

SANITAS HEALTH PLAN BASIC

**GENERAL
CONDITIONS**

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WHAT ARE THE GENERAL CONDITIONS?

IT IS THE TEXT THAT SETS OUT ALL THE OBLIGATIONS AND RIGHTS BOTH OF POLICY-HOLDERS AND OF SANITAS.

PRELIMINARY CLAUSE

This policy is governed by the provisions of the Insurance Contract Act 50/1980, of 8 October, by the Private Insurance Regulation and Supervision Act 30/95, of 8 November, and its implementation rules (Royal Decree no. 2486/98 of 20 November) and by what is agreed in the General Conditions, in any applicable special conditions and in the Particular Conditions, although clauses restricting the rights of Policy-holders 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 precepts.

DEFINITIONS

For purposes of this contract the under-mentioned terms have the following definitions:

ACCIDENT

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

BENEFICIARY

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

BENEFIT

It is the healthcare or payment of insured capital that stems from the filing of a claim covered by the policy. Care is the act of attending to or looking after a person's health.

CLAIM

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

CONGENITAL DISEASE

It is a disease that exists at the time of birth as a result of hereditary factors or conditions acquired during pregnancy up to the time of birth. A congenital condition may be manifested and recognised immediately upon birth or else be discovered later, in any period of the individual's lifetime.

CONSULTANT PHYSICIAN/SURGEON

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

CONTESTABILITY PERIOD

Period of time during which the Insurer may withhold its benefits or contest the contract alleging prior undeclared diseases on the Insured's part. At the end of this period, this capacity will only be open to the Insurer if the Policy-holder and/or Insured has acted fraudulently.

DENTIST

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

DISEASE

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.

EMERGENCY

It is a situation that requires immediate medical care as a delay could prove life-threatening or lead to irreparable harm to the patient's physical integrity.

EMERGENCY HOME SERVICES

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

HOME SERVICES

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

HOSPITAL

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

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

HOSPITALISATION

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

INJURY

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

INSURED

The individual or individuals, designated in the Particular Conditions, in relation to whom the policy is taken out.

INSURER OR INSURANCE COMPANY

Sanitas, Sociedad Anónima de Seguros", the company that assumes the contractually agreed risk.

ORTHOPAEDIC MATERIAL

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

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.

PAEDIATRICIAN

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

PHYSICIAN

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

POLICY

Written document that contains the conditions governing the insurance. The following form an integral part of the Policy: the insurance application, health questionnaire, general, particular and special conditions and the supplements or appendices that are added to it either to complete or amend it.

POLICY-HOLDER

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

PRE-EXISTING DISEASE

It is a disease suffered by the Insured prior to the date when the Policy is taken out or takes effect.

PREMIUM

It is the price of the insurance, i.e. the amount that the Policy-holder or Insured has to pay the Insurer. The premium receipt will also contain the surcharges, duties and taxes that may be legally applicable.

PROSTHESIS

An 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, substitute joints, synthetic skin, intraocular lenses, biological materials (cornea), fluids, gels and synthetic and semi-synthetic liquid substitutes for humours or organic fluids, etc.

REGISTERED NURSE

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

SANITAS 24 HORAS

Telephone information service provided by a team of physicians. The team will advise the Insured on health issues 24 hours a day, 365 days a year. The information thus provided is intended as guidance only and cannot substitute for direct healthcare.

SPECIAL HOME CARE

Care given to the Insured by a general practitioner and/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 on medical prescription. It does not include the expenses generated by attention of a social type, catering, 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.

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.

VISIT

Care relationship between patient and practitioner whereby both are physically present at the same time at the same place.

WAITING PERIOD

Period of time (calculated by months passed as of the effective date of the insurance) during which some of the covers included do not enter into force.

I. OBJECT OF THE INSURANCE

The Insurer hereby assumes, on the terms and with the limits set forth in the General, Particular and, when applicable, Special Conditions and Policy Supplements that may be issued, coverage throughout Spain of the medical care not involving admission to hospital or surgery, according to standard practice, for 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 Conditions.

a) How the services are provided

As specified in the applicable regulatory provisions, care will 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 will be provided in the province of the Insured's choosing where such facilities do exist.

Policy-holders are free to consult the specialist forming part of the Insurer's medical staff. 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 the family doctor. The Insured may change family doctor by simply notifying the Insurer, without having to give any reason.

Upon receiving the due services, the Insured should show the Sanitas card, as well as the last premium paid receipt as evidence of being up to date in the payments. The Insured is also obliged to show his/her National Identity Card if so required.

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

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

The Insurer undertakes to provide home service at the address appearing in the Policy only, and any change thereof will 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 should 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. When exceptional care needs should so require, the Insurer may send the Insured to a public centre for treatment.

b) Care at facilities not approved by the Insurer

The Insurer will 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 last paragraph of the above title, a) "How the services are provided".

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 said care, in order to transfer him/her to one of the centres approved by the Insurer, providing that the clinical situation so permits. Likewise, s/he should supply a written description of the claim within a maximum period of 7 days, in accordance with article 16 of the Insurance Contract Law.

c) Description of the services

The different benefits that form the subject matter of this contract are:

1. Primary Medicine

1.1. General Medicine. Medical care at the consulting room, indication and prescription of tests and basic diagnostic means (analyses and general radiology), during the days and hours set for this by the physician, and at the Insured's home when s/he is unable to go to the doctor's consulting room for reasons solely dependent on the disease s/he is suffering. In this case the telephone requests by the Insured for home care should be made to the doctor between 9 a.m. and 4 p.m.

1.2. Paediatrics and Puericulture. It 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, ultrasonography and general radiology). The same afore-mentioned rules apply to General Medicine.

1.2.1. Child Health Programme. It comprises psychoprophylactic preparation for childbirth with practical and theoretical classes in Puericulture and Psychology, parent school during the child's first year of life, and health examinations of the newborn, metabolic disease tests, audiometry, visual acuity testing, as well as a programme of health checks scheduled at key ages for development during the first four years.

1.3. Registered Nurse Service. Consulting-room and home care, the latter subject to prior prescription by one of the Insurer's doctors only and making the notification calls as specified in point 1.1 relating to General Medicine.

2. Emergencies

In the event of outpatient emergencies healthcare shall be provided at the permanent emergency centres listed in the Guide to Doctors and Services. The Insured may also call the emergency hotline listed in the Guide to Doctors and Services. In justified circumstances, home service will 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 specialities and diagnostic tests

Cover only includes care visits for the specialities listed below, which will be provided by care departments designated by the Insurer. A previous written prescription issued by one of the Insurer's specialists is required.

3.1. Allergy and Immunology. Autovaccines shall be at the Insured's own expense

3.2. Clinical Analyses.

3.3. Anatomic Pathology.

3.4. Anaesthesiology and Resuscitation.

3.5. Angiology and Vascular Surgery. Visit only.

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

3.7. Cardiology. It 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 will be required.

3.8. Cardiovascular Surgery. Visit only.

3.9. General and Gastrointestinal Surgery. Visit only.

3.10. Oral and Maxillofacial Surgery. Visit only.

3.11. Paediatric Surgery. Visit only.

3.12. Plastic and Repair Surgery. Visit only.

3.13. Chest Surgery. Visit only.

3.14. Dermatology.

3.15. Diagnostic imaging. Cover includes routine techniques such as general radiology, ultrasonography, CT-scan, magnetic resonance, angiography, digital arteriography and gammagraphy, bone densitometry, mammography. **Positron tomography is only included for cases and indications defined and accepted by the competent Spanish authorities.** The Insurer shall also be liable for the contrast means, solely in examinations performed as part of outpatient care.

3.16. Endocrinology.

3.17. Geriatrics. Any care arising out of social problems is excluded.

3.18. Haematology and Haemotherapy.

3.19. Internal Medicine

3.20. Nuclear Medicine. Radioactive isotopes.

3.21. Nephrology.

3.22. Pneumology.

3.23. Neurosurgery. Visit only.

3.24. Neurology.

3.25. Gynaecology.

3.26. Odontostomatology. It only includes extractions, stomatological cures stemming from these and buccal cleaning prescribed by the Insurer's dentist.

3.27. Ophthalmology

3.28. Oncology. Cover includes diagnosis and treatment planning by Oncology specialists for the subsidiary illnesses relating to this speciality. The cost of applying treatment shall be borne by the Insured.

3.29. Otorhinolaryngology.

3.30. Psychiatry.

3.31. Rheumatology.

3.32. Traumatology.

3.33. Urology. Visit only.

3.34. Consultant Physicians and Surgeons. Visit only. They will be designated by the Insurer's Management for special cases and upon the reasoned request of one of its specialists.

4. Therapeutic Methods

They shall be performed by the services designated by the Insurer and the prior written prescription of one of the Company's doctors will be required.

4.1. Aerosol Therapy and Ventilotherapy. This service shall be provided for the subsidiary illnesses relating to such treatments. The Insured shall in all events be liable for the cost of the drugs.

4.2. Hemodiálisis. This service will be provided, solely on an outpatient 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. Logophoniatrics. It will only be provided in relation to organic processes for up to a maximum of 6 months a year.

4.5. Oxygen therapy. Outpatient oxygen therapy is only included for **those patients requiring treatment with oxygen during at least 16 hours a day.**

4.6. Radiotherapy. Surface and internal in out-patient care only.

4.7. Rehabilitation. Rehabilitation will be provided as out-patient care exclusively for motor system disorders at centres designated by the Insurer.

4.8. Pain Relief Treatment. Solely as out-patient care. Cover includes implantable medication reservoirs used in pain relief treatment.

5. Other Services

5.1. Ambulance. This service will 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 will 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 will not be required. **This service does not include the transfers required for rehabilitation therapies or for performing diagnostic tests on an outpatient basis.**

5.2. Podiatry. Limited to five sessions a year.

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

6.- SANITAS 24 HORAS

Telephone information service provided by a team of physicians. The team will advise the Insured regarding health queries on treatment, medication, test reading, etc., 24 hours a day, 365 days a year.

II. EXCLUDED RISKS

For the purpose of this policy the following medical and/or hospital expenses are not included:

- a) All hospitalisations, be they medical, surgical or of any other kind, including preventive or social.
- b) Cover does not include any surgical intervention performed during a care visit, in day hospital or while in hospital.
- c) All types of pre-existing and/or congenital diseases, defects or deformations, 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 stem from the former, providing that they were known by the Policy-holder or Insured and not declared.

At the time of subscribing the insurance proposal/application the Policy-holder is obliged to declare, on his 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 recurring 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 will be considered pre-existent and/or congenital and, therefore, excluded from the covers accorded 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 will 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.

- d) 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.
- e) Diseases or accidents that may be directly or indirectly connected with nuclear radiation or radioactive contamination, as well as those stemming from such natural disasters as earthquakes, floods, volcanic eruptions and other seismic or meteorological phenomena, barring lightning.
- f) Healthcare required for the treatment of industrial and occupational diseases or accidents or ones occurring in sports events, that stemming from the use of motor vehicles covered by Compulsory Motor Insurance, as well as the expenses arising from the healthcare provided at Social Security clinics or centres integrated in the National Health System which are not arranged with the Insurer, except as provided in Clause I in the last paragraph of section a) of the chapter "How the services are provided".
- g) Healthcare stemming from chronic alcoholism, drug addiction, intoxications due to abuse of alcohol, psychopharmaceuticals, narcotics or hallucinogens, attempted suicide and self-inflicted injuries, as well as healthcare for diseases or accidents suffered by the Insured with fraudulent intent.
- h) Pharmaceutical products as well as vaccines of all types and parapharmacy products.
- i) All those diagnostic and therapeutic procedures whose safety and efficacy are not duly verified scientifically or have been overtly surpassed by others available are expressly excluded. Likewise, those procedures are excluded that have not sufficiently proven their effective contribution to the prevention, treatment or cure of diseases, alternative medicines, naturopathy, homeopathy, acupuncture, mesotherapy, hydrotherapy, magnet therapy, pressure therapy, ozone therapy, etc.,

maintenance or enhancement of life expectancy, self-sufficiency and eradication or reduction of pain and suffering, and those consisting of mere leisure, rest, comfort or sporting activities (including swimming). Spa therapies and rest cures.

- j) Treatments, including surgery, aimed at remedying sterility or infertility in both sexes ("in vitro" fertilisation, artificial insemination, etc.) and abortion, as well as diagnostic tests connected with such interruption. Study, diagnosis and treatment (including surgery) of impotence.**
- k) Healthcare stemming from infection by Human Immunodeficiency Virus (H.I.V.), AIDS and the diseases relating to this.**
- l) Operations, infiltrations and treatments, as well as any other action that is purely for questions of appearance or of a cosmetic nature. Hair treatments for cosmetic purposes are also excluded.**
- m) General medical check-ups of a preventive nature, except those specified in the description of the services (Clause One C).**
- n) Everything relating to psychology, psychoanalysis, hypnosis, individual or group psychotherapy, psychological tests, narcolepsy, etc., as well as educative therapy, such as language education in congenital processes or special education in patients with mental disease.**
- ñ) 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 (Clause One C).**
- o) Prostheses of any kind whatever, osteosynthesis material, biological or synthetic materials and anatomical and orthopaedic parts.**
- p) Chronic dialysis and haemodialysis treatments.**
- q) Travelling expenses saving ambulances, on the terms specified in the description of the services (Clause One C).**
- r) Surgical techniques or therapeutic treatments using laser.**
- s) Genetic map determinations aimed at ascertaining the predisposition of the Insured or his present or future offspring of suffering from certain diseases related to genetic disorder**
- t) Cover does not include any test, treatment or healthcare relating to pregnancy, childbirth or childcare.**

III. BASES, LOSS OF RIGHTS, CANCELLATION AND INCONTESTABILITY OF THE POLICY

- 1.** This policy has been agreed on the bases of the declarations made by the Policy-holder and the Insured in the insurance application questionnaire regarding his/her state of health and regular occupation.

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 guaranteed benefit:

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

b) In case of aggravation of the risk, if the Policy-holder or the Insured does not inform the Insurer and has acted in bad faith (Art. 12 of the Insurance Contract Act).

c) When the claim is the result of bad faith on the Insured's part (Art. 19 of the Insurance Contract Act).

- 3.** 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 Policy-holder or the Insured has acted with fraudulent intent.
- 4.** 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 will 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 will be obligated to refund the excess premiums received without interest.

IV. WAITING PERIODS

No waiting periods apply.

V. TERM OF THE INSURANCE

- 1.** The insurance is stipulated for the period of time specified in the particular conditions and at its expiration, in accordance with article 22 of the Insurance Contract Act, it will be extended tacitly for periods not exceeding one year. Nevertheless, either of the parties may repudiate extension by giving the other party due written notice not less than two months before the date of expiration of the current period.
- 2.** In respect of each Insured, the insurance lapses:
 - a)** Due to death.
 - b)** If relatives living with the Policy-holder are included in the Policy, when they cease to live at the latter'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 guarantees.
- 3.** 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.
- 4.** The covers contracted shall not take effect until the first premium has been paid.

VI. INSURANCE PREMIUMS

- 1.** In accordance with article 14 of the Insurance Contract Act, the Policy-holder is under the obligation to pay the premium, which shall be effected by direct debit, unless agreed otherwise in the particular conditions.

2. According to article 15 of the above-mentioned Act, the first premium shall fall due once the contract has been signed. If it has not been signed for the Policy-holder'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 guarantee is suspended one month after its expiration date, and if the Insurer does not claim payment within six months of said expiration, the contract will be considered to have lapsed. If the contract has not lapsed or been terminated in accordance with the foregoing conditions, the guarantee becomes effective again twenty-four hours after the day on which the Policy-holder pays the premium. In any case, when the contract is in abeyance, premium payment may only be demanded for the current period.
4. The Insurer is only bound by the receipts issued by the Management or by its legally authorised representatives.
5. At each renewal the annual premium will be determined in accordance with the age reached and the gender of each one of the Insureds by applying the rates that the Insurer has in force at the time of renewal. The Policy-holder grants his/her approval of the premium variations that may occur for this reason.
6. After receiving the Insurer's communication, when appropriate, relating to the variation in the amount of the premiums for the next annual period, the Policy-holder may choose between extending the insurance policy and terminating it at the expiration of the current insurance period. In the latter case, the Policy-holder should 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.

VII. POLICY-HOLDER'S AND/OR INSURED'S OBLIGATIONS AND DUTIES

The Policy-holder 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 will 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 Policy-holder within one month of becoming aware of the reservation or of the Policy-holder'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 will 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 Policy-holder's part, the Insurer would be released from payment of the benefit.

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

The Insurer may propose an amendment in the contract within two months of the day on which the aggravation was declared to it.

In this case the Policy-holder has fifteen days as of receipt of this proposal either to accept or reject it. In case of rejection or of silence on the Policy-holder's part, the Insurer may terminate the contract at the end of this period, after giving the Policy-holder prior notice, offering him/her a further period of fifteen days to answer, after which and within the next eight days notify the Policy-holder 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 Policy-holder or the Insured has not made his/her declaration and a claim arises, the Insurer is released from its benefit provision if the Policy-holder 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. This states: "In this case, at the end of the current period covered by the premium, the amount of the future premium should be reduced in the corresponding proportion, otherwise the Policy-holder would be entitled to termination of the contract and reimbursement of the difference between the premium paid and what s/he should have paid, from the time the Insurer was made aware 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 should obtain the relevant document associated with the care, which should 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 should present his/her Sanitas card, which is a personal and non-transferable document. In case of loss or theft of this card, the Policy-holder and/or Insured is/are under the obligation to inform the Insurer thereof within forty-eight hours, whereupon a new card will be issued and the mislaid or stolen one cancelled. In addition, the Policy-holder 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.

VIII. POLICY-HOLDER'S AND/OR INSURED'S RIGHTS

- a)** Those listed in the description of the services set out in Clause One letter C).
- b)** The Policy-holder 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 Policy-holder 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 should be reduced proportionally, otherwise the Policy-holder 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.

IX. INSURER'S OBLIGATIONS

- a) Besides fulfilling the assured guarantees, the Insurer should furnish the Policy-holder 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 Policy-holder.
- b) The Insurer shall provide the Policy-holder and/or Insured with the Sanitas card(s), stating the emergency services information telephone number.

X. DUPLICATE POLICY

If the Policy gets mislaid, at the request of the Policy-holder or, as the case may be, of the Beneficiary, the Insurer will 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 should be supplied of having notified whoever may be holders of any right by virtue of the Policy, and the applicant should undertake to return the original Policy should it eventually turn up and compensate the Insurer for any damages occasioned by a third party claim.

XI. COMPLAINTS BOOK

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

XII. SUBROGATION

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

The Insurer may not exercise the rights in which the Insured has been subrogated in detriment thereto. The Insured shall be liable for the damages that s/he may cause the Insurer, through his/her acts or omissions, in his/her right to be subrogated.

The Insurer shall not be entitled to subrogation against any of the persons whose acts or omissions may give rise to the Insurer's liability, in accordance with the law, nor against the originator of the claim who is a relative of the Insured in direct or collateral line in the third civil degree of kinship or an adopting parent or adoptive child living with the Insured. This rule shall not take effect, however, if the liability is a result of fraudulent intent or if the liability is covered by an insurance contract. In the latter case, the subrogation shall be limited in its extent in accordance with the terms of said contract.

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

XIII. PRESCRIPTION

The right of the Policy-holder 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.

XIV. COMMUNICATIONS

1. Communications to the Insurer on the part of the Policy-holder, the Insured or Beneficiary shall be remitted to the former's business address as stated in the Policy.
2. Communications to the Policy-holder, 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. Communications remitted by the Policy-holder to the insurance agent who mediates or has mediated in the contract shall take the same effect as if they had been remitted directly to the Insurer.
4. **Payment of the amount of the premium made by the Policy-holder to the insurance agent shall not be considered as made to the Insurer, unless the agent issues the Policy-holder the aforesaid Insurer's premium receipt in return.**

XV. CLAIM CONTROL AND AUTHORITIES

- A. Control over 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 and Finance.
- B. In case of any type of claim in relation to the insurance policy, for the settlement thereof the Policy-holder, Insured, Beneficiary, Aggrieved Third Party or Successor of any of these should proceed to address:
 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 80 or to the e-mail address clientes@sanitas.es-, which shall acknowledge receipt in writing and issue a reasoned written decision.
 2. Once the Insurer's above-mentioned internal channel has been exhausted, or in the event of not being in agreement with its decision, a claim may be lodged with the Insurance Ombudsman designated by the Insurer in the following cases:
 - a) When it is a case of claims involving an amount of not more than EUR 21,000 that affect the interpretation of the General and Particular Conditions of the Policy.

Claims connected with the personal or professional performance of doctors, hospitals and medical services in general supplying healthcare to insureds may not be submitted to the Insurance Ombudsman.

- b) When, even though not meeting the foregoing requirements, the Insurer so agrees.

To file a claim with the Insurance Ombudsman, the claimant should remit a written statement to post office box n° 50.072 (28080 Madrid) setting forth the grounds for his/her claim. In the light of this, the Ombudsman shall give written acknowledgement of receipt and declare himself either competent or non-competent and, after studying the claim, issue – within 1 month of his declaring himself competent barring exceptions in which this time limit may be extended to the legal maximum of 6 months including the period elapsed since its submission to the Insurer's Client Service Department – a reasoned ruling, which shall be communicated in writing both to the claimant and to the Insurance Company, for which it shall be binding.

3. The administrative claim procedure may also be instituted before the Directorate General for Insurance. For this purpose, the claimant should establish that the stipulated time limit for the settlement of the claim by the Insurance Ombudsman has expired or that his/her application has been rejected by the latter.
4. In any case, action may be brought before the relevant Courts and Tribunals

XVI. OTHER

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

XVII. JURISDICTION

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