Act, it shall be extended tacitly for periods of one year. Nevertheless, either of the parties may repudiate extension by giving the other party due written notice not less than two (2) months before the date of expiration of the current period, if it is SANITAS that gives this notice and one month if it is the Policyholder who gives it.

3.2. If the insurance policy is terminated unilaterally at the discretion of the Insurer, 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 **or unless the policy is terminated due to fraud or gross negligence on the part of the Insured.**

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 the Insurer 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.

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

a) To death.

b) For any action of the Insured against healthcare or administrative staff that may violate the right to personal honor and dignity or may be a crime.

3.4. 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.

4. Insurance premiums

4.1. The Insurance Policyholder must pay the premium when the contract is accepted. The cover in the contract will not come into force until the contract has been signed and the first premium has been paid.

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

4.3. 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.

4.4. If, due to the Policyholder's fault, the first premium is not paid, the Insurer is entitled to terminate the contract or legally demand payment based on the Policy. Where payment is not received before the claim arises, the Insurer 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, the Insurer coverage shall be suspended one month after the due date of the premium.

Where the Insurer 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, the Insurer 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 the Insurer.

4.5. 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 the Insurer. 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.

4.6. 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 the Insurer with the details of his/her bank account where the payment of the receipts for this Insurance are to be debited and shall authorise the bank to pay them.

4.7. 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 the Insurer on the date of renewal of each policy being applicable. Such variation of premiums shall be communicated in writing by the Insurer to the Policyholder with at least two months' notice with respect to the renewal date.

4.8. The Policyholder, after receiving notification from the Insurer about the **variation to the premium for the next year can choose to accept the Insurance Contract renewal for the premium proposed by the Insurer or terminate it when the Insurance term in progress ends, in the latter case notifying the Insurer in writing, at least one month before the expiry date, of your wish to terminate it.**

5. Provision of reports

The Policyholder and Insured must provide the Insurer, 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. The Insurer 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 the Insurer lies with the Spanish State and is exercised through the Directorate General for Insurance and Pension Funds of the Ministry of Economic Affairs and Digital Transformation.

b) In case of any type of complaint in relation to the Insurance Policy, for the settlement thereof the Policyholder, Insured, Beneficiary,

Aggrieved Third Party or Successor of any of these should proceed to address:

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

2. Once this internal process has been exhausted or in the event of disagreement with the decision of the Insurer, a signed written complaint, with the claimant's National Identification Document or a document accrediting their identity, may be lodged with **Complaints Service of the Directorate General for Insurance and Pension Funds, on paper or electronically with a digital signature, via its website**. Accordingly, the claimant must prove that the established period for the settlement of the complaint by the Insurer Complaints Management Department has expired, that the complaint has been denied leave to proceed or has been dismissed.

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

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

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

7. Other important legal points

7.1. Subrogation

Once payment of the covered benefit has been assumed, the Insurer 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 the Insurer.

7.2. How to accept the Terms and Conditions

the Insurer will send the Policyholder an email at the address provided in the application form, which will include a link for registering on the website and choosing a security ID.
Any notifications sent by an insurance broker on behalf of the Policyholder will have the same effect as if they were sent by the Policyholder, unless the latter specifies otherwise.

After receiving the password, the Policyholder must go to www.sanitas.es, where the General and Individual Terms and Conditions of the policy are available, which he/she must accept using a code that will be sent to the mobile phone number provided in the insurance application form. For all intents and purposes, using the security ID will be legally equivalent to the policyholder's written signature. the Insurer may refuse to provide the insured cover if the Policyholder does not accept the Policy terms and conditions.

7.3. Notifications

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

7.3.2. Notifications from the Insurer to the Policyholder, Insured or Beneficiary will be sent to the physical or electronic address or to the phone number provided by the Policyholder for each of them when filling out

the insurance application form, unless they notify any changes. The Policyholder authorises the Insurer to send any notifications via electronic means, provided that it is permitted by law.

7.3.3. The Policyholder authorises the Insurer to use his/her mobile phone number and email address to send all notifications, communications and information associated to the policy and to request consent/authorisation for certain medical services via electronic means, provided that it is permitted by law.

7.3.4. The Policyholder accepts the full validity and effectiveness of any notification sent by the Insurer to their home, email address or telephone number provided in the insurance application form, until notified of any changes.

7.3.5. The policyholder accepts the terms and conditions above on his/her behalf and on behalf of the insureds on the policy.

8. Data Protection clause

The personal data, including identity and health data (hereinafter Personal Data), of the Applicant, Policyholder and Insureds (hereinafter Interested Parties), provided through the insurance application form will be processed, in addition to that gathered and provided whilst the contract is in force. The Personal Data is confidential and appropriately protected. The applicant or policyholder guarantees that all of the information about the policyholder and insured(s) provided to Sanitas and Sabadell Seguros is true and that no information has been omitted regarding the health of each insured. The applicant shall be solely liable for any damage or loss, direct or indirect, which may be caused to Sanitas, Sabadell Seguros or to any third party as a result of documents provided to Sanitas and/or Sabadell Seguros containing false, inaccurate, incomplete or outdated data.

The policyholder is responsible for transferring the information contained in this personal data processing clause to all insureds included on the policy, so that both the policyholder and insureds can exercise the rights set out in the Rights of the Interested Parties section.

Similarly, the applicant/policyholder declares that they are acting on their own behalf and on behalf of the insureds when consenting to the data processing set out in this clause. Similarly, the applicant/policyholder states that the insureds understand and accept that they have provided or are providing their personal data to Sanitas and Sabadell Seguros and that Sanitas and Sabadell Seguros provide the applicant/policyholder with identity details regarding the insureds' medical services covered by the policy, unless the policyholder releases Sanitas from its legal duty to inform them in writing or when requested by any of the insureds.

In the case of group policies, the customer entity of the co-insurers (which could be the same as the policyholder in some cases) and the co-insurers may transfer, occasionally and when strictly necessary, the identity details of the minimum and essential insureds to verify that they meet the requirements to benefit from the policy agreed between the customer entity and the co-insurers, or to control the claims rate and consequently, agree on the insurance premium to be applied. The customer entity of the co-insurers assumes the responsibility of informing all insureds of this situation. This data processing is necessary in order to correctly implement and execute the insurance contract.

8.1. Joint personal data controllers

The personal data of the interested parties will be subject to processing, as joint controllers, by the following co-insurance entities:

- **BanSabadellSegurosGenerales, S.A. de Seguros y Reaseguros**, with registered offices at C/ Isabel Colbrand, 22, 28050 Madrid and tax ID A-64194590 (hereinafter **Sabadell Seguros**). Sabadell Seguros is registered on the Register of Insurance Entities of the Directorate-General of Insurance and Pension Funds under entry C-0767 and qualified to operate in the health branch. If you have any questions or

requirements regarding personal data protection, you can contact your Data Protection Officer at DPO_BSSegurosGenerales@BSSeg.com or at the aforementioned postal address.

- **SANITAS, Sociedad Anónima. de Seguros**, with registered offices at C/ Ribera del Loira, 52, 28042, Madrid (hereinafter **Sanitas**). Sanitas is registered on the Register of Insurance Entities of the Directorate-General of Insurance and Pension Funds under entry C0320 and qualified to operate in the health branch. If you have any questions or requirements regarding personal data protection, you can contact your Data Protection Officer at dpo@sanitas.es or at the aforementioned postal address.

8.2 Main purposes and legitimacy of personal data processing

(a) Formalise, develop and implement the insurance contract.
Personal Data processing is necessary in order to formalise, develop, and implement the healthcare insurance contract. This comprises managing and providing support in caring for the health of the applicant/policyholder/insured, and other purposes. Thus, Sabadell Seguros and Sanitas will process the personal data of the applicant/policyholder/insured to manage the relationship with these, manage the policy, and other purposes, and in some cases for automated decision-making based only on analysis procedures for these purposes. In these cases, the interested parties shall have the right to review and challenge the decision and to request human intervention through the channels set out in the Rights of the Interested Parties section. Sanitas may process the Personal Data to conduct surveys on satisfaction with the services received as a result of the contractual relationship and to manage the co-insurance, where applicable.This purpose is based on the need for processing in order to implement these terms and conditions and to manage the healthcare and social care systems and services.

(b) Financial solvency analysis.
Sabadell Seguros and Sanitas may process the identity data of the applicant to consult credit information file systems before taking out the policy as a means of analysing their financial solvency and to prevent and detect possible fraudulent conduct, based on our legitimate interest in adopting the measures necessary to identify and manage possible insurance-related fraudulent conduct.

(c) Technical analysis.
Sabadell Seguros and Sanitas may process personal data, including health data, to perform statistical analysis of the functioning of the technology that supports the services provided, in order to apply technical, security improvements, etc. To do this, we may use the information that you generate by using the technological resources that we offer you in order to improve quality, correct errors, improve usability, etc., based on our legitimate interest in improving the quality of technological resources.

(d) Manage the provision and cover of the healthcare service.
This processing activity involves requesting and obtaining information on the health of the interested parties in order to manage provision of the services included in the insurance contract, assess the cover and appropriate payment to the health providers or reimburse the insured or their beneficiaries for healthcare expenses, and other purposes. For this purpose, they may share and transfer personal data with one another, with the medical professionals who provide the healthcare service, even requesting and obtaining information about your health from these healthcare professionals in order to evaluate the cover and the appropriate payment or reimbursement for the services provided. Likewise, as part of managing the provision and cover of the healthcare service included in the contract, comprising supporting the policyholder/insured in caring for their health, and other purposes, Sanitas may prepare profiles based on their personal data, including health data, to send personalised information, such as guidelines and advice that help the policyholder/insured to take care of their health.

This purpose is based on the need for processing in order to implement these terms and conditions and to manage the healthcare and social care systems and services.

(e) Research by creating profiles in order to design the healthcare models included in this contract.
Sanitas may need to process the policyholder/insured's personal data, including health data, to prepare profiles that allow Sanitas to design healthcare models adapted to these profiles in order to provide the prevention service to the policyholder/insured, as part of the cover included in this healthcare insurance contract taken out by the policyholder. This purpose is based on the need for processing in order to implement these terms and conditions and to manage the healthcare or treatment.

(f) Offer and manage the care and prevention programmes included in this contract.
As part of its support in caring for the policyholder/insured's health, and using the analyses and profiles carried out, Sanitas shall offer the policyholder/insured healthcare and prevention programmes designed according to the previous section. The healthcare and prevention programmes shall be offered and managed bearing in mind the characteristics and specific needs of the policyholder/insured. Therefore, Sanitas shall need to process their personal health data in order to offer and manage the healthcare models that specifically adapt to the policyholder/insured. This purpose is based on the need for processing in order to implement these terms and conditions and to manage the healthcare or treatment.

(g) Manage the health promotion service.
As part of the healthcare support provided under the existing contractual relationship, Sabadell Seguros and Sanitas needs to process the policyholder/insured's personal data, including health data, in order to design specific health management plans for each interested party. To this end, as a result of the profiling based on the interested party's personal data, Sabadell Seguros and Sanitas shall manage the formulation of personalised health plans and proactive monitoring programs in order to ease management of complex cases (such as serious illnesses or prolonged hospitalisation), and shall manage the provision of chronic patient care and also the provision of emergency care. This purpose is based on the need for processing in order to implement these terms and conditions and to manage the healthcare or treatment.

(h) Manage access and use of the MiSanitas tool available as part of the insurance contract.
Sanitas may need to process the policyholder/insured's personal data, including health data, in order to manage and provide access to the interested party and ensure the correct functioning, of MiSanitas (the insurance management portal), either through the website or app developed for this purpose. In the context of using MiSanitas, it shall process the personal data to offer the interested party health recommendations and provide information and messages about receipts and reimbursements, and enable them to manage their appointments, etc. This purpose is based on the need for processing in order to implement these terms and conditions and to manage the healthcare and social care systems and services.

In addition, as part of the service Sanitas provides the policyholder/insured with a Health Folder service (accessible via MiSanitas) so that they can request the transfer and filing of personal data, including health data, (e.g. doctor's reports or diagnostic tests) in a tool for the exclusive use of the policyholder/insured. However, if the policyholder/insured decides to use this service, privacy information will be provided separately from this policy.

(i) Manage the video consultation and chat service.
This processing activity requires obtaining and managing new information and data (including health data) gathered from the interested party via their remote communications with the healthcare professional and by providing documentation in order to answer the queries of the

interested party in the context of the medical care provided. In this context, Sanitas will process, and where appropriate, transfer personal data to the third parties designated by the policyholder/insured in order to provide the video consultation, chat or other services made available by Sanitas to the extent that it is part of the policyholder/insured's insurance benefits. This purpose is based on the need for processing in order to implement these terms and conditions and to manage the healthcare and social care systems and services. Likewise, it will be able to manage the recording of the video consultations held as a result of using the 24-hour Emergencies service in order to manage claims related to the service received via video consultation by the policyholder/insured, based on the need for treatment for the aforementioned purpose and to meet the legitimate interest of Sanitas in storing the documents that allow processing of queries and claims from the policyholder/insured. Sanitas will also be able to manage the recording of the video consultations held within the framework of the 24-hour Emergencies service in order to improve the quality of service provided, albeit always with your consent.

(j) Actuarial risk management.
Sabadell Seguros and Sanitas will need to process the policyholder/insured's personal data, including health data, in order to carry out a statistical-actuarial analysis for both determining the associated risk and pricing of the policies of customers and potential customers either prior to taking out the insurance policy or whilst it is in force in response to the new circumstances of the insured or a change in the actuarial base. This purpose is legal as this processing is necessary in order to fulfil a legal obligation, which is imposed by the regulations applicable to insurance and reinsurance entities; and for managing healthcare and social care systems and services.

(k) Record the telephone conversations held between the interested parties and Sanitas in relation to this policy.
The recordings will be made for use in Sanitas' quality control processes in order to improve the quality of the service provided to the interested parties, based on Sanitas' legitimate interest in maintaining quality control processes and for managing healthcare and social care systems and services. Likewise, Sanitas may use these recordings, where applicable, as evidence in the case of any claim that may arise between the parties, protecting the confidentiality of the conversations held, based on the legitimate interest of Sanitas in formulating, exercising or ensuring the defence of claims and the need for processing to ensure the above. The interested party may ask Sanitas for a copy or written transcription of the recorded conversations between the two parties via the channels specified in the Rights of Interested Parties section.

(l) Meet the obligations legally required of the co-insurers.
In some cases, Sabadell Seguros and Sanitas shall need to process the policyholder/insured's personal data, including health data, in order to meet their legal obligations. Sabadell Seguros and Sanitas shall process the personal data in order to meet the obligations set out in the insurance act, tax laws and data protection regulations, and others. This purpose is legal as this processing is necessary in order to fulfil legal obligations applicable to Sanitas and for managing healthcare and social care systems and services.

(m) For Sabadell Seguros to send marketing communications.
Sabadell Seguros may contact the applicant/policyholder/insured to inform them about the services included in their contract, special offers or similar or complementary products to those taken out that may be of interest and also to ascertain their opinion and level of satisfaction with the service received. In order to continually improve the customer experience and correctly personalise the communications, it may occasionally prepare segmentations or profiles based on the applicant/policyholder/insured's personal data and take individual automated decisions. For this purpose and to ensure internal management of the co-insurance relationship between the joint data controllers, it may

occasionally be necessary for Sabadell Seguros and Sanitas to exchange data.

This purpose is legal because it is necessary in order to meet the legitimate interest of Sabadell Seguros in sending its customers information and recommendations related to its products and services that may be of interest, which are similar or complementary to those taken out. However, Sabadell Seguros guarantees the interested parties (a) their right to oppose personal data processing for direct marketing purposes and (b) their right to obtain human intervention by expressing their opinion and impugning any individual automated decision taken.

(n) For Sanitas to prepare profiles for marketing purposes and to commercially improve the services provided.

Our goal is to offer the applicant/policyholder/insured the products and services that best suit their interests and needs. To do this, Sanitas may take automated decisions based on preparing profiles using the applicant or policyholder/insured's personal data, including their health data, in order to adapt their experience with Sanitas as closely as possible to their needs and personalise it during provision of the service included in the insurance contract. In particular, the above will be carried out in order to:

1. Manage and send marketing communications based on the applicant's or policyholder/insured's profile via any channel, including electronic, related to similar products and services to those included in the insurance contract. This purpose is legal based on the legitimate interest of Sanitas and Sabadell Seguros to publicise the services, new products, special offers, etc. that best suit the applicant's or policyholder/insured's profile related to the services included in the contract and to manage the healthcare and social care systems and services. If the insurance has not been taken out, the purpose is legal based on the interested party's consent, as the data is processed with prior authorisation.

2. Send marketing communications based on the applicant's or policyholder/insured's profile via any channel, including electronic, related to new products and services. The purpose is legal, based on the interested party's consent, as the data is processed with prior authorisation.

3. Send marketing communications based on the applicant's or policyholder/insured's profile via any channel, including electronic, related to third-party products and services. The purpose is legal, based on the interested party's consent, as the data is processed with prior authorisation.

4. Anticipate the health needs of the policyholder/insured, including, for example, detecting when resources need to be increased in order to offer personalised care to the policyholder/insured. This purpose is legal, based on the legitimate interest of Sanitas and Sabadell Seguros to offer the best possible services to support the policyholder/insured in taking care of their health and the need for processing to manage the healthcare and social care systems and services.

(o) Carry out anonymization and pseudonymization procedures on the personal data, including health data, for marketing purposes, to improve the relationship with the policyholder/insured and for scientific research or statistics.

Sabadell Seguros and Sanitas may occasionally apply certain processing methods to the applicant's and policyholder/insured's personal data, including health data, in order to prevent it from being possible to establish a relationship between the physical person identified or identifiable and the personal data processed or to prevent the personal data from being attributed to a certain person without using additional information that is stored separately. These procedures will be applied in order to process the anonymized or pseudo-anonymized data for scientific or statistical research purposes, or in order to ascertain the trends in the health of individuals, according to certain factors, for example, usage of the health insurance, establish disease patterns, etc., and in order to understand which services best suit certain groups and inform them and, ultimately, to improve the relationship

between Sabadell Seguros and/or Sanitas and the policyholder/insured. This purpose is legal based on the legitimate interest of Sanitas and Sabadell Seguros to manage the healthcare and social care systems and services and based on its need for scientific research or statistics purposes.

(p) Transfer personal data to group companies.
1. In order to send marketing communications from the respective group companies based on the interested party's profile via any channel, including electronic, and based on the consent given by the interested party.

2. In order to anticipate the policyholder/insured's health needs by the respective group companies preparing profiles and carrying out statistical analyses in order to improve the services provided by group companies and offer them to the policyholder/insured, depending on their individual characteristics, based on the consent given by the interested party.

3. For internal administration purposes, based on the legitimate interest of Sabadell Seguros and Sanitas in sharing and optimising systems and processes within the corporate group for internal administration purposes, including processing customers personal data.

(q) Transfer personal data to third parties.
Sabadell Seguros and Sanitas may transfer the applicant/insured's personal data to any entity with which it establishes collaboration links in order to implement the contractual relationship with the applicant/insured. In particular, the categories of recipients, identified in the Additional Information, will be co-insurers and reinsurers, insurance brokers, entities with which a business link is established, health professionals, medical centres, hospitals and others. Sabadell Seguros and Sanitas may transfer the personal data:

1. For risk reinsurance purposes, based on the legitimate interest of Sanitas and Sabadell Seguros in managing the risk taken on and the need for processing in order to manage the healthcare and social care systems and services.

2. Analyse usage of the Sanitas website and apps based on the consent given by the interested party.

8.3 Source of the personal data

The source of the personal data may vary in each case. In particular, Sabadell Seguros and Sanitas sell their healthcare insurance products as co-insurers through the Operador de Bancaseguros Vinculado **BanSabadell Mediación, OBSV, del Grupo Banco Sabadell, S.A.**, which gathers, as the processor, the personal data of the interested parties, including health data, on behalf of the co-insurance entities. Likewise, other personal data that may be processed is that provided through forms (such as the contact form) and which has been generated as a result of providing the service or that has been obtained from brokers or collaborating third parties.

8.4. Personal data storage period

Sabadell Seguros and Sanitas will process the policyholder/insured's personal data and store it for the duration of the contractual relationship with the policyholder/insured or until the obligations applicable by law expire.

For the purposes for which the policyholder/insured has given their consent to process their personal data or for which there is the option to object, Sanitas will cease to process the personal data for that particular purpose immediately after the interested party withdraws their consent or exercises their right to oppose.

All of the above is understood without affecting the subsequent storage required in order to formulate, exercise or defend potential claims, to comply with clinical documentation storage obligations, applicable law permitting, or to make personal data available to judges and courts, the Public Prosecutor's Office or Public Administrations. During this additional period, Sabadell Seguros and Sanitas shall store the personal data locked. When this period ends, Sabadell

Seguros and Sanitas undertake to stop processing the personal data. Notwithstanding the above, personal data may be kept for longer periods when necessary, provided that it is processed exclusively for healthcare, medical, scientific or statistical research purposes and taking into account the specific case. More information is available in Additional Information.

8.5. Access to personal data

For optimum provision of the service, third-party Sabadell Seguros and Sanitas service providers may need to access the policyholder/insured's personal data as the data processors.

The applicant/policyholder/insured understand that some of these service providers may be located in countries outside the European Economic Area or do not offer a level of security equivalent to Spain. To ensure that personal data is processed with a level of security equivalent to that already in place, Sabadell Seguros and Sanitas have adopted the appropriate guarantees. Likewise, international transfers are made under the protection of an adequacy decision from the European Commission, under the protection of the authorisation of the Spanish Agency for Data Protection or are covered by appropriate security measures. More information about international transfers is available at International Data Transfers at www.sanitas.es/RGPD. To obtain a copy of said authorisation, the applicant/policyholder/insured can contact Sanitas through the means set out in the Rights of Interested Parties section.

In addition to the access to personal data that third-party providers may have as national or international data processors, within the framework of providing a service, Sabadell and Sanitas shall transfer personal data to other entities, within the group or third-party entities, as specified in the Main Purposes and Legitimacy of Personal Data section.

In addition to the above, the applicant/policyholder/insured understands that Sabadell Seguros and Sanitas may transfer or communicate personal data in order to meet their obligations with Public Administrations, the General Directorate of Insurance and Pension Funds, or the Spanish Tax Office, when required, in accordance with current law, and where appropriate, to others bodies such as the National Security Forces and Legal Bodies.

Likewise, the applicant/policyholder/insured understands that Sabadell Seguros and Sanitas may request, require and share their personal and health data with health professionals or centres, hospitals and other entities, including co-insurance entities and entities with which it maintains reinsurance or collaboration relationships and they therefore understand that it will be necessary for these to reciprocally transfer their personal data in order to manage reinsurance, co-insurance, comprehensive care programs, for better knowledge and assessment of the risks to be covered, fraud prevention, to determine the healthcare required, payment to healthcare providers or reimbursement of healthcare expenses to the insured and to process the claims submitted by the insureds.

8.6. Rights of interested parties

Interested parties may exercise their rights of access, rectification, objection, deletion, data portability and restriction of processing and to reject automated processing of the personal data at any time.

Sanitas informs the interested parties about the possibility that it gives them to exercise their rights to access, rectification, object, erase, data portability and restriction of processing and to reject automated processing of the personal data gathered by Sanitas. These rights can be exercised by interested parties or by their representative, where applicable, at no cost by sending a written and signed request - a copy of their national identity card or equivalent proof of identity may be requested - to the following address: Calle Ribera del Loira no. 52, 28042, Madrid, Spain, FAO: Insurance GDPR or via the Mi Sanitas portal (http://www.sanitas.es/misanitas/online/clientes/contacto/index.html). Interested parties can also exercise their right using the forms

provided for this purpose in the ARCO Rights section of the Additional Information. In the case of representatives, these must also provide proof of identity by sending a written document, along with a copy of the national identity card of the person they represent or equivalent proof of identity, which is specified in the Additional Information.

In addition to the aforementioned rights, the applicant/policyholder/insured has the right to withdraw their consent at any time by following the procedure described above, without this withdrawal of their consent affecting the lawfulness of processing before its withdrawal. The applicant/policyholder/insured's personal data can continue to be processed to the extent to which applicable law permits. The applicant/policyholder/insured can get more information about each of the rights mentioned in this section in the Additional Information.

They may also contact the Data Protection Officer of either of the joint data controllers at the email addresses specified in section II with any queries related to the protection of their rights and, as a last resort, contact the Spanish Data Protection Office to request protection of their rights or file a complaint. www.aepd.es.

Notwithstanding the above, Sanitas hereby informs the applicant/policyholder/insured that a system of internal conflict resolutions is available in which the Data Protection Officer has an active role as a mediator in order to ensure more agile management of any claim that the applicant/policyholder/insured sends to the postal or email address specified in the Joint Data Controllers section. Therefore, the applicant/policyholder/broker is encouraged to contact the Data Protection Officer before filing a complaint with the corresponding supervisory authority.

8.7. Revoke consent to receive marketing communications.

As mentioned in the previous section, the applicant/policyholder/insured has the right to withdraw their consent to be sent marketing communications at any time by notifying Sanitas that they no longer wish to receive them. To do this, the applicant/policyholder/insured can withdraw their consent either by following the procedure described in the previous section or by clicking on the link included in each marketing communication, thereby cancelling electronic marketing communications.

8.8. Minors.

In general, the personal data of children under eighteen years old shall only be processed if their parents or guardians have given their consent, when it is necessary in order to implement the insurance contract or in order to comply with legal obligations or meet a legitimate interest of Sanitas.

However, pursuant to current law, children under fourteen years old (or the age that can be legally set for these purposes) will have the right to access their own medical information and the rights afforded to them by law.

8.9. Additional Information

Sanitas and Sabadell Seguros provide the applicant, policyholder and insureds with Additional Information on processing of their personal data at www.sanitas.es/RGPD/coasegurosabadell and invite them to consult it.

8.10. Amendment of the privacy policy.

This privacy policy may be amended pursuant to applicable law at each given time. In any case, the applicant/policyholder/insured will be duly notified of any amendment to the privacy policy so that they are aware of the changes made to the processing of their personal data and, when required by applicable regulations, the applicant/policyholder/insured may give their consent.

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.

10. Prevention of money laundering and financing of terrorism

The Insurer shall not undertake any service in the Insured cover of this policy if this constitutes an infringement of Spanish, United Kingdom, European Union, United States of America, or international laws in general, reserving the right, in the corresponding cases, to cancel the membership of the Insured affected by said offense. Similarly, you may reject the inclusion of a new Insured, if this may lead to a breach of any of these laws.

11. How to contact us

Customer Service

91 752 28 52 / 93 362 34 49 / 900 909 069

12. Co-insurance Clause

The benefits guaranteed by this policy are covered under co-insurance, with the percentages specified for the following entities:

SANITAS S.A. de Seguros	50%
BanSabadell Seguros Generales	50%

This co-insurance is established in a single policy, issued by SANITAS S.A., hereinafter the insurer, and must be signed by the Policyholder and/or insured and by all co-insurers, thereby rendering it completely valid for all of them. In the event of issuing supplements or appendices, the insurer will issue a single document that must also be signed by all the co-insurers, except in cases of regularisation of the premium and those that do not modify the financial conditions of the contract, which will be signed by the insurer only on behalf of the entire co-insurance table. Consequently, the Policyholder and/or insured will only sign the contract documents issued by the insurer.

For the premiums to come into effect, the Insurer will issue and present for payment one receipt for all the shares. Payment will clear the Policyholder's debt with each of the co-insurers, without affecting the payments between said co-insurers that would subsequently take place.

In their relationships with the Policyholder and/or the Insured, the co-insurers will always be represented by the Insurer, even when declaring, processing or settling the claims that arise. The Policyholder and/or insured must only contact the Insurer to inform them of contingencies they must report to their insurers and all communications between these and the Policyholder and/or insureds will go through it.

Likewise, in the event of a claim, the decisions that must be taken to defend the interests of the insured and the co-insurers will be taken with the agreement of the insured and the Insurer, except when delegated to the other co-insurer due to special circumstances and also by mutual agreement.

Without affecting the Insurer's decision-making powers set out in the previous paragraph, when the technical complexity and financial significance of the claim thus dictates, the Insurer may consult the decision that corresponds to the other co-insurer.

The representation of the Insurer does not extend to possible legal or arbitration proceedings that may arise from this contract, and are filed by the Policyholder and/or the insured or injured party; therefore, during these proceedings all co-insurers must be sued for their respective fees, although they may subsequently entrust the leading company with managing the proceedings. When the purpose of the lawsuit is to claim the corresponding compensation from one or more co-insurers, having already been paid by the others, the claim will only be lodged against the companies that owe the benefit.

This contract may be terminated::

1. By the Insurer, on behalf of all co-insurers, in all cases in which the law and this contract grant insurers the power to terminate it.

2. By the Policyholder in the cases covered by law and in this contract by contacting the insurer only.

The act of terminating or not extending the contract is indivisible and may only be exercised by the leading company, on behalf of all co-insurers. Consequently, a co-insurer may only be separated or excluded from the co-insurance table when the contract is extended, under the terms and conditions set out in the following paragraph:

The Policyholder may oppose the extension of this contract, either in its entirety, or with respect to one or more of the co-insurers, in both cases contacting the affected insurer and the co-insurers. The Insurer will have the same right, and must notify the Policyholder and affected companies of their total or partial renouncement of the contract. Likewise, every co-insurer may oppose the extension of their participation in the contract, giving the Policyholder and the Insurer the two months advanced notice provided for by law.

In all cases, notification of the resolution or non-extension of the contract must be given with the notice set out in this contract.

The Policyholder and/or Insured and the co-insurers of the risk, agree to the content of this contract by signing it, understanding that the provisions of the preceding clauses do not mean that the co-insurers jointly meet the obligations undertaken by this policy. The liability undertaken by each of them is their own and is independent from that of the other co-insurers, which is determined according to the percentages set in the co-insurance table and without being able to demand, for any reason, payment of compensation that exceeds that resulting from applying these percentages.

Executed in duplicate in Madrid, 10 March 2025

For the Insured / Policyholder

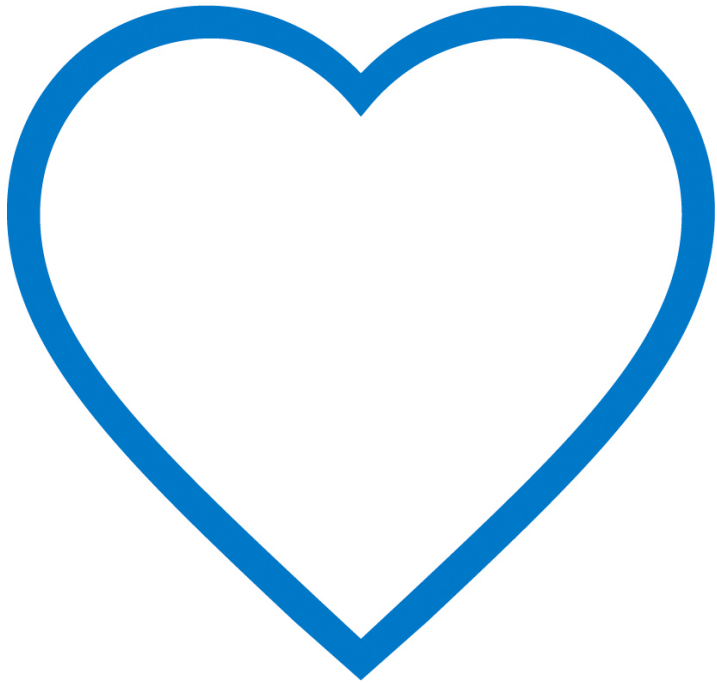
For the Insurer

Javier Ibañez
Sanitas, S.A. de Seguros

Bernardino Gómez Aritmendi

BanSabadell Seguros Generales, S.A. de Seguros y Reaseguros

SERVICES PROVIDED BY SANITAS MAYORES



Sabadell Seguros Generales | Sanitas

Services provided by Sanitas Mayores

Without detriment to the insured covers offered in this policy, and additionally and not related thereto, Insured members will be entitled to access certain services provided by SANITAS MAYORES S.L. under the terms and conditions stipulated below:

Advisory Service

The purpose of the advisory service is to facilitate greater knowledge and information about their health and the possibility of receiving state-funded assistance.

This service includes:

- Geriatric assessment of the senior citizen's situation: integral geriatric assessment enables the detection and quantification of the senior citizen's problems, needs and capabilities.

  Geriatric assessment is provided as part of a scheduled appointment, which can be arranged by calling 900 373 079.

- Advice on the best service according to the senior citizen's needs: based on the result of the geriatric assessment, the Insurer helps select the resource that best fits their needs (home help, day centre or care home).

- Accompanying the senior citizen: once we have selected the resource, they are advised and/or accompanied in the process of applying for state-funded assistance, whether for a non-professional carer, financial assistance to pay for a period at a day centre or care home, or to sign up to the waiting list for public places.

  It comprises up to a maximum of 1 service per member during all the annuities that the member remains in the policy.

Social relations service

The social relations service provides the senior citizen with supervision from highly qualified professionals, who help them take part on a regular basis in activities that build on their interpersonal relations, leading to a positive effect on their health.

This service includes:

- Access to day centres: this includes the possibility of attending the day centres within the Sanitas Mayores network for 1 day per week. During the day at the centre, they can attend the workshops and activities arranged for that day at the centre, providing they are on a group basis.

  Transport service to the day centre is excluded. Individual activities on offer at the centre are not included in this service.

- Invitation to parties at SANITAS day centres and care homes: members can attend parties held at care homes or day centres in the Sanitas Mayores network, by registering beforehand.

- Invitation to outings: there is a possibility of taking part in one outing per month. The terms and conditions of these outings are established by the centre. The senior citizen can choose to take part in an outing as long as the centre has an available place when it is requested.

  The catering service will only be provided when offered by the centre and it will be excluded when provided at any other restaurant or cafeteria.

Healthcare service

The healthcare service comprises one of the following services:

- Rehabilitation: a physical therapy plan adapted to the personal needs of the senior citizen is offered after a functional assessment.

  The exercise programmes in this geriatric rehabilitation are devised and guided by professionals in physiotherapy and

rehabilitation. The purpose is to offset, where possible, the consequences of a lack of activity in the adult population.

- Preventive physiotherapy: physical therapy that aims to combat or delay the evolving processes of age and/or inactivity that may lead to disorders of the organs, apparatus and systems and even if there are no symptoms at the outset they could progress to the physical incapacity of the senior citizen.

- Keep fit: this consists of a fitness programme to help senior citizens improve their physical and mental health, and maintain their independence in terms of daily activities and delay the appearance of diseases associated to this age group.

The senior citizen can choose from one of the three servic**es indicated and is entitled to one group session per week of rehabilitation, physiotherapy or keep fit**, depending on the option chosen, from those provided at day centres or care homes in the Sanitas Mayores network.

This service excludes individual sessions and classes.

Other benefits

The senior citizens named as Insured members in this product will have priority on the waiting lists when requesting a place in a SANITAS care home.

They will also have a €100 discount each month off the amount to be settled during their stay at the care home or a €50 discount each month off the amount to be settled for their time at the day centre (for full days). If the stay does not coincide with a full monthly payment, the discount will be proportional to the period actually completed.

Offer not applicable to insured parties who were beneficiaries of any of the services prior to registering as insured parties on the policy.

The services described will be offered by SANITAS MAYORES as a benefit for the Insured members of this product. The expenses arising from the other services and activities that these Insured members can undertake at the care homes will be charged to the Policyholder, who will only have a discount off the market rate.

The telephone number 900 373 079 is available for any information regarding care homes and the services provided by Sanitas Mayores, as well as for date appointments.