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USEFUL PHONE NUMBERS AND ADDRESSES

- Personal diary

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**YOUR GENERAL TERMS
AND CONDITIONS**

Sanitas Sociedad Anónima de Seguros

Entered in the Register of the Directorate General of Insurance (Dirección General de Seguros) on 10 February 1958

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

Business address: Ribera del Loira, 52 - 28042 Madrid

Tax Registration No A-28037042

Glossary of terms

For the purposes of these Special Terms and Conditions of Sanitas Multi insurance, the following definitions apply:

ACCIDENT

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

INSURED

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

INSURER OR INSURANCE COMPANY

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

AMBULATORY CARE

Any medical, diagnostic, surgical or therapeutic care NOT involving hospitalization or home-based hospitalization. This care will always be provided at an authorized care site (not at home). Includes all services provided as part of the consultation infrastructure.

SPECIAL HOME CARE

This policy does not cover special home-based care, defined as care provided by a general or family practitioner or registered nurse at the address appearing in the Policy, when the patient's condition needs special attention but not to the extent of

requiring admission to hospital, and always by prior medical prescription. Special home care does not include the expenses generated by social assistance, catering, underwear, food, medication, monitoring, healthcare material and non-specific care provided by a general practitioner or registered nurse or the continual presence of health professionals at the Insured's home.

BENEFICIARY

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

OUTPATIENT CLINIC

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

Registered nurse ('ATS', 'DUE')

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

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.

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.

PRE-EXISTING DISEASE

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

CONVENTIONAL ROOM

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

HOSPITAL

Any legally authorised public or private establishment for the treatment of diseases or bodily injuries, provided with the means

for performing diagnoses and surgical operations. Such an establishment must be attended by a physician 24 hours a day. For the purposes of the Policy, hotels, rest homes, spas, facilities intended primarily for the treatment of chronic diseases and similar institutions are not regarded as hospitals.

HOSPITALISATION

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

DAY HOSPITALISATION

Involves the use by an Insured registered as a patient of hospital care units specifically designated as such to receive any type of medical, diagnostic, surgical or therapeutic care requiring presence of less than 24 hours

SURGERY

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

INJURY

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

OSTEOSYNTHESIS MATERIAL

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

ORTHOPAEDIC MATERIAL

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

PHYSICIAN

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

CONSULTANT PHYSICIAN/SURGEON

Physicians within the Insurer's medical network designated as consultant physicians in the Medical Guide, consultation with whom requires prior authorization from the Insurer, in response to a reasoned request from a specialist within the network.

DENTIST

Practitioner who is suitably qualified to perform the whole range of prevention, diagnostic and therapeutic activities relating to anomalies and diseases of the teeth, the mouth, the jaws and their adjoining tissues.

CHILDBIRTH

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

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.

CONTESTABILITY PERIOD

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

POLICY

Written document that contains the Terms and Conditions governing the insurance. The Policy comprises: the insurance application, health questionnaire, general, particular and special terms and conditions and the supplements or appendices that are added to it either to complete or amend it.

BENEFIT

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

PREMIUM

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

PROSTHESES

Any element of any kind that temporarily or permanently replaces the absence of an organ, tissue, organic fluid, member or part of any of these. By way of example, such mechanical or biological elements as heart valve replacements, replacement joints, synthetic skin, intra-ocular lenses, biological materials (cornea), fluids, gels and synthetic and semi-synthetic liquid substitutes for humours or organic fluids, medicinal product reservoirs, outpatient oxygen therapy systems, etc.

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.

CHILDCARE GP

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

NEWBORN

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

SANITAS 24 HOURS

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

HOME SERVICES

Visit at the home appearing in the Policy at the Insured's request on the part of the family doctor (general practitioner), paediatrician, registered nurse, in those cases in which the Insured is not in a condition to attend the doctor's or registered nurse's surgery because of his/her disease.

EMERGENCY HOME SERVICES

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

LOSS

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

POLICYHOLDER

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

EMERGENCY

An emergency is a situation that requires immediate medical care as a delay could

prove life-threatening or lead to irreparable harm to the patient's physical integrity.

Preliminary clause

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

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

What's covered by the Policy?

1. PRIMARY CARE

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

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

1.2.1. Care for newborns: Covers healthcare to a newborn child at the Company's partner facilities and the related expenses, provided the newborn is registered with the Insurer.

1.2.2. Children's health programme: Comprises psychoprophylactic preparation for childbirth with practical and theoretical classes in childcare and psychology, parent school during the child's first year of life, and health examinations of the newborn, including metabolic disease tests, hearing tests, otoemissions and visual acuity testing. Similar programmes not covered by

the Insurer's medical network are not included.

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

2. EMERGENCIES

This covers healthcare provided in cases of emergency at the permanent emergency centres listed in the User Guide to Doctors and Services. In justified circumstances, home service shall be provided by the round-the-clock emergency services, **only in those localities where the Insurer has an arrangement for the provision of this service.**

3. MEDICAL AND SURGICAL SPECIALTIES AND DIAGNOSTIC TESTS

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

3.1. Allergy and immunology: Autovaccination shall be at the Insured's own expense.

3.2. Clinical analysis

3.3. Anatomic pathology

3.4. Anaesthesiology, resuscitation and pain treatment: any manner of implantable material is expressly excluded.

3.5. Angiology and vascular surgery.

3.6. Digestive system: comprises prevention of colorectal cancer, medical

consultation, physical examination, endoscopic examinations as necessary, **subject to a prior written prescription by a physician within the Insurer's network.**

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

3.8. Cardiovascular surgery: Surgical techniques using robotic systems are excluded.

3.9. General and gastrointestinal surgery: Includes the laparoscopic approach for procedures in the gastrointestinal tract in which its efficacy has been proven, **conducted solely by practitioners specially approved by the Insurer for such procedures.**

3.10. Oral and maxillofacial surgery

3.11. Paediatric surgery.

3.12. Plastic and reconstructive surgery

3.13. Thoracic surgery

3.14. Dermatology

3.15. Endocrinology

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

3.17. Haematology and haemotherapy

3.18. Internal medicine

3.19. Nuclear medicine

The Insurer shall also be liable for the contrast means.

PET and PET/TC are covered only for indications authorized by the Spanish Medicinal Product and Medical Device Agency (Agencia Española de Medicamentos y Productos Sanitarios) using the drug fludeoxyglucose. Specifically, those indications are:

A/ Oncology diagnosis:

- Characterization of solitary pulmonary nodule.
- Detection of a tumour of unknown origin, evidenced by e.g. cervical adenopathy
- Liver or bone metastases
- Characterization of a pancreatic mass

B/ Staging:

- Head and neck tumours, including guided assisted biopsy.
- Primary lung cancer.
- Locally advanced breast cancer.
- Cancer of the oesophagus.
- Pancreas carcinoma.
- Colorectal cancer, especially upon recurrence
- Malignant lymphoma.
- Malignant melanoma, with Breslow in excess of 1.5 mm, or lymph node metastases upon initial diagnosis

C/ Monitoring of response to therapy:

- Malignant lymphoma.
- Head and neck tumours.

D/ Upon reasonable suspicion of relapse, detection of:

- Highly malignant gliomas (III or IV)
- Head and neck tumours.
- (Non-medullary) thyroid cancer: patients with increased serum

thyroglobulin and body scan using negative radioactive iodine

- Primary lung cancer.
- Breast cancer.
- Pancreas carcinoma.
- Colorectal cancer
- Ovary cancer.
- Malignant lymphoma.
- Malignant melanoma.

E/ Neurology:

- Pinpointing of epileptogenic foci in pre-surgical assessment of temporal lobe epilepsy

3.20. Nephrology: Comprises urinary tract lithotripsy and dialysis techniques in acute stages, **expressly excluding dialysis techniques for the treatment of chronic disease.**

3.21. Neonatology

3.22. Pneumology

3.23. Neurosurgery

3.24. Neurology

3.25. Obstetrics and gynaecology: Comprises screening to prevent breast and cervix neoplasms, and assessment and basic diagnosis of infertility and sterility.

Fetal surgery is excluded.

Surgical techniques using robotic systems are excluded.

Prophylactic surgery is excluded.

All genetic testing, except karyotype, Leiden factor 5 and prothrombin gene mutation 20210, is expressly excluded.

Any testing in support of fertility treatment is also excluded.

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

3.27. Ophthalmology: comprises laser photocoagulation and cornea transplant surgery. **The transplantable cornea must be paid for by the Insured.**

Other laser surgery techniques (refractive surgery to correct myopia, hyperopia, astigmatism, presbyopia, or any indication that may arise in future) are excluded.

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

3.29. Ear, nose and throat: Covers laser surgery.

3.30. Proctology

3.31. Psychiatry.

3.32. Rheumatology

3.33. Radio diagnosis/Imaging diagnosis: comprises standard diagnostic techniques.

Also covers:

A) Colonography by computer assisted tomography (CAT) for the following indications:

- Colon cancer and colonic polyposis screening in patients with no known history of colon cancer, polyposis or intestinal

inflammatory disease, provided that family antecedents of such disorders are present, or the patient is a screening candidate on an age basis (50 and above)

- Colon cancer and colonic polyposis screening in patients in whom conventional colonoscopy is contraindicated by reason of their clinical situation, or involves high risk.
- As a supplement to conventional colonoscopy if that technique fails to examine the full length of the colon.

Cover for this diagnostic test is subject to the Insured sharing the cost of the service to the extent expressly stipulated in the special terms and conditions of his/her policy.

B) CAT coronography: covered only for patients with symptoms of coronary disease with non-conclusive ischemia test results, valve replacement surgery, post-operative coronary stenosis bypass assessment and malformations of the coronary tree.

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

3.34. Interventional or invasive radiology: Subject to prior written prescription by one of the Insurer's physicians and after the former's authorisation.

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

3.36. Consultant physicians and surgeons: This consultation is subject to prior authorization from the management of the Insurer for specialists thus designated in the Medical Guide to the Insurer's medical network, in response to a reasoned request by a network specialist.

3.37. Urology: covers vasectomy, study and diagnosis of infertility and sterility, and urinary tract lithotripsy. **Surgical techniques using robotic systems are excluded.**

3.38. Rehabilitation

4. THERAPEUTIC SERVICES

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

4.1. Aerosol therapy and ventilation therapy: The Insured shall bear the cost of any medication.

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

4.3. Urinary tract lithotripsy

4.4. Speech therapy: Only available in connection with organic processes **for up to a maximum of six (6) months a year.**

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

4.6. Chemotherapy: The Insurer shall provide the cytostatic medication that the patient may need in as many cycles as may be necessary. This medication shall always be prescribed by the Oncology specialist in charge of the patient's care. Treatments are covered by the Insurer, **provided that they are applied at a care centre, including on a day hospital basis,** and are commercially available on the home market

and are duly authorised by the Ministry of Health, for the indications specified in the product data sheet.

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

4.8. Physiotherapy: It is covered on an outpatient basis only, and exclusively for disorders originating in the musculo-skeletal system, **other than chronic or degenerative processes.** It is always provided at centres designated by the Insurer. For inpatient treatment, this cover only includes service provided for recovery of the musculo-skeletal system secondary to orthopaedic surgery and cardiac rehabilitation for recovery after surgery with extra-corporal circulation. It also includes lymphatic drainage after a mastectomy arising from cancer.

Neurological rehabilitation, pelvic floor rehabilitation, outpatient cardiac rehabilitation and language rehabilitation in non-organic disorders or using robotic systems are excluded.

4.9. Pain treatment: Only implantable reservoirs (of the port-a-cath type) are included. **Implantable pumps for drug delivery and medullar stimulation electrodes are expressly excluded.** Similar programmes not covered by the Insurer's medical network are not included.

5. OTHER SERVICES

5.1. Ambulance: An ambulance service shall be provided on land for the transfer of patients to and from hospital, providing that the healthcare resources arranged are not adequate to attend to the Insured at the place where s/he is or the latter requests to go to his/her place of residence. To request this service, it shall be necessary to have

the order slip of one of the Insurer's doctors duly processed at its offices, saving urgent cases, when this slip shall not be required. **This benefit does not include any travel required for rehabilitation therapy, diagnostic tests, or outpatient attendance to medical visits.**

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

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

5.4. Prostheses: will always be supplied by entities designated by the Insurer.

Cover only comprises, subject to a prior written prescription by a specialist within the Insurer's network, the internal prostheses and internal implantable materials expressly listed below, up to the insurance ceilings stipulated, as the case may be, in the Special Terms and Conditions of this policy.

1. Ophthalmology: Monofocal intraocular lens used for cataract surgery.

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: Vascular prostheses (stents, peripheral or coronary bypasses, medicalized or non-medicalized, excluding those used in the aorta in any of its sections and aortic valvulated tubes); cardiac valves, excluding aortic valvulated tubes and any other percutaneous or transapical implant; pacemaker, excluding any kind of defibrillator or artificial heart; coils and/or embolization materials.

4. Chemotherapy or Pain Treatment: Reservoirs.

5. Other surgical materials: Abdominal meshes, except those used as ceiling systems in laparoscopic surgery; urological suspension systems; cerebrospinal (hydrocephalus) fluid shunts; breast prostheses and expanders, **exclusively in the breast affected by prior tumor surgery.**

If so required by the Insurer, the Insured must furnish reports and/or cost estimates.

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

6. HOSPITALISATION

Hospitalisation shall be at the clinic or hospital designated by the Insurer, with the patient occupying a conventional single room with a bed for an accompanying person, **except in psychiatric, intensive-care and incubator hospitalisation.** The Insurer shall be liable for the cost of the treatment, the stays, the patient's board, cures and their material, besides operating theatre expenses, anaesthetic products and medications.

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

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

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

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

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

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

7. SECOND OPINION

This cover includes a second opinion on medical diagnosis or treatment in the event of serious chronic diseases requiring scheduled care of which the course necessitates exceptional

diagnostic or therapeutic measures and/or whereof the life prognosis is seriously compromised. Such second opinion shall be issued by leading specialists, healthcare centres, physicians or academics in any country in the world. To use this service, the Insured shall send the clinical dossier comprising written medical information, X-rays or other image diagnoses, excluding dispatch of any biological or synthetic materials. The dossier shall be delivered with due confidentiality to the relevant specialist or centre, according to the disease in question.

8. SANITAS 24 HOURS

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

9. PSYCHOLOGY

Individual temporary psychological care is included, by prescription from a Sanitas-listed psychiatrist, family health advisor, oncologist or paediatrician for treatment of disorders amenable to psychological intervention. Also covers simple psychological diagnosis and psychometric tests, except test forms, which shall be at the Insured's own expense.

Cover excludes psychoanalysis, psychoanalytic therapy, hypnosis, narcolepsy and psychosocial and neuropsychiatric rehabilitation services. The service must be authorised by the Insurer prior to provision, by telephone or at a Sanitas branch. Such authorisation shall require that service be provided by a Company-listed practitioner, up to a limit of 4 consultations a month and 15 consultations a year.

10. QUALIFICATION PERIODS

All the benefits assumed by the Insurer by virtue of the Policy shall be provided from the time it enters into force. **However, the foregoing general principle does not apply to medical, surgical and/or hospital healthcare in the events detailed below, to which shall apply the specified qualification periods:**

- **180 days for vasectomy and fallopian tube ligation**
- **300 days for childbirth healthcare**
- **180 days for psychological treatment**

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

What's not covered?

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

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

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

even in peace time, and officially declared epidemics.

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

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

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

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

7. All diagnostic and therapeutic procedures whose safety and efficacy are not duly verified scientifically or which have been clearly surpassed by other available procedures are expressly excluded. Likewise, compensation is excluded for those procedures that have

not sufficiently proven their effective contribution to the prevention, treatment or cure of diseases, maintenance or enhancement of life expectancy, self-sufficiency and relief or reduction of pain and suffering, and those consisting of mere leisure, rest, comfort or sporting activities. Spa therapies and rest cures.

8. Homeopathy is excluded, unless it is covered by the Particular Terms and Conditions of the Policy.

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

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

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

12. Hair treatments for cosmetic purposes are excluded.

13. Hospitalisation for problems of a social nature.

14. General medical check-ups of a preventive nature other than those specified in the description of the services in section What's covered by the Policy?

15. Educational therapy in all its forms, such as language education in

congenital processes or special education in patients with mental disease.

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

17. Prostheses of any kind or nature, except those prostheses listed in the description of the services in section What's covered by the policy?. Excluded except as listed in paragraph 5.4 of Clause 1, What's covered by the policy?. Orthopaedic material of any kind, external fixating devices, biological or synthetic materials, grafts, aortic endo-prostheses, valvulated tubes, defibrillators and artificial hearts are all excluded.

18. Chronic dialysis and haemodialysis treatments

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

20. Refractive surgery of any type for myopia, hyperopia, and astigmatism.

All surgical techniques or therapeutic procedures using laser, except:

- intraocular ophthalmic disease treatments
- haemorrhoid treatments
- clinical (not cosmetic) peripheral vascular surgery
- ear, nose and throat
- in musculoskeletal physiotherapy

The green laser technique for prostate surgery is expressly excluded.

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

22. Sex change surgery.

23. New diagnostic, surgical and therapeutic techniques not included in this Policy are excluded.

24. Operations, infiltrations and treatments, as well as any other operation that is purely for questions of appearance or of a cosmetic nature are expressly excluded. Any kind of disorder or complication which may occur subsequently and which is directly and mainly caused by the Insured's undergoing an operation, infiltration or treatment of a purely aesthetic or cosmetic nature are also expressly excluded.

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

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

27. Platelet- or growth-factor-rich plasma is expressly excluded.

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

29. All medicinal products not on the market in Spain.

Form of service provision

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

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

1. Through the medical network

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

Upon **receiving applicable services**, the Insured **must exhibit his/her Sanitas card**. The Insured is also obliged to

show his/her National Identity Card if so required. Whenever the Insured receives a service covered by the policy, he/she must share the cost of the service to the extent stipulated in the special terms and conditions.

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

Namely, for the highly complex surgical interventions specified below (surgery of the central nervous system, bariatric surgery, heart and spine surgery), the Insurer reserves the right to designate the healthcare centre and the professionals who will perform the intervention on a case by case basis and beforehand.

The foregoing paragraph notwithstanding, in **life emergency cases** an order by one of the Insurer's physicians shall suffice for these purposes, although the Insured shall notify the Insurer of the fact and obtain its confirmation within 72 hours of admission to the hospital institution or the provision of the healthcare service. In these emergency circumstances, the Insurer shall be bound financially up to the time when it expresses objections to the physician's order, in the event of considering that the policy does not cover the medical act or hospitalisation.

The Insurer undertakes to provide home service at the **address appearing in the Policy only, and any change thereof shall have to be notified** by registered letter **at least eight days prior to the request for any service**.

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

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

2. At facilities not partnered with the Insurer

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

In emergency circumstances as defined herein, the Insurer will accept liability for the medical-healthcare expenses occasioned at private centres, although the Insured should notify it by any means within 72 hours of the provision of the said care, in order to transfer him/her to one of the centres approved by the Insurer, provided that the clinical situation so permits. Likewise, he/she shall supply a written description of the claim within a maximum period of 7 days, in accordance with article 16 of the Insurance Contract Act.

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

Other features of your insurance

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

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

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

a) If in the process of completing the questionnaire the Policyholder or Insured inaccurately reports or fraudulently omits any fact known to him/her that might bear upon appraisal of the risk, the Insurer may terminate the Agreement within thirty days following the date on which it becomes aware of such omission (article 10 of the Insurance Act).

b) In the event of aggravation of the risk, if the Policyholder or the Insured fails to inform the Insurer and has acted in bad faith (article 12 of the Insurance Act).

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

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

3. The Policyholder may rescind the Policy when the doctors' list is altered, providing that it affects the family doctor or the obstetrician or the local paediatrician or 50% of the specialists making up the

doctors' list provided by the Insurance Company, which shall keep the full updated list of these specialists at its offices at the Insured's disposal so that it may be consulted.

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

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

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

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

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

This right applies only to natural-person Policyholders acting for purposes other

than their own business or occupational activity.

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

DURATION OF INSURANCE

1. The insurance is stipulated for the **period of time specified in the Particular Terms and Conditions** and at its expiration, in accordance with article 22 of the Insurance Contract Act, it shall be extended tacitly for periods not exceeding one year. Nevertheless, either of the parties may repudiate extension by giving the other party due written notice not less than two (2) months before the date of expiration of the current period.

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

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

a) **By reason of death.**

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

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

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

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

INSURANCE PREMIUMS

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

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

3. **If the second and successive premiums are not paid, the Insurer's cover is suspended one month after its expiration date**, and if the Insurer does not claim payment within six (6) months of said expiration, the contract shall be considered to have lapsed. If the contract has not lapsed or been terminated in accordance with the foregoing conditions, the cover becomes effective again twenty-four (24) hours after the day on which the Policyholder pays the premium. In any case, when the contract is in abeyance,

premium payment may only be demanded for the current period.

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

5. Whenever the contract is renewed the Insurer may change the annual premium and the amount of the Policyholder's contribution to the cost of services in accordance with the technical and actuarial calculations made based on the increase in healthcare service costs, the type and increase of benefits guaranteed and the inclusion of medical technological innovations that were not covered at the time the Policy was arranged.

The premiums to be settled by the Policyholder vary according to the age reached by each Insured, their gender and the geographical area corresponding to where the services are rendered, applying the rates determined by the Insurer at the time each Policy is renewed.

6. After receiving the Insurer's notice, when appropriate, relating to the variation in the amount of the premiums for the next annual period, the Policyholder may choose between extending the insurance Policy and terminating it at the expiration of the current insurance period. In the latter case, the Policyholder shall notify the Insurer in writing of his/her desire to terminate the contractual relationship at its expiration date. Payment of the first premium corresponding to the premium for the current extension period shall signify acceptance of the set of new insurance contract conditions.

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

RIGHTS AND DUTIES

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

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

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

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

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

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

The Insurer may propose an amendment in the contract within two (2) months of the day on which the aggravation was declared to it. In this case the Policyholder has fifteen (15) days as of receipt of this proposal either to accept or reject it. In case of rejection or of silence on the Policyholder's part, the Insurer may terminate the contract at the end of this period, after giving the Policyholder prior notice, offering him/her a further period of fifteen (15) days to answer, after which and within the next eight (8) days notify the Policyholder of the final cancellation.

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

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

d) Lessen the consequences of the claim by using all the means at his/her disposal for

early recovery. Non-compliance with this duty with evident intent to harm or deceive the Insurer shall release the latter from all benefit obligations stemming from the claim.

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

f) For the use of the relevant services as described in Clause One, the Insured shall present his/her Sanitas card, which is a personal and transferable document. In case of loss or theft of this card, the Policyholder and/or Insured is/are under the obligation to inform the Insurer thereof within forty-eight (48) hours, whereupon a new card shall be issued and the mislaid or stolen one cancelled.

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

g) If the assistance the biological mother receives during the delivery is covered by Sanitas, newborn infants may be included in the policy with full rights if the inclusion of the biological mother under the policy took effect at least 365 days prior to childbirth. The Policyholder must notify Sanitas of the birth within thirty (30) calendar days following the date of birth by completing an insurance application.

Sanitas may itself process subscriptions for newborn children satisfying the requirements referred to in the foregoing paragraph.

In any case, Sanitas shall only cover the newborn's healthcare if its inclusion has been made in the Insurance Company.

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

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

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

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

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

3. Insurer's obligations

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

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

COMPLAINTS

1. Complaints book

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

2. Lapse of right to claim

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

3. Supervision and venues of complaint

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

B. In the event of any complaint in connection with the insurance agreement, the Policyholder, Insured, Beneficiary, aggrieved third party or the successors or assigns of any of the foregoing must apply to:

1. The Insurer's Client Service Department -by means of a letter **addressed to calle Ribera del Loira n° 52 (28042 Madrid) or to fax n° 91,585 24 88 80 or to the e-mail address departamentocalidad@sanitas.es**, which shall acknowledge receipt in writing and issue a reasoned written decision, **within the statutory deadline of two (2) months** from the date of filing of the complaint.

2. Once the Insurer's above-mentioned internal process has been exhausted, or in

the event of disagreement with the formers decision, a complaint may be lodged with the Insurance Ombudsman designated by the Insurer in the following cases:

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

b) When the Insurer so agrees even though the foregoing requirements are not met. To file a claim with the **Insurance Ombudsman**, the claimant shall remit a written statement to post office box n° 50.072 (28080 Madrid) setting forth the grounds for his/her claim. The Ombudsman shall issue a written acknowledgement of receipt and declare whether or not he/she is authorised to examine the complaint. If the Ombudsman declares that he/she is authorised, he/she shall examine the complaint and within the legal deadline of two (2) months from the date the complaint was filed with the Insurer shall issue a reasoned decision, written notice of which shall be served on the complainant and the Insurer, on whom the decision shall be binding.

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

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

OTHER IMPORTANT LEGAL POINTS

1. Subrogation

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

The Insurer shall not be entitled to subrogation against any of the persons whose acts or omissions may give rise to the Insured's liability, in accordance with the law, nor against the originator of the claim who is a relative of the Insured in direct or collateral line in the third civil degree of kinship or an adopting parent or adoptive child living with the Insured.

But this rule shall not be effective if the liability stems from bad faith or if the liability covered by means of an insurance contract. In the latter case, the subrogation shall be limited in its scope in accordance with the terms of that contract.

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

2. Duplicate Policy

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

The request shall be made in writing explaining the circumstances of the case, evidence shall be supplied of having notified whoever may be holders of any right by virtue of the Policy, and the applicant shall undertake to return the original Policy should it eventually turn up

and compensate the Insurer for any damages occasioned by a third party claim.

3. Notices

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

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

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

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

4. Personal data protection clause

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

Nevertheless, he/she authorises the Insurer to ask physicians, clinics and other institutions for - and he/she therefore authorises such persons to provide to the Insurer - any data on the health of the persons included under the policy that the Insurer may deem expedient for the management of the insurance, for offering comprehensive healthcare programmes that the Insurer may have available to improve its healthcare process, for the

proper appraisal and assessment of the risks to be covered, to prevent fraud, and to attend to the claims put forth by the insured parties.

Furthermore, and in accordance with *Ley 15/1999 de 13 de diciembre de Protección de Datos de carácter Personal* (the Spanish Data Protection Act 1999) and Royal Decree 1720/2007 of 21 December 2004, approving the implementing rules of the aforementioned Act, the Insurer informs the policyholder and the insured parties and they consent to all their personal data being entered in files held by the Insurer for the purpose of the company's activities, the effectiveness of contractual relations, the provision of integrated care programmes that will allow them to improve their health, the understanding of reasons for cancelling the policy, fraud prevention and the sending, by any means, of advertising or other offers that might be of interest from the entity and third parties with which it collaborates, authorising SANITAS to use their data to send them the information that best meets their particular needs. For the purpose of preventing fraud, the insured parties expressly consent to the Insurer keeping such data as are necessary, even after the contractual relationship has ended. If the Policyholder/Insured withholds consent for his/her data to be entered in such files and subsequently processes, the insurance contract cannot be arranged.

In addition, the insured parties and the policyholder expressly authorise assignment of those data to companies of the Sanitas Group identified at www.sanitas.es, relating to financial, insurance, social and healthcare, and/or health and welfare products and services, and for the reason of co-insurance and/or reinsurance of the risk and any other person with which SANITAS creates ties of

cooperation, for the effectiveness of contractual relations with the insured and for sending advertising from those companies.

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

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

He/she may exercise their statutory rights of challenge, access, rectification and erasure of these data at the Insurer's head office at Calle Ribera del Loira 52, 28042 Madrid, Customer Relations Department.

If the policyholder and/or insured parties do not wish to receive commercial information from the Insurer or, as applicable, from other companies the Insurer collaborates with, or who do not wish their data to be transferred to other companies except for the effectiveness of contractual relations, they must make this known in writing to the following e-mail address: relacionesclientes@sanitas.es.

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

OTHER

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

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

JURISDICTION

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

Executed in duplicate originals at Madrid, 20 June 2012

For the Insured/Policyholder

For the Insurer

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

**SUPPLEMENTARY COVERS
OF YOUR POLICY**

Sanitas Dental

In this type of services the Policyholder does not need to pay any amount to the odontologist.

The medical care covered will be only provided by the doctors included in the list of odontologists of the medical staff corresponding to this policy.

This medical care will be provided only at the clinic of the odontologist, excluding expressly care out of it.

The services and acts listed below are object of coverage:

GENERAL AND PREVENTIVE ODONTOLOGY

- General dentistry consultation: examination and diagnosis
- Topical fluoride treatments
- Oral cleansing/tartar removal
- Treatment for dental sensitivity
- Fissure sealer

SURGICAL PROCEDURES

Extractions

- Simple extraction
- Extraction of non-impacted third molars
- Extraction of impacted teeth (including impacted third molars)
- Extraction of root remains
- Dental section
- Dressings

Minor surgery

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

Orthodontic surgery

- Surgical-orthodontic treatment (fenestration) (per tooth)

CONSERVATIVE DENTISTRY

- Provisional obturation

COSMETIC DENTISTRY

Whitening

- Photoactivacion whitening brace (for treatments performed at the clinic)

CHILDREN'S DENTISTRY

- Consultation
- Buccodental education
- Intraoral X-rays (children up to 12 years)
- Topical fluoride treatments
- Fissure sealer
- Extraction of deciduous teeth

PROSTHESES

- Occlusal analysis
- Selective carving
Fixed prosthesis
- Recementation

PERIODONTICS

Nonsurgical treatments

- Periodontal examination (periodontal X-rays) (per arch)
- Periodontal X-ray series

Surgical treatments

- Gingivectomy (per quadrant)

ORTHODONTICS

Supplementary treatments

- Consultation
- X-ray study for orthodontics
- Extraction of deciduous teeth
- Simple extraction

- Revisions (in latency or resting periods)
- 1st replacement metal brackets
- 1st replacement ceramic brackets
- 1st replacement self-binding brackets
- 1st replacement sapphire brackets
- Orthodontics box
- Oral protector for orthodontics

DENTAL IMPLANTS

- Implantology study
- Implantology maintenance for treatments covered under Milenium

IMAGING DIAGNOSIS: RADIOLOGY/OTHERS

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

TEMPOROMANDIBULAR JOINT PATHOLOGY

- Occlusal analysis
- Selective carving

EMERGENCIES

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

SERVICES WITH PREMIUM PAID BY THE POLICYHOLDER:

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

b) The Policyholder will assume the cost of the appropriate services in compliance with

the schedule for premiums applicable at the time provided.

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

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

SURGICAL PROCEDURES

Minor surgery

- Frenectomy (upper or lower)

Pre-prosthetic surgery

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

CONSERVATIVE DENTISTRY

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

ENDODONTICS

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

COSMETIC DENTISTRY

Whitening

- Custom tray tooth whitening (per treatment)

- Internal whitening of non-vital tooth (per session)
- Tooth whitening by photoactivation (laser, plasma, xenon) (per tooth)
- Dental bleaching: mixed treatment photoactivation plus brace (one arch per treatment)
- Dental bleaching: mixed treatment photoactivation plus brace (both arches per treatment)

Dental reconstruction

- Reconstruction of aesthetic composite front (per tooth)
- Intraoral repair of porcelain (per tooth)
- Porcelain facing
- Injected facing
- Zirconia facing
- Injected crown
- Zirconia crown

CHILDREN'S DENTISTRY

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

PROTHESIS

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

Fixed prosthesis

- Bridge/crown/space maintainer removal (per tooth)
- Metal inlay
- Composite inlay
- Porcelain inlay
- Provisional resin crown
- Metal-porcelain bridge or crown
- Noble metal-porcelain bridge or crown
- Porcelain bridge or crown

- Injected bridge or crown
- Zirconia bridge or crown
- Fiberglass bridge or crown
- Monoradicular cast stump
- Multiradicular cast stump
- Zirconia stump
- Maryland support (unit)
- Attaches

Removable prosthesis

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

PERIODONTICS

Non-surgical treatments

- Periodontal maintenance
- Curettage (radicular scraping and smoothing) (per quadrant)
- Periodontal bracing (per tooth)
- Curettage (scraping and smoothing) (per tooth)

Surgical treatments

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

ORTHODONTICS

Supplementary treatments

- Study and diagnosis for orthodontics
- Retention appliance (end of treatment) (per arch)
- Renewal mobile device, replacement or loss
- Appliance repairs (due to appliance breakage)
- Orthodontic microscrews
- 2nd replacement metal brackets (unit)
- 2nd replacement ceramic brackets (unit)
- 2nd replacement self-binding brackets (unit)
- 2nd replacement sapphire brackets

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

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

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

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

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

- Start of both arches (includes first devices)

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

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

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

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

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

DENTAL IMPLANTS

- Implantology maintenance for treatments not covered by Milenium
- Dental Implant surgery*
- Osteointegrated implant (unit)
 - Closed maxillary sinus lift
 - Open maxillary sinus lift
 - Regeneration with biomaterials (lyophilised bone, etc.)
 - Membrane (unit)

Guided surgery

- Study for guided implantological surgery
- Supplement per implant in guided surgery (unit)
- Preoperative barium brace for dental scan
- Surgical brace (for guided surgery)

Prosthesis over implants

- Metal-porcelain crown over implant
- Noble metal-porcelain crown over implant
- Injected crown or bridge over implant
- Zirconia bridge or crown over implant
- Provisional crown for immediate charge
- Titanium stump (per tooth)
- Zirconia stump over implant (per tooth)
- Overdenture on implants (per appliance)
- Hybrid prosthesis (per arch)

- Supra- or mesostructure (unit)
- Precious metal supplement
- Prosthetic additament (intermediate pieces)
- Prosthetic additament for immediate charge
- Locator (unit)
- Micromilled Bar (on 5 implants or fewer)
- Micromilled Bar (on 6 implants or more)

TEMPOROMANDIBULAR JOINT PATHOLOGY

- Assembly and study of semi-adjustable articulator
- Revisions, brace adjustments
- Neuromyorelaxation brace (Michigan type)

If you need to contact us

If you need to contact us, please do not hesitate to use any of the contact options listed below.

Customer service 902102 400



A telephone helpline on which you can ask us about our services and the covers under your policy, get confirmation for referral authorizations requiring Sanitas approval, and provide us with suggestions and comments.

International healthcare cover 91 345 65 84

Telephone helpline for emergency medical care outside Spain.

Sanitas 24 hours 902 106102



Your queries will be dealt with by health professionals, 24 hours a day, 365 days a year. You may request medical advice and ask questions about treatments and the implications of analytical findings.

24-hour emergency line 902 103 600

Emergency telephone helpline, 24 hours a day, every day of the year.



Second opinion 902 408 409

Helpline providing second opinions on diagnoses and treatment of serious and chronic diseases, supplied by leading specialists anywhere in the world.



To arrange cover 901 100 210

Helpline to sign up to Sanitas products and services.

Headquarters: Ribera del Loira, 52 -28042 Madrid
Fax 91585 87 00 Website www.sanitas.es

Useful phone numbers and addresses

Use this sheet to jot down the phone numbers and addresses of specialists you visit most often or the most useful ones.

This will help you locate their contact details quickly when you need them.

DOCTOR:	Specialty:
Telephone:	
Address:	

DOCTOR:	Specialty:
Telephone:	
Address:	

DOCTOR:	Specialty:
Telephone:	
Address:	

DOCTOR:

Specialty:

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DOCTOR:

Specialty:

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Address:

DOCTOR:

Specialty:

Telephone:

Address:

DOCTOR:

Specialty:

Telephone:

Address:

**YOUR PARTICULAR
TERMS AND CONDITIONS**

Complementary guarantee

The additional guarantees listed below will only be provided to policyholders who have specifically taken them out under this policy and provided that they are reflected in the policy documentation that is sent to each insured party and which individually specifies the additional guarantees taken out by each policyholder as applicable.

Sanitas Dental

Description of the insurance:

- **Insurable group: employees of the policyholders and their spouses or common-law partners and respective offspring.**
- **Insured group: persons belonging to the insurable group in relation to whom the policyholder has notified Sanitas in writing of their inclusion as insured in this policy, this entering into force as of the 1st day of the calendar month following that during which said notification was made.**

PERSONAL DATA PROTECTION

The GROUP and SANITAS have reached an agreement whereby the persons designated as "Insured Group", "members", "insured parties" or "beneficiaries" (interchangeably) may benefit from the terms agreed in that agreement to arrange a healthcare policy, which terms are better than those SANITAS offers individual members. In order to ascertain membership of the GROUP for each "member" or "insured party" and his/her consequent entitlement to benefit from the terms of that policy, it may be necessary for the parties to share the basic identifying data of the policy "beneficiaries" or "members".

To ensure the confidentiality of the information of any kind that the parties must share with one another under this agreement, and particularly if such information contains personal data of the policy "beneficiaries" or "members" which may from time to time have to be communicated, the parties undertake a duty to uphold the strictest confidentiality as to all such information as may be disclosed to each by the other party during the term of effect of this contract as a result of the services undertaken by virtue of this document.

If the MEMBERS of the GROUP arrange the healthcare policy with SANITAS, the latter will be the controller of the data file collated as a result of the arrangement of the healthcare policy, and may process such data as necessary to give effect to the insurance contract, and for such other purposes as to which it may have requested consent from the data subjects. Such consent must have been obtained by SANITAS via the procedures put in place by that company for the purpose, including, by way of example, direct registration of the "beneficiary" or "member" over the website provided by SANITAS to GROUP beneficiaries, or by handwritten signature by the beneficiary of the insurance application.

If the parties must disclose data on the "beneficiaries" or "members" covered by the agreement, they must do so to ascertain, first, that such persons exhibit the necessary

characteristics to benefit from the terms of the policy agreed between the GROUP and SANITAS, i.e., to ascertain membership of such persons of that Group, and, secondly, to monitor the incidence of loss events, and consequently agree upon the applicable insurance premium. Data subjects must be informed of such disclosure, which will be permitted by article 11.2 c) of the Data Protection Act 1999.

The parties undertake properly and at all times to comply with the Data Protection Act 1999 (*Ley Orgánica 15/1999*) and any other prevailing or future laws and regulations on the matter.

The parties must hold one another harmless against any economic liability that may arise out of third-party claims for breach of any of their duties or obligations under this clause or under applicable laws and regulations on personal data protection, provided that one of the parties is held by a final court decision to be exclusively liable.

SHARING IN THE COST OF SERVICES

What is co-payment?

Co-payment in the cost of services is a practice adopted by the majority of health insurance companies. It involves asking the policyholder for a symbolic amount each time he or she uses the policy. This is to make policyholders aware of the responsible use of care services and avoid unnecessary saturation. It offers all members better availability when it is really required. Below we specify the co-payment you will be required to make for each use of the care services:

Every time the Policyholder and/or Insured uses the Sanitas card, he or she shall have to satisfy the following amounts to the Insurer by way of participation in the cost of services:

- For the SANITAS DENTAL Policy:
 - €3.00 euros --> Services included in the dental policy without payment to franchises and services indicated in these specific terms and conditions as INC (included).
 - €0.00 euros --> All other dental product services
- For the SANITAS MULTI Policy:
 - €2.00 --> Technical Medical Consulting, rehabilitation, physical therapy, general medicine, general paediatrics and maternity
 - €2.00 --> 24-hour Sanitas services (plus cost of call)
 - €5.20 --> Hospital admissions, hospital emergencies and ambulances
 - €5.20 --> Home emergencies
 - €11.70 --> Monofocal intraocular lens
 - €11.70 --> Psychology
 - €12.00--> Childbirth classes
 - €4.00 --> Visits, all other diagnostic tests, home visits and all other services
 - Hospital Emergency (annual frequency)
 - - 0 to 10 services in the same year --> €5.20
 - - from 11 to 999 services in the same year --> €10.00
 - Rehabilitation Sessions (annual frequency)

LIMITS TO THE CAPITAL INSURED APPLICABLE TO PROSTHESES BY THIS POLICY

Area	Prosthesis – implantable item	Capital insured per prosthesis
Ophthalmology	Intraocular lens (monofocal for cataract surgery)	100€
Traumatology and orthopaedic surgery	Hip prosthesis	3,500€
	Knee prosthesis	3,500€
	Prosthesis of other joints (shoulder, elbow, foot, hand, etc)	3,500€
	Spinal fixation (one vertebral level = 2 vertebrae)	4,500€ any intervention with more than one level requires assessment with a medical report and estimate
	Intervertebral discs (unit)	4,500€
	Material for intervertebral (or interspinal) interposition	2,500€
	Vertebroplasty / kyphoplasty	2,000€
	Ligament prostheses (including biological from national tissue banks)	1,800€
	Osteosynthesis material	2,000€
Cardiovascular area	Vascular prostheses (stent by-pass) (expressly excluding any section of the aorta and vessels with valves)	1,800€
	Cardiac valves (expressly excluding vessels with valves)	4,500€
	Pacemaker (not including any type of defibrillator)	6,000€
	Coronary stent (unit – drug –eluting or not)	2,000€
	Coils	No limit
Chemotherapy or pain treatment	Reservoirs	800€

Surgery	Abdominal meshes	500€
	Urological suspension systems	1,000€ with estimate and authorisation
	Systems for bypass of cerebrospinal fluid (hydrocephaly)	1,500€
	Breast prostheses and expanders (provided there has been prior tumour surgery in the affected breast)	1,000€

YOUR POLICY QUALIFICATION PERIODS

What qualification periods apply?

Qualification periods indicate the time that must pass between enrolment in health insurance and the possibility of requesting the use of stated healthcare services.

For the **Sanitas Multi** product:

The qualification periods in your Terms and Conditions do not apply to the insurance policy hereunder.

SUPPLEMENTAL COVERS OF YOUR POLICY

In addition to the covers arranged in this policy the following is/are also covered:

The following shall be applicable:

In order to receive insurance coverage for colonoscopy diagnostic testing via computed tomography (CT) indicated in the Imaging Radiodiagnostic-Diagnostic section of the General Terms and Conditions, the insured party shall contribute to the cost of the service, in a one-off payment of three hundred (300) euros, payment of which is mandatory prior to the rendering of the service. This diagnostic test may only be performed in specially approved centres chosen by the Insurance Provider.

In the Dental Healthcare Cover, the Insured must bear the cost of services in accordance with the scale of deductible amounts in force at the time of service provision.

The Policyholder agrees that he/she must pay the insurance premium or premium instalment agreed under the policy act as specified in these particular terms and conditions within 30 days.

The information contained in the present document is confidential and in accordance with Organic Law 15/1999 of December on the Protection of Personal Data and complementary regulations.

The Policyholder and/or Insured expressly accepts every one of the clauses set forth in the Particular Terms and Conditions and in the General Terms and Conditions, which he/she receives together with this document and declares to be aware of.

In particular, he/she agrees to the limitation clauses contained in those general terms and conditions and, as the case may be, in these particular terms and conditions, which have been printed in properly visible form pursuant to article 3 of the Insurance Contract Act.

Pursuant to article 107 of the Private Insurance Supervision Regulation, the Policyholder and/or Insured declare(s) that he/she/they has(ve) received on this day prior to the formation of the contract all the information referred to in article 104 of the Regulation (i.e., laws and regulations applicable to the insurance contract, venues of complaint and applicable procedure), which information also appears in this insurance policy.

Executed in duplicate originals at Madrid, 13 November 2012

For the Insured/Policyholder

For the Insurer



Sergio de Andrés Osorio

Customer Manager

Sanitas, S.A. de Seguros

DENTAL DEDUCTIBLES

SANITAS DENTAL

Services 2013

Deductibles 2013/€

PREVENTIVE DENTISTRY

General dentistry consultation: examination and diagnosis	inc
Topical fluoride treatments	inc
Oral cleansing/tartar removal	inc
Treatment for dental sensitivity	inc
Fissure sealer	inc

SURGICAL PROCEDURES

- EXTRACTIONS

Simple extraction	inc
Extraction of non-impacted third molars	inc
Extraction of impacted teeth (including impacted third molars)	inc
Extraction of root remains	inc
Dental section	inc
Dressings	inc

- MINOR SURGERY

Frenectomy (upper or lower)	48.50
Removal of epulis/small mucosal cysts	inc
Drainage of gingival/parodontal abscesses	inc
Apicoectomy	inc
Dental cyst	inc

- PREPROSTHETIC SURGERY

Vestibuloplasty (per quadrant)	112.50
Alveolar regularization (per quadrant)	112.50
Removal of torus (per quadrant)	112.50

- ORTHODONTIC SURGERY

Surgical-orthodontic treatment (fenestration) (per tooth)	inc
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CONSERVATIVE DENTISTRY

Fillings / obturation	36.00
Reconstruction	46.00
Direct pulp coating	14.50
Indirect pulp coating	9.50
Provisional obturation	inc

ENDODONTICS

Consultation for symptom treatment (opening, instrumentation and drainage)	16.50
Root-end filling material (MTA)	75.00
Fiberglass or carbon post	50.00
Monoradicular endodontics	75.00
Biradicular endodontics	102.00
Polyradicular endodontics	139.50
Monoradicular re-endodontics	91.00

SANITAS DENTAL

Services 2013

Deductibles 2013/€

Biradicular re-endodontics	118.00
Polyradicular re-endodontics	155.50

COSMETIC DENTISTRY

- WHITENING

Custom tray tooth whitening (per treatment)	250.00
Internal whitening of non-vital tooth (per session)	53.50
Tooth whitening by photoactivation (laser, plasma, xenon) (per tooth)	48.50
Dental bleaching: mixed treatment photoactivation plus brace (one arch per treatment)	300.00
Dental bleaching: mixed treatment photoactivation plus brace (both arches per treatment)	350.00
Photoactivation whitening brace (for treatments performed at the clinic)	inc

- DENTAL RECONSTRUCTION

Reconstruction of aesthetic composite front (per tooth)	51.50
Intraoral repair of porcelain (per tooth)	66.50
Porcelain facing	214.00
Injected facing	235.50
Zirconia facing	267.50
Injected crown	342.50
Zirconia crown	400.00

CHILDREN'S DENTISTRY

Consultation	inc
Buccodental education	inc
Intraoral X-rays (children up to 12 years)	inc
Topical fluoride treatments	inc
Fissure sealer	inc
Extraction of deciduous teeth	inc
Obturation of deciduous teeth	36.00
Pulpotomy without reconstruction	45.00
Pulpectomy without reconstruction	75.00
Preformed metallic crown	53.50
Apical formation (full treatment)	64.50
Fixed space maintainer	75.00
Removable space maintainer	90.00
Bridge/crown/space maintainer removal (per tooth)	11.50
Guided occlusion (per tooth)	40.00
Oral screen	45.00

PROSTHESES

Assembly and study of semi-adjustable articulator	43.00
Occlusal analysis	inc
Selective carving	inc
Diagnostic polishing (per tooth)	25.00

SANITAS DENTAL

Services 2013

Deductibles 2013/€

- FIXED PROSTHESIS

Bridge/crown/space maintainer removal(per tooth)	11.50
Recementation	inc
Metal inlay	52.00
Composite inlay	75.00
Porcelain inlay	128.50
Provisional resin crown	22.00
Metal-porcelain bridge or crown	193.00
Noble metal-porcelain bridge or crown	246.50
Porcelain bridge or crown	150.00
Injected bridge or crown	342.50
Zirconia bridge or crown	400.00
Fiberglass bridge or crown	250.00
Monoradicular cast stump	80.50
Multiradicular cast stump	96.50
Zirconia stump	180.00
Maryland support (unit)	64.50
Attaches	128.50

- REMOVABLE PROSTHESIS

Removable acrylic (1 to 3 teeth)	182.00
Removable acrylic (4 to 6 teeth)	235.50
Removable acrylic (more than 6 teeth)	273.00
Hypoallergenic resin supplement (per arch)	39.00
Repair (APL)	30.00
Repair (rebase) (per appliance)	60.00
Repair (addition of a retainer)	41.00
Repair (metal support)	25.00
Repair (add piece to acrylic removable)	36.00
Complete (one arch, upper or lower)	280.00
Skeletal (per tooth)	43.00
Skeletal (base structure)	187.50
Flexible removable (from 1 to 3 teeth) (Flexite, Valplast, others)	374.50
Flexible removable (from 4 to 6 teeth) (Flexite, Valplast, others)	396.00
Flexible removable (more than 6 teeth) (Flexite, Valplast, others)	428.00
Ceramic shoulder or neck (per tooth)	30.00

PERIODONTICS

- NON-SURGICAL TREATMENTS

Periodontal examination (periodontal X-rays) (per arch)	inc
Periodontal maintenance	30.00
Periodontal X-ray series	inc
Curettage (radicular scraping and smoothing) (per quadrant)	48.75
Periodontal bracing (per tooth)	37.50
Curettage (scraping and smoothing) (per tooth)	9.00

SANITAS DENTAL

Services 2013

Deductibles 2013/€

- SURGICAL TREATMENTS

Gingivectomy (per quadrant)	inc
Flap surgery (per quadrant)	96.75
Regeneration with biomaterials (lyophilised bone, etc.)	160.50
Membrane (unit)	214.00
Crown lengthening	130.00
Apical replacement flap (per quadrant)	198.00
Graft free gum	130.00

ORTHODONTICS⁽¹⁾

- SUPPLEMENTARY TREATMENTS

Study and diagnosis for orthodontics	64.50
Consultation	inc
X-ray study for orthodontics	inc
Extraction of deciduous teeth	inc
Simple extraction	inc
Retention appliance (end of treatment) (per arch)	128.50
Revisions (in latency or resting periods)	inc
Renewal mobile device, replacement or loss	120.00
Appliance repairs (due to appliance breakage)	32.50
Orthodontic microscrews	150.00
1 st replacement metal brackets	inc
2 nd replacement metal brackets (unit)	2.00
1 st replacement ceramic brackets	inc
2 nd replacement ceramic brackets (unit)	5.00
1 st replacement self-binding brackets	inc
2 nd replacement self-binding brackets (unit)	8.00
1 st replacement sapphire brackets	inc
2 nd replacement sapphire brackets (unit)	10.00
Orthodontics box	inc
Oral protector for orthodontics	inc

TREATMENT WITH FIXED APPLIANCES

- WITH METAL BRACKETS

Start of one arch; upper or lower (including first appliance)	231.50
Start of both arches (including first appliances)	385.50
Treatment	2,172.50

- WITH CERAMIC BRACKETS

Start of one arch; upper or lower (including first appliance)	445.50
Start of both arches (including first appliances)	642.00
Treatment one arch	2,386.50
Treatment both arches	2,600.50

SANITAS DENTAL

Services 2013

Deductibles 2013/€

- WITH SAPPHIRE BRACKETS

Start of one arch; upper or lower (including first appliance)	795.50
Start of both arches (including first appliances)	1,242.50
Treatment one arch	2,736.50
Treatment both arches	3,200.50

- WITH SELF-BINDING BRACKETS

Start of one arch; upper or lower (including first appliance)	499.00
Start of both arches (including first appliances)	695.50
Treatment one arch	2,440.00
Treatment both arches	2,707.50

- WITH AESTHETIC SELF-BINDING BRACKETS

Start of one arch; upper or lower (including first appliance)	699.00
Start of both arches (including first appliances)	895.50
Treatment one arch	2,640.00
Treatment both arches	2,907.50

- WITH INVISIBLE TECHNIQUE

Start treatment under 12 months of age	3,210.00
Start treatment over 12 months of age	4,280.00

INTERCEPTIVE TREATMENT

- WITH FIXED APPLIANCES

Start of one arch; upper or lower (including first appliance - quad helix)	160.50
Start of both arches (including first appliances)	321.00
Treatment	1,658.50

- WITH REMOVABLE APPLIANCES

Start of one arch; upper or lower (including first appliance)	193.00
Start of both arches (including first appliances)	385.50
Treatment	1,658.50

MIXED TREATMENTS

- ORTHOPAEDIC FORCE WITH FIXED APPLIANCES

Start of one arch; upper or lower (including first appliance)	374.50
Start of both arches (including first appliances)	428.00
Treatment	2,397.00

- ORTHOPAEDIC FORCE WITH REMOVABLE APPLIANCES

Start of one arch; upper or lower (including first appliance)	407.00
Start of both arches (including first appliances)	481.50
Treatment	2,397.00

DENTAL IMPLANTS

Implantology study	inc
Implantology maintenance for treatments covered under Milenium	inc
Implantology maintenance for treatments not covered by Milenium	53.00

SANITAS DENTAL

Services 2013

Deductibles 2013/€

- DENTAL IMPLANT SURGERY

Osteointegrated implant (unit)	682.50
Closed maxillary sinus lift	64.50
Open maxillary sinus lift	187.50
Regeneration with biomaterials (lyophilised bone, etc.)	160.50
Membrane (unit)	214.00

- GUIDED SURGERY

Study for guided implantological surgery	300.00
Supplement per implant in guided surgery (unit)	150.00
Preoperative barium brace for dental scan	500.00
Surgical brace (for guided surgery)	850.00

- PROSTHESIS OVER IMPLANTS

Metal-porcelain crown over implant	235.50
Noble metal-porcelain crown over implant	289.00
Injected crown or bridge over implant	342.50
Zirconia bridge or crown over implant	400.00
Provisional crown for immediate charge	200.00
Titanium stump (per tooth)	187.50
Zirconia stump over implant (per tooth)	290.00
Overdenture on implants (per appliance)	428.00
Hybrid prosthesis (per arch)	1,796.00
Supra- or mesostructure (unit)	96.50
Precious metal supplement	APQ
Prosthetic additament (intermediate pieces)	187.50
Prosthetic additament for immediate charge	187.50
Locator (unit)	480.00
Micromilled Bar (on 5 implants or fewer)	2,250.00
Micromilled Bar (on 6 implants or more)	2,250.00

IMAGING DIAGNOSIS: RADIOLOGY/OTHERS

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

TEMPOROMANDIBULAR JOINT PATHOLOGY

Assembly and study of semi-adjustable articulator	43.00
Revisions, brace adjustments	32.50
Occlusal analysis	inc
Selective carving	inc
Neuromyorelaxation brace (Michigan type)	230.00

Inc: Services included in insurance coverage with no deductible charged / **APQ:** according to price and quotation / **ALP:** according to laboratory price.

(1) For all orthodontics treatments, the price listed is stated per patient and finished work. This price does not include subsequent reviews.

According to the particular conditions of the policy, these services may be associated with a deductible amount.