GENERAL TERMS AND CONDITIONS

Sabadell Health Protection

Sabadell Protección

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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Sanitas Sociedad Anónima de Seguros

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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 andspecifically accepted.

Glossary of terms

For the purposes of this document of the **Sabadell 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.

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.

MEDICINAL PRODUCTS
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 technical equipment, a specially designated area and specialised health professionals in a healthcare or hospital setting.

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

Indicate as an example that all lithotripsy, radiotherapy, chemotherapy, interventional radiology, haemodynamic and endoscopy procedures and procedures covered that require laser 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, 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

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

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

Clause II: Benefits

The benefits covered by this policy are conditional on compliance with the qualifying periods indicated below and always when they are conditions subsequent to the contracting of the policy and not known by the insured or in case of prior conditions known to the insured, were declared to the insurance company by the insured when taking out the policy without the insurance company excluding these conditions.

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 correspond to the following specialities:

1. Primary care

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 healthcare 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

3.1. Allergology

The cover includes determination of complete allergen-specific IgE (natural extracts) but **excludes specific IgE determination of recombinant allergens and IgG4.The IgE antibody qualitative test and molecular diagnosis of the allergy (microarrays) are excluded.**

3.2. Clinical Analysis

Intestinal dysbiosis tests, ALCAT food sensitivity tests, DAO enzyme activity (DAO) tests, qualitative antibody screen kit and multiple PCR tests are not included.

3.2.1. Genetic Studies

It includes only genetic studies, **in affected and symptomatic patients, whose purpose is to diagnose a certain disease that cannot be diagnosed through other studies or complementary tests, or genetic studies that are essential in order to prescribe treatment (except for genetic studies expressly excluded in the excluded risks section). All genetic studies with a low diagnostic performance are also excluded from the cover, that is, when the probability of being able to diagnose the disease by carrying out the genetic study is less than 10%. Requires prior authorisation from the Insurer after assessing the medical report.**

Includes the study of BRCA 1 and BRCA 2 genes or the gene panel for studying hereditary breast and ovarian cancer in peripheral blood under the following indications:

A) patient without personal history of breast or ovarian cancer who meets the following requirements:
- with 2 or more 1st or 2nd degree relatives aged under 50 years old affected by breast cancer
- with 2 or more 1st or 2nd degree relatives affected by ovarian cancer at any age
- with 2 or more 1st or 2nd degree relatives aged under 50 years old affected by breast cancer and ovarian cancer at any age

B) patient aged over 50 years old with a history of breast cancer
- with 2 or more 1st or 2nd degree relatives aged under 50 years old affected by breast cancer
- with 2 or more 1st or 2nd degree relatives affected by ovarian cancer at any age
- with 2 or more 1st or 2nd degree relatives aged under 50 years old affected by breast cancer and ovarian cancer at any age

C) male patient with breast cancer
D) patient aged under 50 years with breast cancer
E) patient with ovarian cancer (+/-) breast cancer

HLA DQ2/DQ8 molecule study is included **for under 16s that meet the following three criteria only:**

- **with justified clinical suspicion**
- **positive IgA anti-tissue transglutaminase antibodies in blood with values that are 10 times higher than the normal value**
- **positive IgA anti-endomysial antibodies in blood**

It excludes HLA class I and II DNA typing, PCA3 study, genome sequencing, full gene clinical exome study, microarray, pharmacogenetics (except for the study for diagnosing dihydropyrimidine

dehydrogenase deficiency) and gene therapy.

3.3. Anatomic Pathology

Includes the performance of therapeutic targets: BRAF, ALK, K-RAS, N-RAS, HER2, EGFR, C-KIT, ROS-1, PDL-1, microsatellite instability in colon cancer, MGMT methylation in brain tumours, somatic BRCA1 and BRCA2 in ovarian cancer prior to the administration of certain pharmaceutical products, provided that the summary of product characteristics as established by the Spanish Agency of Medicinal Products and Medical Devices requires that such targets be determined. These criteria also apply to the speciality of genetic testing.

3.4. Anaesthesiology

3.5. Angiology and Vascular Surgery

3.6. Digestive System

Liver elastographs are covered **annually by the Insured solely to evaluate the progression in the degree of hepatic fibrosis in chronic liver diseases, excluding conditions related to alcoholism.**

The technique for submucous endoscopic dissection **is only included for the treatment of lesions of pre-malignant or incipient malignant colorectal/gastric mucosa in which conventional polypectomy has been ruled out and where surgical treatment is being considered. Prior authorisation from the Insurer is required after assessment of the medical report.**

MR-enterography is included.

Gastric balloon treatment and any endoscopic treatment for obesity are excluded.

Barret radiofrequency treatment of the oesophagus **for extensive low-grade dysplasia over 5 cm and moderate or high-grade dysplasia is included.**

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

3.7. Cardiology

Includes a cardiac MRI scan and a cardiac stress perfusion MRI, and the medication required for these tests. Determination of troponin is covered **under admission to hospital only**.

Three-dimensional electrophysiological cardiac mapping is included **for the following cases only: atrial fibrillation, arrhythmias in congenital heart disease, hereditary ventricular arrhythmias and ventricular tachycardia associated with ischemic etiology scarring**.

Excludes implantable loop recorder.

3.8. Cardiovascular Surgery

The cryoablation technique and percutaneous techniques for the replacement or repair of heart valves are excluded.

3.9. General and Gastrointestinal Surgery

Includes laparoscopic surgery. Laser and extirpation techniques for haemorrhoid treatment and treatment for sclerosis using elastic bands are included; **the elastic bands being covered by the Insured**.

3D Laparoscopy, Bariatric surgery, metabolic surgery in diabetes and any type of abdominoplasty or cosmetic surgery are excluded.

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

Includes arthroscopic surgery. **Endoscopic spinal surgery and other new techniques are excluded, unless the Insurer has informed the policyholder in writing that it is included in the cover.**

3.12. Paediatric Surgery

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

3.13. Reconstructive Surgery

Septorhinoplasty, diastasis recti and lipoedema surgery are excluded. All operations with a cosmetic component, including those based on psychological reasons, are excluded.

3.14. Chest Surgery

3.15. Dermatology

3.16. Endocrinology

3.17. Geriatrics

3.18. Haematology and Haemotherapy

Comprises autologous bone marrow and parentperipheral blood cell transplants **solely for treatment of haematological tumours.**

Leukocyte immunophenotypic study only covered in the study of leukaemias and lymphomas.

3.19. Internal Medicine

3.20. 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.

3.21. Nephrology

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

3.22. Pneumology

Includes endobronchial ultrasound in the following indications:

- Negative TBNA (endobronchial ultrasound-guided transbronchial needle aspiration)
- cancer staging of a radiologically normal mediastinum in suspected or confirmed lung cancer
- re-staging following induction chemotherapy
- diagnosis of mediastinal masses, peribronchial, paratracheal or intrapulmonary hilar.

Requires prior authorisation from the Insurer after assessing the medical report.

3.23. Neurosurgery

Includes only surgery with surgical navigation assistance for intracranial processes and intraoperative electro-physiological monitoring for intracranial processes and for spine surgery.

Endoscopic spinal surgery and other new techniques are excluded, unless the Insurer has informed the policyholder in writing that it is included in the cover.

3.24. Clinical Neurophysiology

3.25. Neurology

3.26. Obstetrics and Gynaecology

Includes laparoscopic gynaecological surgery.

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.**

It also includes family planning: tubal ligation, IUD implantation **(the IUD is paid by the Insured)**, regardless of the therapeutic purpose, and follow up of treatment with anovulation medicines.

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 and use of genome sequencing platforms for breast cancer prognosis (ONCOTYPE, MAMMAPRINT, PROSIGNA) prescribed by a specialist on the medical chart and whenever necessary for the treatment in accordance with the recommendations set out for each genomic platform mentioned above. **Requires prior authorisation from the Insurer after assessing the medical report.**

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.**

PLGF and SFLT1 levels (indicators of preeclampsia) are excluded.

Includes pelvic floor rehabilitation **only for women with moderate-severe urinary incontinence due to pregnancy and delivery, with a limit of 1 year after delivery and provided that it has been authorised by the Insurer. A maximum of 5 sessions per delivery** are covered.

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

The Insured can also 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.

3.26.1. Breast Surgery

Breast surgery is covered in the following situations:

- Benign tumours. **Excludes breast reconstruction.**
- Malignant tumours: includes surgery on the affected breast and prophylactic surgery on the contralateral breast if considered a therapeutic option following the BRCA1 and BRCA2 result. Includes posterior breast reconstruction.
- Individuals not affected by breast cancer in which prophylactic breast surgery is considered a therapeutic option following the BRCA1 and BRCA2 result. Includes subsequent breast reconstruction.

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

The only reconstruction methods included in the cover are: **post-mastectomy breast reconstruction, with expanders and prosthesis, reconstruction with dorsi myocutaneous flap, DIEP flap and TRAM flap.**

3.26.2. Neonatology Care

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

3.26.3. Newborn care

Covers the costs of a newborn's healthcare, **provided that the child has been registered with the Insurer and has this cover.**

This policy does not cover the expenses arising from gestational surrogacy, for neither the mother nor the newborn.

3.27. Ophthalmology

Includes laser photocoagulation **exclusively for ischemic retinopathies, macular oedema, glaucoma and peripheral lesions of the retina (holes or tears); corneal cross-linking for keratoconus treatment; and surgery for cornea transplant with the cornea to transplant** being paid for by the Insurer.

Orthoptic, pleoptic and refractive surgery (for myopia, hyperopia and astigmatism) is excluded.

3.28. Medical Oncology

The treatment prescription must always be performed by the Medical Oncology specialist in charge of the patient's care. The Insurer must pay for treatment if conducted at a healthcare site, whether on the basis of an oncology day unit or on an inpatient basis, if necessary.

It includes specifically cytotoxic medicines **that are authorised for sale on the Spanish market and provided that they are used for the treatments expressly specified in**

accordance with the product datasheet and whose administration is via parenteral in as many cycles as necessary, or via bladder instillation.

Includes intraperitoneal chemotherapy **in cases of peritoneal carcinomatosis due to tumours of the ovary or of digestive origin; and intrathecal chemotherapy in cases of high-grade lymphomas or meningeal carcinomatosis.**

It also includes medication without anti-tumour effect, **administered along with cytostatic medications during the chemotherapy session in order to prevent adverse or side effects.**

Includes the use of sodium iodide I 131 **for treating overactive thyroid and thyroid cancer and the use of 90Y-Yttrium Citrate for radioisotopic synoviorthesis.**

It includes a study to rule out dihydropyrimidine dehydrogenase deficiency in patients who are candidates for parenteral dihydropyrimidine treatments.

Experimental treatments, treatments for compassionate use, hormonal therapy, immunostimulants, immunosuppressants, gene therapy and treatments carried out for indications not included in the product datasheet of the medicine are expressly excluded.

3.29. Ear, Nose and Throat

Includes CO2 laser surgery and radiofrequency surgery.

The cost of cochlear implants and all pre- and post-surgery consultations and diagnostic tests for adjusting the device are excluded. Any type of rhinoplasty operation is also excluded, except surgery secondary to trauma or non-cosmetic pre-surgery, which always requires prior assessment of the medical reports by a doctor from this speciality.

3.30. Psychiatry

Psychiatric admission **only covered as part of admission** (that is with an overnight stay) **and only includes the treatment of acute outbreaks. It is limited to a maximum period of 50 days per Insured/year.**

3.31. Radiodiagnosis/Imaging Diagnosis

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

It also includes:

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

- Screening of colon cancer and colon polyposis in patients without a known clinical history of colon cancer, polyposis orinflammatory intestinal illness, as long as they present family background of these pathologies or are candidates to screening for age reasons (from the age of 50).
- Screening of colon cancer and colonpolyposis in patients in which the conventional colonoscopy is contraindicated due to their clinical situation or entails a higher risk.
- As a complement to conventional colonoscopy when this has been unable to reach the full length of the colon.

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

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

and for evaluation of stents or coronary grafts.

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

Assessment of the calcium score is excluded.

3.32. Radiotherapy

The radiotherapy cover includes oncological processes only **and only the following methods: intensity modulated radiotherapy (IMRT), 3D external conformal radiotherapy, stereotactic brain and body radiotherapy (IGRT/SBRT), interoperative radiotherapy and brachytherapy.**

It also includes stereotaxic radiosurgery for treating tumour processes, mainly malignant, cerebral arteriovenous malformations and as the final stage of therapy in trigeminal neuralgia.

Proton therapy and neutron therapy are excluded, and any techniques other than those expressly mentioned are excluded, unless the Insurer has informed the policyholder in writing that it is included in the cover.

Requires prior written authorisation from the Insurer after evaluation and with a doctor's report provided by the insured.

Radioembolization with spheres is excluded.

3.33. Rehabilitation

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

3.34. Rheumatology

3.35. Urology

Includes Multi-parametric Magnetic Resonance of the prostate in the following indications:

- 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 4 or PIRADS 5.**

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

Includes laser photo-vaporization and enucleation of the prostate.

Includes laser endourethral and vesical lithotripsy.

Prostate cryotherapy, irreversible electroporation and other focal therapies are excluded.

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

4.1. Ambulance

Transfers in ambulance from the place where the insured is located to the hospital where he/she will be admitted or to which he/she presents for an emergency and under the Insurer coverage shall be covered. Also covered are return transfers of the insured from the hospital to their home and those made between hospital centres on the the Insurer list of healthcare providers if the care resources at the hospital where the Insured is found are not those that their medical care requires. Transfers for chemotherapy and radiotherapy treatments at a Day Hospital are also covered. In all these cases the service will be provided by land within the national territory using the means agreed on by the Insurer and so long as the physical state of the Insured impedes his/her transfer by other ordinary means (taxi, private car, etc.) and is authorised via the Sanitas 24-hour hotline.

This benefit does not include transfers required for physiotherapy treatments, diagnostic tests or to attend doctor's visits nor generally any other type not covered in the paragraph above. Service provisions by providers not agreed with or by the Spanish regional or national public health service are therefore excluded.

4.2. Special Care in the Home of the Insured

This will be performed by the healthcare teams designated by the Insurer, **provided that the Insurer has arranged for the service to be provided in the place in question** when the patient's illness requires special care but does not require admission to hospital nor specialised equipment, **always under prescription from a doctor and with the authorisation of the Insurer, after assessment of the medical report provided by the Insured. The medicines, material and equipment will always be covered by the Insured. Does not include care for social problems.**

4.3. Obstetric-Gynaecological Nursing (Midwifery)

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

4.4. 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.

It includes shockwave therapy for **chronic osteotendinous injuries (more than 6 months' evolution) of the musculoskeletal system with a maximum of 5 sessions per joint and year.**

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

Under admission to hospital, it will be provided **only and exclusively for the recovery of the musculoskeletal system secondary to an orthopaedic operation and recovery of the heart immediately after an acute myocardial infarction and after surgery with extracorporeal circulation.**

It also includes lymphatic drainage after surgery for an oncology process. **Requires prior authorisation from the Insurer after assessing the medical report.**

Includes pelvic floor rehabilitation **exclusively under the criteria set out in the Obstetrics and 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.

Any type of home physiotherapy treatment is 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.

4.5. 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.**

4.6. Nutrition

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

4.7. Odontology

Only includes consultations, tooth extractions (simple teeth, third molars, impacted teeth and root remains), and cleaning, performed during the consultation.

4.8. 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.

4.9. Prostheses

Only covers internal prostheses and internal implantable materials expressly listed below.

The Insured must provide the reports and/or quotations if the Insurer so requires.

1. Ophthalmology: It includes **only simple monofocal intraocular lenses, excluding toric, monofocal plus and extended depth-of-focus lenses and any other model of advanced monofocal lens** used in cataract surgery. Also includes corneal tissue **exclusively from national tissue bank for cornea transplant.**

2. Traumatology and Orthopaedic Surgery: Hip, knee and other joint prostheses; columnar fixation material; intervertebral disc; intersomatic or interspinal intervertebral material; vertebroplasty/kyphoplasty material; biological bone ligament material obtained from tissue banks in Spain; osteosynthesis material; bone substitutes **exclusively for columnar surgery and bone grafts after tumour surgery.**

3. Cardiovascular Area: the following vascular prostheses: stents, peripheral or

heart bypasses, medicalised or non-medicalised, aortic endoprothesis, which will require express authorisation from the Insurer after assessing the medical report; cardiac valves **except for values or valve repair devices implanted via percutaneous or transapical replacement**; aortic valve ducts, provided they are associated to aortic valve surgery; pacemakers, **except any type of defibrillator or artificial heart; coils and/or embolization materials**.

4. Chemotherapy or Pain Treatment: reservoirs.

5. Other surgical materials: abdominal wall meshes, except biological meshes; biliary stent; oesophageal endoprosthesis, duodenal and colonic; urethral endoprosthesis; urological suspension systems; cerebrospinal fluid (hydrocephalus) derivation systems; testicular prosthesis; breast implants and expanders, in both the breast affected by previous tumour surgery and in cases in which prophylactic mastectomy is considered a therapeutic option after the results of BRCA1 and BRCA2.

6. Bone fixation materials in cranium and/or maxillofacial surgery. Includes bone substitutes, only for bone void filler after tumour surgery.

4.10. Mother and Baby Programme

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

4.11. 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.

It also includes simple psychological diagnosis. Psychometric tests **will be covered by the insured**.

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

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

4.12. 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.

5. Hospital admission

Hospitalisation in a clinic or hospital.

In case of admission, the patient shall occupy a conventional, individual room with a bed for relatives, except in psychiatric hospitalisation, in ICU and in incubator and SANITAS will cover the expenses arising from performing diagnostic and therapeutic methods, surgical treatments (including operating theatre and medicine expenses, **provided that they are used in accordance with the indications set out on the product datasheet, except medicine that is not authorised for sale in Spain) and bed and board of the patient.**

The use of radiopharmaceuticals for therapeutic purposes is excluded, except for the use of sodium iodide I 131 for treating thyroid cancer.

Excludes care for social reasons.

6. Preventive medicine

Includes programmes applied to healthy populations covering different activities such as medical consultations, physical exams and basic diagnostic tests prescribed by the specialist concerned for early disease diagnosis:

6.1. Paediatrics: Provides for consultation with a specialist, newborn health checks (including metabolic screening and early hearing impairment detection via OAEs or AEPs where necessary) and regular health checks to monitor child development **(from birth to 11 years of age).**

6.2. Gastrointestinal Tract: Includes consultation with a specialist and a physical examination as well as basic diagnostic tests (e.g., test for blood hidden in faeces or colonoscopy).

6.3. Cardiology: Includes consultation with a specialist and a physical examination as well as basic diagnostic tests (e.g., ECG, basic blood and urine tests) and a stress test to establish coronary risk.

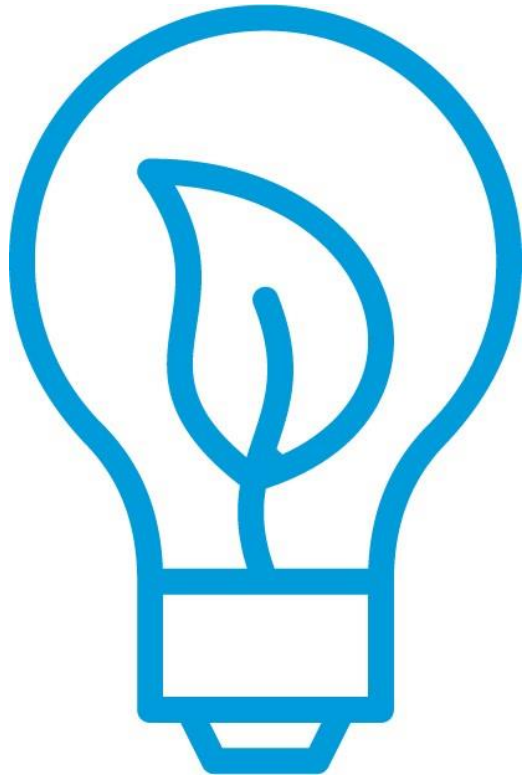
6.4. Pneumology: Includes consultation with a specialist and a physical examination as well as basic diagnostic tests (e.g., chest x-ray).

6.5. **Gynaecology:** Provides for an annual gynaecological check for cervical, endometrial and breast cancer prevention. Includes consultation with a specialist and a physical examination as well as basic diagnostic tests (e.g., ultrasound scan, mammogram, pap smear test or gynaecological ultrasound scan).

6.6. Urology: Provides for a medical consultation with a specialist and basic blood tests (including PSA determination) and urine tests, along with other basic diagnostic tests (e.g., ultrasound scan and/or prostate biopsy).

The recommended frequency for these exams varies in line with the characteristics of each case, which is why it is up to the specialist to establish recommendations in accordance with the risk.

ADDITIONAL COVERAGES OF YOUR INSURANCE



Sabadell Protección

Sanitas

Traffic and Occupational Accidents Cover

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

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

Overseas emergency healthcare cover

What is it? Use of services and time limit

This is a policy add-on which will cover emergencies abroad due to illness or accident, **provided that the care required occurs within 90 consecutive days from the start of the trip.**

For everything that does not expressly go against the provisions of this add-on, the provisions of the policy terms and conditions, including its limitation clauses and exclusions, will apply to the urgent medical care abroad guarantee.

To cover this care, **it is essential for the Insured** to be up to date with payment and, **before any medical service is provided (except in a life-threatening emergency), the Insurer must be contacted and prior authorisation sought** via the phone number on the back of the card.In the event of a life-threatening emergency, the Insured shall visit the nearest clinic or hospital and must report this to SANITAS within a maximum of 7 days starting from the date of admission, supplying Sanitas with a copy of the emergency report.

For Sanitas to accept the care provision, all the required documents must be supplied (travel receipts, medical report justifying the emergency and all other reports needed, bills and payment receipts).

What is not included?

- **medical expenses abroad under €3.**
- **costs arising from the diagnosis or treatment of a physiological condition or an illness that was known about before the trip began, unless it is a clear or unforeseeable complication; treatments arranged in Spain;**
- **mental and chronic illnesses causing alterations in the Insured's health.**

What services are included?

1. Medical Costs

During the validity of the policy the Insurer guarantees the Insured emergency healthcare assistance abroad for:

- medical expenses (doctors, surgeons and hospitals/clinics)
- medicine prescribed by a doctor
- emergency dentist expenses **up to €300 per Insured, excluding expenses related to endodontic treatments, cosmetic reconstructions of previous treatments, teeth cleaning, caps, and implants**
- Hospital fees
- Fees for an ambulance ordered by a doctor for a local journey

All of these expenses must be incurred outside of Spain and provided through the centres appointed by the Insurer.

Limits

€12.000 per person and year.

2. Transfer of sick and injured individuals to a care centre

What is included?

The Insurer ill pay for this transfer under medical observation through to the care centre where the patient can be treated.

The Insurer medical service shall decide on and choose the means of transport and medical centre/hospital the Insured must attend, in accordance with the medical order applicable to the case.

3. Extension of a companion's hotel stay for hospitalisation of the Insured

When the Insured has to be admitted to hospital on a doctor's orders and in accordance with the medical service, the Insurer shall reimburse the costs arising from the necessary extended hotel stay for their companion - if also Insured by Sanitas - **up to a maximum of €60 per day and up to a maximum of 10 days**.

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

If during the trip the Insured should be hospitalised for more than five days and no direct family member is with him or her, SANITAS shall make a regular-flight, return plane ticket (economy class) or train ticket (first class) available to a companion with regular place of residence in Spain. The Insurer shall pay **up to €60 per day for up to 5 days** in respect of hotel accommodation to cover this person's costs.

5. Transport in the event of death

In the event of the death of the Insured, the Insurer shall organise and meet the expenses for the transfer of the coffin to the place of burial in the country of his or her usual place of residence, as well as the minimum compulsory coffin expenses, embalming costs and administrative formalities. Where applicable and following a request from the Beneficiaries, the Insurer shall meet the costs of incineration in the place of death and transportation of the ashes to the place of burial in the country of his or her usual place of residence. **The Insurer will not meet funeral or burial expenses**.

6. Early return of Insured accompanying relatives

If the Insured is transferred by reason of death under the cover "Transfer in Event of Death" and this circumstance prevents accompanying Insured family members from returning to their homes by the means planned originally, the Insurer will bear the cost of their travel to their permanent place of residence in Spain. **Maximum two adults and accompanied children under the age of 14**.

7. Accompanying children

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

8. Search and retrieval of luggage and personal belongings

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

9. Dispatch of documents and personal belongings overseas

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

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

10. Advance of funds

The Insurer shall advance funds of **up to €1,500** to the Insured, when required.The Insurer shall require some kind of special guarantee ensuring the Insured repays the advance. In any event, the amounts advanced shall be returned to the Insurer within a maximum period of 30 days.

11. Legal advice

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

12. Advance of the amount for bail demanded abroad

If the Insured is prosecuted or incarcerated in the country in which it arises, the Insurer shall issue an advance equal to the amount of bail demanded by the local authorities **up to a maximum of €10,000**. The Insurer reserves the right to request a special guarantee from the Insured to ensure repayment of the advance. In any event, the amounts advanced shall be returned to the Insurer within a maximum period of two months.

13. Dispatch of medication

What is included?

If the Insured needs a medicine prescribed by a doctor and cannot acquire it in the place where he or she is holidaying, the Insurer shall locate it and send it to him or her by the fastest means and in compliance with local laws.

What is not included?

Cases where the medicine is no longer manufactured and is unavailable in the regular distribution channels in Spain are excluded. The Insured shall repay the Insurer the price of the medicine upon presentation of the bill.

14. Transmission of urgent messages

The Insurer shall, through a 24-hour service, accept and transmit urgent messages from the Insured, so long as they have no other means of making them reach their destination and so long as they are a consequence of a guarantee covered by the contract.

Digital Cover

1. 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.

2. Medicine delivery

The Insurance Company will find the medication and send it where the Insured

party **is a maximum of 6 times per Insured and annuity.**

The Insured party can request this service through the "MI SANITAS" restricted members area which can be accessed through the www.sanitas.es website, sending us the prescription they were previously sent electronically by their the Insurer doctor.

They can also request the service by calling 91 353 63 48, in which case the the Insurer-appointed service provider will remove the original prescription from the home of the Insured party.

The medication will be sent to the place in Spain where the Insured party is, within 3 hours after the request. The medication must be authorised for sale in Spain and the Insured party must pay the related amount upon delivery.

The Insurer will not be held responsible for the condition of the medication. Nor does it guarantee the effectiveness of the service if it cannot be provided for any reason or if it is provided in a manner other than that intended. Cases of delay in delivery or defects in the condition of the medication not directly attributable to the company that the Insurer has contracted for the service provision are excluded from any liability.

3. Home/work-based physiotherapy

The Insurance Company will be responsible for finding, sending and paying for a physiotherapist in the place of residence or workplace of the Insured, in Spain, for treatments prescribed by their doctor. **This guarantee is limited to 5 one-hour sessions per insured and year.**

The Insured party must supply any medical reports and tests required by the physiotherapist for the good organisation of sessions.

4. Healthcare programmes cover

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. 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.

5. 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

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.

2. CUSTOMER SERVICE

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

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. CUSTOMER SERVICE

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

3. 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. CUSTOMER SERVICE

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

3. 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).**

Pregnancy

1. PURPOSE OF THE COVER

To provide the Insured with information, guidelines and professional and personalised attention on pregnancy, postpartum and the baby's first few months of life in order to help the Insured to enjoy a healthy pregnancy and postpartum and offer advice on taking care of the baby.

Service provided by midwives and nurses specialising in maternity 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.

2. CUSTOMER SERVICE

The service times are Monday to Friday from 09:00 a.m. to 10:00 p.m., except bank holidays in Spain and local holidays in Madrid.

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.

2. CUSTOMER SERVICE

The service times are Monday to Friday from 09:00 a.m. to 10:00 p.m., except bank holidays in Spain and local holidays in Madrid.

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.

2. CUSTOMER SERVICE

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

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.

2. CUSTOMER SERVICE

The service times are Monday to Friday from 09:00 a.m. to 10:00 p.m., except bank holidays in Spain and local holidays in Madrid.

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.

2. CUSTOMER SERVICE

The service times are Monday to Friday from 09:00 a.m. to 10:00 p.m., except bank holidays in Spain and local holidays in Madrid.

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.

COMPLEMENTARY COVERAGES OF YOUR INSURANCE

Sabadell Protección

Sanitas

Reimbursement of Expenses Cover

The medical benefits object of coverage by this policy under the modality of contracted medical network in Spain and the network of participating centres and within the same limits and exclusions can also be covered under the modality of reimbursement of expenses, except for the medical services, included in the insured cover of this policy, that are only provided through the medical chart or reimbursement modality and expressly specified in the Individual Terms and Conditions. The reimbursement by the Insurer of the expenses corresponding to the insured medical benefits already mentioned, will be performed according to the reimbursement percentages and specific insured capital limits for each contracted benefit, according to which is specified in the Particular Terms and Conditions of this policy and following the regulations for reimbursement management established in this General Terms and Conditions. In all cases, these services must be performed by professionals and medical centres and hospitals that meet all of the legal requirements for conducting their activity in the country where it is carried out.

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

In the event that the insured has reimbursement and emergency cover abroad, when using the latter and whenever the insured capital limit of this cover is exceeded, the insured may request a reimbursement of excess expenses they may have incurred, under the terms and conditions and within the specific limits and percentages set out in the Individual Terms and Conditions.

A) Insured capital limits

1. Hospital health care

With the same extent of insured coverage as that mentioned under the modality of contracted medical network, the Insurer shall pay up to the limits and sublimits of insured capital established in the Particular Terms and Conditions of the policy, the expenses caused by inpatient treatment, surgical operations, child delivery or caesarean, surgeons' and their assistants' fees, midwifes, anaesthetists, operating theatres use, materials and medicaments, ICU care, as well as inpatient expenses that include upkeep and conventional room whit companion bed. The limit for deliveries or cesarean sections includes: medical fees, midwives, anaesthetists, use of the operating theatre, material and medications, admission to maternal ICU, and hospitalisation expenses that include room and board in a conventional room with a bed for a companion.

Surgical operations performed to the same Insured on the same day, by the same professional, shall be considered a sole operation in what refers to the application of the corresponding limit of insured capital. If the operations have been assigned a different level of difficulty by the Spanish Medical Colleges Organisation (OMC), the higher level of difficulty will be taken into account to define the insured capital limit.

The amounts indicated in the invoices for the use of specific surgical technics, provided that they are included in the cover insured by this policy, (laparoscopy, laser, etc.) shall be included in the limit corresponding to surgeons' and assistants' fees.

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

2. Outpatient care

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

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

B) Reimbursement percentage

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

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

C) Procedure for the reimbursement of expenses.

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

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

In case of surgical operation or programmed inpatient treatment, he/she must communicate such circumstance to the Insurer since the moment in which he/she has knowledge of the date in which such surgical operation or inpatient treatment is going to take place and, in any case, within the maximum term of seven (7) days counted from the date from which he/she knew this.

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

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

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

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

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

- Application of reimbursement, duly completed.

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

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

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

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

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

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

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

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

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

D) Payment of the amounts due to be reimbursed.

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

Once all the required documents are received and all corresponding checks are made, to establish the existence of a claim, the Insurer will reimburse or consign the guaranteed amount.

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

1. QUALIFYING PERIODS

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

- **Vasectomy and tubular ligation:** 10 months
- **Psychology:** 6 months
- **Complex diagnosis tests:** 6 months
- **The complex therapeutic methods as defined in the glossary:** 10 months
- **Group 0 to II operations, as classified by the Spanish Medical Colleges Organisation:** 3 months
- **Child delivery or caesarean except premature birth (less than 37 weeks):** 8 months
- **Hospitalisation and group III to VIII operations, as classified by the Spanish Medical Colleges Organisation:** 10 months

2. MAXIMUM AGE FOR TAKING OUT THIS ADD-ON

The maximum age for taking out the policy is 64 years old. Only those who are under 64 years old can be included as Insureds on the policy, unless agreed otherwise and without affecting the maximum ages that may be set, where applicable, for additional or supplementary benefits on this Policy.

Supplementary sudsidy cover for hospital admission

Included in the insured cover

The Insurer will pay daily compensation for Healthcare under Hospitalisation for the total time the Insured must stay in hospital, provided that this hospitalisation, even though it might be insured cover on the policy, is not provided under the insured cover of the policy. The daily amount and the maximum number of days in hospital that could be included in the insured cover per insured and year will be set out in the Individual Terms and Conditions of the Policy. If the insured is hospitalised more than once in the same year of the contract, the days hospitalised in each period will be added up in order to calculate the aforementioned time limit.

Not included in the insured cover

- **Any type of hospitalisation that is not included in the insured cover and those in which the Insurer covers the cost of hospitalisation.**
- **Psychiatric hospitalisation and those that do not last more than a minimum period of 24 consecutive hours.**
- **The day of admission and/or the day of discharge if they occur after 15.00 of that day.**
- **Insureds over 70 years old.**

Waiting periods

8 months starting from the date the insured is added to the policy.

Territorial scope of cover

Spain.

Processing

The insured must provide a medical report confirming the hospitalisation period, the reasons for hospitalisation and for the treatment received, specifying the hospital where it was carried out and identifying the professionals who intervened. An invoice confirming payment of the stay in hospital must also be provided or if it has been paid by another private insurance company or the National Health Service, document confirming this cover. The report must be provided within a maximum of 7 days from the date of hospital discharge.

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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 Clause III of 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 "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 "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.
- To request reimbursement, the Insured must submit an invoice showing payment, with a breakdown of the amount corresponding to the laboratory tests and 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 has no outstanding 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.**

Pharmacy with delivery of medication

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. 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, once the Insured submits the invoice in proof of payment of the medication and the doctor's prescription.

1.1. MEDICATION DELIVERY SERVICE PROVIDED BY THIRD PARTIES

This supplementary pharmacy cover also includes the cost of delivering the prescribed medication to the Insured's location, under the terms and conditions set out in the present section.

To use the service, the Insured must request it by calling 91 353 63 48 or accessing the MI SANITAS customer area of the website www.sanitas.es and sending the doctor's

prescription via electronic means. Once the service has been requested and within a maximum of 3 hours a courier will go to the Insured's home or their location within Spain, including the islands, Ceuta and Melilla. Neither the Insurer nor any company it may engage to provide this service shall be held responsible if the medication is not dispensed at the pharmacy because the Insured's identification is required, depending on the type of medication concerned, or if the prescription was not considered valid for any reason. The only medications covered by the medication delivery service are those that have been prescribed by a physician for a condition the Insured suffers and which is covered by the policy. Therefore, other medications or products in general which are sold in pharmacies and do not meet the abovementioned requirements are not covered, nor are those that do not require a doctor's prescription for dispensation.

The medication delivery service provided by third parties may be requested up to a maximum of **6 times per year and Insured**, regardless of the number of Insured parties included in the policy.

The Insured must pay for the medication upon delivery and may subsequently seek its reimbursement from the Insurer under the terms and conditions described above and inaccordance with any other applicable policy stipulations.

The Insurer shall not be held responsible for the state of the medication. Neither does it guarantee the effectiveness of the service if it cannot be provided for any reason or if it is provided in a manner other than that intended, any delays in delivery or defects in the state of the medication not directly imputable to the company engaged by the Insurer to provide the service are excluded from responsibility.

Other digital benefits

The Insurer shall provide the insured with other digital benefits associated to caring for their health. These benefits shall be announced gradually and will be available in the Mi Sanitas private area of www.sanitas.es and on the app.

Cover in the United States

The services included in this policy cover may be provided to the insured in the United States:

- **Only in the centres appointed by the Insurer for this purpose.**
- It is an **essential** condition that these services are **previously authorised by the Insurer**, which will manage and process the services covered.

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

- **Total limit in the United States: €30.000.**
- **Hospital care up to €24.000, with a sub-limit for childbirth of €1.500.**
- **Outpatient care up to €6.000.**

This cover is provided under a partnership agreement with these healthcare facilities arranged by the Insurer and will be without effect if that agreement terminates.

1. QUALIFYING PERIODS

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

- **Psychology:** 6 Months
- **Complex diagnosis tests:** 6 Months
- **Group 0 to II operations, as classified by the Spanish Medical Colleges Organisation:** 3 Months
- **Hospitalisation and group III to VIII operations, as classified by the Spanish Medical Colleges Organisation, vasectomy and tubular ligation included:** 10 Months
- **The complex therapeutic methods as defined in the glossary:** 10 Months
- **Child delivery or caesarean except premature birth (less than 37 weeks):** 8 Months

Clause III: Exclusions from cover

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

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

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

B. 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.**

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

D. Hospitalisation for problems of a social nature.

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

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

G. All diagnostic, surgical or therapeutic methods, procedures or techniques that appear after the date of taking out the policy except where the Insurer, in compliance with art 126.2 of Royal Decree 1060/2015 of 20 November on the Organisation, Supervision and Solvency of Insurance and Reinsurance Companies has communicated to the Policyholder in writing that they have been included in the Insured covers under the terms and within the limits established in said communication.

Also excluded are any therapeutic method, surgical technique or diagnostic test performed within a clinical trial or not used in regular clinical practice due to lack of safety or efficacy, considering these to be those not approved by the European Medicines Agency and/or the Spanish Agency of Medicinal Products and Medical Devices, as well as by the health technology evaluation agencies of Spain's regional health services or national Ministry of Health.

Also excluded from coverage are therapeutic methods, surgical techniques and diagnostic tests that have been clearly surpassed by other available ones.

H. Any type of service relating to:

• Conditions or treatments that are not covered or any other medical benefit with a direct relation to a treatment that was not done under the policy's insurance coverage for not being covered by 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.

• Transplants of organs, tissues, cells or cells components, except autologous transplant of both bone marrow and progenitor cells of peripheral blood due to haematologic lineage tumours and cornea transplant.

• Heterologous transplants.

• Any surgical procedure on unborn babies.

• Any surgical technique using robotic surgery equipment.

• Genetic studies for ascertaining the predisposition of the Insured or their current or future ascendants or descents of suffering diseases related to genetic alterations. Tumour and liquid biopsy genetic studies are expressly excluded, except: BCRA1 and BCRA2 determination, the genetic panel for studies of hereditary breast and ovarian cancer and genomic tests for breast cancer (ONCOTYPE; MAMMAPRINT and PROSIGNA) under the conditions detailed in previous sections. It excludes HLA class I and II DNA typing, PCA3 study, genome sequencing, full gene clinical exome study, microarray, pharmacogenetics (except for the study for diagnosing dihydropyrimidine dehydrogenase deficiency) and gene therapy.

• Prostheses and implantable material, except those set out in the corresponding section of the general terms and conditions. **Exclusions include: any type of external prosthesis; personalised prostheses; any type of orthopaedic material; external fixation devices; biological or synthetic materials; grafts; valved conduits,** except valved conduits associated to aortic valve surgery; **cardiac valves and valve repair devices implanted via percutaneous or transapical replacement; implantable infusion pumps for medicine, spinal cord stimulation electrodes, defibrillators and artificial hearts.**

• Operations, infiltrations and treatments, as well as any other action that is purely for questions of appearance or of a cosmetic nature. In terms of breast

surgery, only those caused by tumour disease are included, the following being expressly excluded: prophylactic operations, except those that meet the criteria detailed in the breast cancer section; and those performed to correct breast hypertrophy and/or gynecomastia. Any kind of disorder or complication which may occur subsequently and which is directly and/or mainly caused by the Insured's undergoing an operation, infiltration or treatment of a purely aesthetic or cosmetic nature are also expressly excluded.

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

• Hyaluronic acid, whether sold as a medicine or health product.

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

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

• Alternative medicine, naturopathy, homeopathy, acupuncture, mesotherapy, hydrotherapy, 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 health farms.

• 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.

• Endoscopic spine surgery is excluded.

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

• Ophthalmic photocoagulation exclusively for ischaemic retinopathies, macular oedema, glaucoma and peripheral retinal lesions (holes or tears).

• Corneal cross-linking for keratoconus treatment.

• Haemorrhoid treatments.

• Clinical (not cosmetic) peripheral vascular surgery.

• Ear, nose and throat CO2 laser.

• In musculoskeletal physiotherapy.

• Laser endourethral and vesical lithotripsy.

• Laser vaporization and enucleation of the prostate**.**

J. Travel expenses except those covered in the ambulance section of these General Terms and Conditions.

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

L. The following human medicines:

- **Those administered to the patient outside of hospital or in a day hospital, except chemotherapy administered via parenteral by a healthcare professional in appointed centres and using bladder instillation in the case of MITOMICINA and BCG. Medication in ventilation therapy or aerosol therapy, as well as over-the-counter products.**

- **Medicinal products not on the market in Spain.**

- **The following special medicines:**
  - **Vaccines/autogenous vaccines and other biological medicinal products**
  - **Medicines of human origin**
  - **Advanced therapy medicinal products (gene and cell)**
  - **Medicinal plant products**
  - **Homeopathic medicinal products**
  - **Radiopharmaceuticals for therapeutic purposes (for example yttrium (90Y) chloride, ibritumomab tiuxetan (90Y), radium-223 dichloride, lutetium (177Lu) oxodotreotide, etc.) except those mentioned in Medical Oncology, such as sodium iodide I 131 for treating overactive thyroid and thyroid cancer, as well as the use of 90Y-Yttrium Citrate for radioisotopic synoviorthesis.**
  - **Adoptive cell transfer therapies (for example CAR T-cell therapy, adoptive transfer of autologous tumour infiltrating lymphocytes (TIL)) and any other therapies not expressly mentioned, are excluded, unless the Insurer has informed the Policyholder in writing that it is included in the cover.**

  All pharmacokinetic studies are excluded.

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

N. Bariatric surgery is excluded in obesity and metabolic surgery is excluded in diabetes, and gastric balloon and endoscopic treatments for obesity are also excluded.

Ñ. Radiosurgery is excluded.

O. Parkinson surgery is excluded.

P. Epilepsy surgery is excluded.

Q. Sclerosis treatments with foam and microfoam in the Angiology and Vascular Surgery speciality and any other speciality are excluded.

R. Treatment with High Iintensity Focused Ultrasound (HIFU) is excluded.

Clause IV: Qualification periods

All benefits which under this policy are assumed by the Insurer, on the basis of the approved medical network, will be provided from the time this contract becomes effective. **HOWEVER, THE FOREGOING GENERAL PRINCIPLE DOES NOT APPLY TO MEDICAL, SURGICAL AND/OR HOSPITAL HEALTHCARE IN THE EVENTS DETAILED BELOW, TO WHICH SHALL APPLY THE SPECIFIED QUALIFICATION PERIODS:**

Qualification Periods for the modality of Contracted Medical Network:

- **Vasectomy and tubular ligation:** 10 Months
- **Psychology:** 6 Months
- **Complex diagnosis tests:** 6 Months
- **The complex therapeutic methods as defined in the glossary:** 10 Months
- **Group 0 to II operations, as classified by the Spanish Medical Colleges Organisation:** 3 Months
- **Child delivery or caesarean except premature birth (less than 37 weeks):** 8 Months
- **Hospitalisation and group III to VIII operations, as classified by the Spanish Medical Colleges Organisation:** 10 Months

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

Clause V: Form of service provision

1. Through the contracted medical network

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

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. 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.

1.3. Prior prescription for the performance of the service

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

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

1.4. Prior prescription and authorisation for the performance of the service.

As a general rule, for surgical operations, inpatient treatment and counselor professionals, prior express authorisation by the Insurer shall be needed, after the written prescription of the professionals belonging to the Insurer network. Such authorisation shall be also needed for certain therapeutic methods, diagnosis tests and other care services, whenever such is said in the General 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.).

1.5. Prior authorisation for the service to be performed by expressly accredited professionals

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

1.6. Prior authorisation and express designation of the physician

More particularly, for surgical procedures of great complexity, as indicated below: neurosurgery, heart surgery and backbone surgery, that are covered by this policy, the Insurer shall appoint the healthcare centre and the professionals to perform the surgery in each individual case and prior to the specific surgical procedure.

1.7. 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, Ambulance 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).

1.8. 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.

1.9. 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.

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

1.10. Care in providers not recognised by the Insurer.

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

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.

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, profession, Insured's sport practices and in general those habits of life that can be of relevance for a correct assessment of the risk that is the object of the insurance by this policy being it essential that the Policyholder/Insured provides with complete truthful about the questions posed since these constitute the basis for the acceptance of the risk of the present agreement,** being the mentioned Insurance Application a constituent part of it.

1.2. The Policyholder's duty, before the conclusion of the contract, to declare 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.

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

The maximum age for taking out the policy is 75 years old. Only those who are under 75 years old can be included as Insureds on the policy, unless agreed otherwise and without affecting the maximum ages that may be set,

where applicable, for additional or supplementary benefits on 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) Transfer of residence abroad or not residing a minimum of six (6) months in national territory. The premium shall correspond to the Insurer until the date on which the Insured communicates and credits such circumstance.

c) 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 is only bound by the invoices issued by the Management or by its legally authorised representatives.

4.8. The Insurer may modify the premium and the amount of participation of the Insured in the cost of services with each renewal of the Contract. This review is based on technical-actuarial criteria made and based on the variation in the cost of healthcare services, the type, the frequency of use of the benefits covered and the inclusion of technological medical innovations that were not covered on the initial effective date of the policy.

The premiums to be paid by the Policyholder will vary according to the age achieved by each of the Insured, the geographical zone corresponding to the place of performance of the services, the tariffs established by 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.

4.9. 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.**

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

5. Registering newborns

Newborn children can be included in the policy with all its rights since their date of birth if the care provided to the mother whilst the child delivery has been provided by the Insurer within the coverage of the mother's policy and if the inclusion of the father as an Insured in the policy has taken place at least 240 days prior to the child delivery. For this to be effective, the Policyholder must

communicate to the Insurer such circumstance within the 30 natural days following the date of birth, by means of completing an Insurance Application.

In any case, **the Insurer will only cover the newborn's healthcare when and if he/she is included as Insured in the Insurer.** If the inclusion of the newborn is communicated once the term mentioned above has elapsed or without fulfilling all the requirements indicated in the paragraph above this, the Insurer by virtue of the information provided by the Policyholder in the Insurance Application can deny the inclusion of the newborn as Insured member.

In the event of gestational surrogacy, the Policyholder must notify SANITAS to add the child as an insured on the policy within 30 calendar days of registering the child on the Spanish Civil Register as the child of the insured/insureds. **The insured cover shall come into effect on the date the insured is added to the policy and any expenses incurred before adding the insured to the policy shall not be covered and the expenses incurred before the mother or newborn are discharged from hospital after the birth shall not be covered under any circumstances.**

6. 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.

7. Complaints

7.1. 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.

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

8. Other important legal points

8.1. 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.

8.2. 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.

8.3. Notifications

8.3.1. 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.**

8.3.2. 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.

8.3.3. 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.

8.3.4. 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.

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

9. 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.

9.1. 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.

9.2 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.

9.3 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.

9.4. 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.

9.5. 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.

9.6. 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.

The interested parties or their representative, where applicable, may exercise these rights at any time and at no cost (unless the request is excessive or unfounded) by sending a written and signed request, along with a copy of their national identity card or equivalent proof of identity, to the following address: Calle Ribera del Loira nº 52, 28042, Madrid, Spain, FAO: LOPD Seguros or via the MiSanitas 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.

9.7. 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.

9.8. 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.

9.9. 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.

9.10. 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.

10. Jurisdiction

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

11. 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.

12. How to contact us

Customer Service

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

13. 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, 22 December 2021

For the Insured / Policyholder

For the Insurer

Javier Ibañez
Sanitas, S.A. de Seguros

Claudio Chiesa

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