

# **SANITAS HEALTH PLAN COMPLETE**

**GENERAL  
CONDITIONS**

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**Tax Registration No. A-28037042**

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**17,330,836.32 €**

Licensed to sell the following types of insurance:  
MEDICAL, ASSISTANCE AND  
CASH BENEFIT

**HEADQUARTERS AND MAIN OFFICE: RIBERA DEL LOIRA, 52. 28042 MADRID**

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# WHAT ARE THE GENERAL CONDITIONS?

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THIS DOCUMENT SETS OUT THE RIGHTS AND OBLIGATIONS OF SANITAS AND THE INSURED.

## INTRODUCTION

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This policy is governed by the provisions of the Spanish Insurance Contract Act 50/1980 of 8 October and by the Private Insurance Regulation and Supervision Act 30/95 of 8 November, its implementation rules (Royal Decree no. 2486/98 of 20 November) and by what is agreed in the General Conditions and the Membership Certificate.

## DEFINITIONS

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The following terms shall have the following meanings :

### **ACCIDENT**

Bodily injury suffered while the policy is in force, as a result of an unforeseen external event.

### **ACUTE CONDITIONS**

Diseases, illnesses or injuries which suddenly appear, without warning.

### **BENEFICIARY/INSURED**

The individual or individuals, listed in the Membership Certificate, who are covered by the policy.

### **CONSULTATION AT HOME**

Consultation with a general or family doctor or nurse at the address that appears in the policy, when the Insured is unable, due to their illness/condition, to attend the doctors surgery.

### **CHILDBIRTH**

Normal childbirth is understood as taking place 37 to 42 weeks after the mother's last menstruation. Early or premature childbirth takes place in week 28 to 36 of gestation.

### **CHRONIC CONDITIONS**

A disease, illness or injury (including a mental condition) which has at least one of the following characteristics:

- Has no known cure
- Leads to permanent disability
- Is caused by changes to the body which cannot be reversed
- Requires the person with the condition to be specially trained or rehabilitated
- Needs prolonged supervision, monitoring or Treatment.

### **CLAIM**

The application for benefit for expenses associated with medical Treatment and which are covered under the policy.

### **CLAIM EVENT**

An event which leads to Treatment that is covered or partially covered by the Policy. A Claim Line can include separate types of treatment relating to a single cause.

**CONGENITAL CONDITION**

A congenital disease or condition is one that is present at the time of birth, whether apparent at the time of birth or discovered later.

**CONSULTATION**

A meeting with a Doctor to discuss, diagnose and treat a disease, illness or injury at which both Doctor and patient are physically present in the same place and at the same time.

**CONTESTABILITY PERIOD**

Period of time during which the Insurer may withhold benefits or contest the contract alleging prior undeclared diseases on the Insured's part. At the end of this period, benefits may be excluded only if the Policyholder and/or Insured have acted fraudulently.

**CONTRACT YEAR**

A period of cover commencing the Insured's valid date or renewal date, ending at midnight of the day prior to the Insured's next renewal date, or the date of cancellation of the contract.

**CO-INSURANCE PERCENTAGE**

This is the percentage of covered medical expenses that is payable by the Policy-holder or the Insured towards medical expenses covered under the policy and that are not covered by the Insurer.

**COMMENCEMENT DATE**

This is the date on which cover commences under the policy, in accordance with the Membership Certificate.

**DAY CASE TREATMENT**

Treatment which for medical reasons normally requires the patient to be admitted to hospital and normally requires them to occupy a hospital bed during the day, but not overnight.

**DENTIST**

A person who is permitted by medical authorities in the country where treatment is to take place to perform preventative, diagnostic and treatment relating to conditions and diseases of the teeth, mouth, jaw and associated ligaments on individuals and the community.

**DISEASE**

Any change to the health of an individual 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.

**DOCTOR/CONSULTANT/SENIOR CONSULTANT**

A surgeon, anaesthetist or physician who is legally qualified to practice medicine or surgery following attendance at a recognised medical school, and is recognised by the relevant authorities in the country in which the Treatment takes place as having specialised qualification in the field of, or expertise in, the Treatment of the disease, illness or injury being treated. In the Insurer Network in Spain there are also Senior Consultants who are the consultants specialised in complex cases. Treatment from Senior Consultants will only be covered if a Doctor in the Network has referred the Beneficiary.

By recognised medical school the Insurer means a medical school which is listed in the World Directory of Medical Schools as published by the World Health Organisation

**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**

Treatment received at the home of the Insured in cases of emergency, provided by a family Doctor and/or Nurse.

**FAMILY DOCTOR**

Doctor who is legally qualified in medical practice following attendance at a recognised medical school to provide medical Treatment, which does not require a consultant's training, and is licensed to practice medicine in the country where the Treatment is received.

By recognised medical school the Insurer means a medical school which is listed in the World Directory of Medical Schools as published by the World Health Organisation

**FAMILY DOCTOR FOR CHILDREN**

A family doctor entrusted with the care of the healthy child, both in physical and mental aspects of its development.

**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, as existing primarily for:

- carrying out major surgical operations, or
- providing Treatment which only consultants can provide, and is attended by a doctor 24 hours a day.

The Hospital must be attended by a Doctor 24 hours a day.

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

**HOSPITALISATION**

Means the admission of the Insured to a Hospital and their stay at the Hospital for at least 24 hours.

**IN PATIENT TREATMENT**

Treatment that for medical reasons normally requires the patient to be admitted to a Hospital and to stay in a Hospital bed overnight or longer

**INJURY**

Physical damage or hurt to otherwise healthy tissue or in a healthy organ.

**INSURER**

Sanitas, Sociedad Anónima de Seguros, the legal entity underwriting the Policy.

**NEW BORN**

Means a child who is within the first 28 days following birth.

**NURSE**

A nurse whose name is currently on any register or roll of nurses maintained by any statutory nursing registration body in the country in which the Treatment takes place.

**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.

**OUT PATIENT TREATMENT**

Treatment which does not normally require the patient to be admitted to hospital or stay in a hospital bed (consultations, care services at home, diagnosis tests or treatments)

**POLICY**

Written documents that contain the conditions of this insurance policy. Including: the Application, Health Questionnaire, General Conditions, Membership Certificate, Group Contract and any other Special Conditions, Supplements or Appendices that are added to it either to complete or amend it.

**POLICY-HOLDER**

The individual or company that has entered into the Policy, who, together with the Insurer, has legal rights under the contract relating to the cover that has been arranged.

**POLICY LIMIT**

The annual maximum benefit payable by the Insurer as shown on the Membership Certificate, or for each benefit as shown on the Table of Benefits.

**PRE-EXISTING CONDITION**

Any symptom of, or any disease, illness or injury which began before the Commencement Date of the first Membership Certificate for the insured's current continuous period of cover which lists the person with the disease, illness or injury.

**PREMIUM**

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.

**PRIVATE ROOM**

A single room equipped with private bathroom and oxygen facilities. Suites or rooms provided with an anteroom are not considered Private Room.

**PROSTHESIS**

An artificial body part which is designed to form a permanent part of the body. For example, items such as replacement cardiac valves, prosthetic joints, artificial skin, intra-ocular lenses, biological material (cornea), fluids, gels and synthetic liquids or semi-synthetic organic liquids etc. are classified as prostheses.

**RENEWAL DATE**

The anniversary of the Commencement Date.

**SANITAS 24 HOURS**

A 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 health-care.

**SECOND EUROPEAN COUNTRY OF COVER**

This is the country specified by the Beneficiary on the Application Form. For the purpose of this Policy, the second European country can only be within Europe. Once selected, it cannot be changed without the permission of the Insurer.

### **SPECIAL HOME CARE/OUTPATIENT HOSPICE CARE**

Care given to the Insured by a family doctor or 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 advice. It does not include costs when special home care is arranged or continued for purposes of convalescence, rehabilitation or general nursing, or is mainly for any custodial, domestic or supervisory reasons. Nor does it cover the permanent presence of medical staff at the Insured's home address.

### **SURGERY**

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

### **TREATMENT**

Medical services needed to diagnose, cure or relieve a condition, which for medical reasons, needs to be provided by a medical practitioner.

### **WAITING PERIOD**

Period of time after joining the policy during which some benefits are not covered by the Insurer.

## **I. PURPOSE OF THE INSURANCE**

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The Insurer hereby assumes, under the terms and conditions of these General Conditions and with the limits set forth in the Membership Certificate and, where applicable, Special Conditions and Policy Supplements that may be issued, cover for the medical and surgical care in Spain and in a second European country chosen by the Insured when applying for the policy, both on an outpatient and inpatient basis, of the diseases, illnesses or injuries comprised in the Policy.

Eligibility for cover under the Policy is only available to those who have a residence and a bank account in Spain, and who have specified a second European country.

As specified in article 103 of the Spanish Insurance Contract Act, the Insurer assumes the necessary Emergency care in accordance with the Policy Conditions.

### **A) PROVISION OF SERVICES**

#### **A.1 In Spain:**

##### **A.1.1 Inpatient, Day Case and Out Patient Treatment in the Insurer Network.**

When Treatment is received within the Insurer Network, medical expenses for Treatment covered under the Policy will be settled by the Insurer directly with the hospitals, doctors, etc. Treatment may be received in all locations in which there are accredited members of the Insurer Network.

Beneficiaries may go directly to their family Doctor or Consultant, who may refer them to another medical provider within the Network for tests, diagnostic procedures etc. A family doctor in the Insurer Network will be assigned to each Insured and, if applicable, a family doctor for children.

When receiving Treatment in the Insurer Network, the Insured must present their Sanitas Health Plan card, together with the receipt for the last subscription payment. The Insured must also present a national ID card, passport or any other official form of identity, if requested.

Pre-authorisation from the Insurer is required for Surgical Operations, In Patient and Day Case Treatment, Consultant or Doctor Treatment, some therapeutic Treatments and diagnostic tests to be undertaken in the Network, with prior referral

from a Insurer Network doctor. This authorisation will be provided unless the Treatment required or condition is not covered under the policy. The authorisation guarantees payment by the Insurer.

Pre-authorisation of Treatment is not required in case of an Emergency, and referral from a Doctor in the Network is sufficient. The Insured should notify the Insurer within 72 hours of beginning Treatment. The Insurer will pay for all covered medical expenses in these circumstances, until the Insured is notified otherwise by the Insurer.

Home Care is only covered when received at the home address notified to the Insurer for treatment included in the Policy and when provided by an Insurer Network doctor. If the Insured changes their address, they must notify the Insurer in writing by recorded delivery at least eight days before Treatment is received.

If the Insured is temporarily resident at another address in Spain, which does not have an Insurer office, the Insured must show the Sanitas Health Plan card in order to get the benefits covered by the policy at one of a number of local affiliate offices of Sanitas. Administrative procedures in each of these offices may vary and must be accepted by the Insured. In exceptional circumstances, the Insurer may refer or transfer the Insured to a public Hospital to receive Treatment.

### **A.1.2. Inpatient, Day Case and Out Patient Treatment in Spain but outside the Insurer Network.**

When Treatment is received in Spain but outside the Insurer Network, Treatment costs will be reimbursed according to the Co-Insurance shown in the Table of Benefits. Any costs not covered shall be the responsibility of the Insured.

In order to make a Claim the Insured must take the following steps:

1. The insured or someone acting on behalf of the Insured must notify the claim to the Insurer within the following time limits
  - (a) In an Emergency, within 5 working days of the Treatment being received.
  - (b) In the case of Surgery or planned Hospitalisation, at least 7 working days before the date of Treatment.
  - (c) The above mentioned time limits shall not contravene article 16 of the Spanish Insurance Law that states "The insured or the beneficiary should notify the insurer of any claim within the 7 days of becoming aware of the claim unless the Policy states a longer time limit."
2. For claims involving Surgery, Hospitalisation, diagnostic tests and other Treatments together with the notification of the Claim Event the Insured will send to the Insurer medical information that specifies the diagnosis and type of illness, the name of the place where Treatment was received, the date of admission, the probable duration of the Treatment and its likely nature.
3. The Insured should follow closely the advice of their Doctor and should give the Insurer any information requested regarding the Claim Event and its consequences.
4. The Policy Holder, the Insured or the Insured's family should permit a doctor appointed by the Insurer to examine the Insured in order to verify any issue regarding the Insured's state of health.
5. The Policy Holder or the Insured should notify the Insurer of the end of any period of Hospitalisation.
6. The Policy Holder or the Insured should present the Insurer with the following documents:
  - 6.1. A fully completed claim form.
  - 6.2 Receipts and original invoices of any costs incurred by the Insured, duly separated and accompanied by the following information.
    - a) The patient's name.
    - b) Details, dates and costs of the Treatment.
    - c) Identification of the person or entity providing the Treatment with their name, surname, address, tax number (NIF) and practice identification number.
  - 6.3 Original receipts
  - 6.4 Original medical prescriptions for the Treatment received by the Insured, save that for Consultations where such prescriptions are not necessary.

6.5 Original medical report explaining the Treatment provided to the Insured, the development of the illness, with a prognosis and assessment of future Treatment.

Failure to comply with paragraphs 1 to 6 above shall be grounds for denial of a claim, unless such failure to comply was due to circumstances beyond the Policy Holder, Insured or their families' control.

Should the Insured suffer any of the illnesses noted in these General Conditions that is eligible for reimbursement, the Insurer will pay the Policy holder or the Insured the appropriate sum by the method detailed below.

Once all the required documentation has been received, and the appropriate checks have been made regarding the Claim Event, the Insurer within ten working days will reimburse or make the appropriate payment according to the circumstances.

Should the Claim Event last for longer than three months, the Policy Holder or the Insured should send to the Insurer the invoices for the costs incurred in the previous three months.

If the Insurer has, without cause, failed to reimburse the claim three months after the Claim Event, the amount to be reimbursed by the Insurer shall increase at 50% the current Spanish basic rate of interest. This shall be calculated daily and without need for a court judgement. Two years after the claim has been made, the annual interest cannot be less than 20% (article 20 of the Spanish Insurance Act).

Reimbursement for Treatment received in Spain outside the Insurer Network will be paid in Euros only by bank transfer to the Spanish bank account of the Insured or the Policy-holder.

## **A.2 In the second European country of cover**

### **A.2.1 In Patient and Day Case Treatment received in a Hospital included in the List of Participating Hospitals and Clinics.**

In the second European country of cover, the Insurer supplies the Insured with a List of Participating hospitals and clinics for in patient treatments only.

When receiving Treatment in a Hospital listed in the current Participating Hospitals and Clinics List, the Insured should present their Sanitas Health Plan card as proof of identity.

The Insurer will reimburse, directly to the Hospital, the medical costs covered by the Policy according to the Co-Insurance specified in the Table of Benefits. The remaining costs shall be the responsibility of the Insured

Preauthorisation from the Insurer should be obtained for all Day Case and In Patient Treatment. This authorisation will be provided unless the Treatment required or condition is not covered under the policy.

In case of an emergency the Insured should notify the Insurer within 72 hours of starting Treatment, or as soon as is reasonably possible.

The Insured should complete a claim form at the Hospital, which will claim the expenses direct from the Insurer. Prior to leaving the Hospital, the Insured must pay any Co-Insurance.

### **A.2.2. In Patient and Day Case Treatment received from Clinics and Hospitals not included in the List of Participating Hospitals and Clinics, and all Out Patient Treatment.**

When Treatment is received in a Hospital not included in the Insurer List of Participating Hospitals and Clinics, or for all Out Patient Treatment, expenses for the Treatment should be paid directly by The Insured to the provider. The Insurer will reimburse the corresponding amount, subject to the limits and special conditions of the Policy

The Insured must send to the Insurer the following documents within six months of receiving the treatment:

- a fully completed claim form
- the original invoices and receipts

If requested by the Insurer, the Insured must provide:

- prescriptions (except for consultations)
- original medical reports and other information regarding Treatment included on the claim form
- original results of any diagnostic tests
- written confirmation of whether a claim can be made against another company or person.

Reimbursement for Treatment in the second European country shown on the Membership Certificate can be made either by cheque or electronic transfer in the currency in which the claim is made or in Euros in fifteen working days. Reimbursement will not be made in any other currency.

If a conversion from one currency to another is needed, the Insurer will use the exchange rate, as detailed below, that applies on either the date on which the invoices were issued or the last date of the Treatment, whichever is later. The exchange rate will be the average of the buying and selling rates across a wide range of quoted rates by the banks in London on each working day. If the date on which the invoices were issued or the last date of Treatment, whichever is the latest date, is not a working day the Insurer will use the exchange rate that applies on the last working day before that date.

## **B) DESCRIPTION OF THE SERVICES**

The benefits included on the Policy are:

### **1. Primary Medicine**

**1.1. General Medicine.** Medical care in a Consulting Room, diagnosis and prescription basic diagnostic tests (e.g. blood tests and general radiology), by appointment with the Doctor, 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 Spain, through the Insurer Network, the telephone requests by the Insured for Home Care should be made to the Doctor between 9 a.m. and 4 p.m. In urgent cases the Insured should go to the permanent emergency services established by the Insurer, or else use the telephone service that appears for this purpose in the Guide to Doctors and Services.

**1.2. Paediatrics.** The care of children up to 14 years of age, both in a Doctor's Consulting Room and at home, indication and prescription of tests and basic diagnostic tests (e.g. analyses and general radiology). Treatment should be obtained as detailed in rule 1.1, above.

**1.2.1. Newborn care.** Treatment received by a newborn will be covered for the newly born child from the time of its birth, if the newly born has been enrolled in the Policy.

If Treatment is for or relating to a Congenital illnesses, cover will only apply for a period of 28 days following the birth.

**1.2.2. Child Health Programme in the Insurer Network in Spain.** This comprises pre-natal counselling including practical and theoretical classes in raising children and Psychology, parental classes during the child's first year of life, and checkups for the newborn, tests for metabolic disease, hearing tests, sight testing, neonatal ultrasonography, as well as a programme of health checks scheduled at key ages for development during the first four years.

There is no cover for similar programmes undertaken outside the Insurer Network in Spain or in the second European country shown on the Membership Certificate.

**1.3. Nursing Care.** Medical assistance in a Doctor's Consulting Room, and at home on medical referral by a Consultant or family doctor only, and subject to request as specified in Paragraph 1.1 in the Section called General Medicine for assistance within the Insurer Network.

### **2. Emergencies**

In Spain, through the Insurer Network, cover comprises emergency healthcare that will be provided at the permanent emergency centres listed in the Guide to Doctors and Services. The Insured can also get in touch with the Emergency Service using the details included in this Guide. When necessary, family doctor 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.

Emergency Treatment outside the Insurer Network and in second European country shown on the Membership Certificate is not restricted to those facilities listed in the Guide to Doctors and Services, but may be received at any centre providing eligible emergency medical Treatment, or from a local family doctor, or at home, when justified.

### **3. Medical and surgical specialities and diagnostic tests**

**3.1. Allergy and Immunology.** De-sensitisation is not covered under the Policy.

**3.2. Clinical Analyses.**

**3.3. Anatomic Pathology.**

**3.4. Anaesthesiology and Resuscitation.**

**3.5. Angiology and Vascular Surgery.**

**3.6. Digestive System.** In the Insurer Network in Spain a Colorectal Cancer Prevention Programme is included for persons over 40 years of age, comprising a medical consultation, a physical examination, a specific test and a colonoscopy, if required. In the case of persons under 40 years of age, prior written medical referral by an Insurer Doctor will be required.

The Colorectal Cancer Prevention Programme is only available within the Insurer Network in Spain, and not outside the Insurer Network in Spain, nor in the second European country shown on the Membership Certificate.

**3.7. Cardiology.** In the Insurer Network in Spain a Coronary Risk Prevention Programme is included for persons over 40 years of age, comprising a cardiological consultation, an electrocardiogram and the relevant analyses and supplementary tests. In the case of persons under 40 years of age, prior written medical referral by an Insurer Doctor will be required.

The Coronary Risk Prevention Programme is only available within the Insurer Network in Spain, and not outside the Insurer Network in Spain, nor in the second European country shown on the Membership Certificate.

**3.8. Cardiovascular Surgery.**

**3.9. General and Gastrointestinal Surgery.** Cover includes the laparoscopic approach, for cholecystectomy, inguinal and hiatus hernia.

**3.10. Oral and Maxillofacial Surgery.**

**3.11. Paediatric Surgery.**

**3.12. Plastic and Repair Surgery.**

**3.13. Chest Surgery.**

**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 where indicated by generally accepted international medical practice Spanish authorities and the relevant authorities in the second European country shown on the Membership Certificate. The Insurer shall also be liable for the contrast means.

**3.16. Endocrinology.**

**3.17. Geriatrics.** Any inpatient admission or care arising out of problems of a social nature is excluded.

**3.18. Haematology**

**3.19. Internal Medicine.**

**3.20. Nuclear Medicine.**

**3.21. Nephrology.**

**3.22. Neo Born Care.**

**3.23. Respiratory Care Services.**

**3.24. Neurosurgery.**

**3.25. Neurology.**

**3.26. Obstetrics and Gynaecology.**

**3.26.1. Obstetrics.**

**3.26.2. Gynaecology.** Cover includes preventive care, with regular check-ups aimed at early diagnosis of breast and cervical neoplasms. Cover also includes diagnosis of infertility and sterility and laparoscopic gynaecological interventions.

In the Insurer Network in Spain contraception using contraceptive pill (care visit, Treatment and review), IUD implantation (the Insured bearing the cost of the device) and Treatment of any resulting complications are covered.

There is no provision for similar services undertaken outside the Insurer Network in Spain, nor in the second European country shown on the Membership Certificate

**3.27. Consultants' fees for dentistry.** Cover is limited to Consultations, extractions and Treatment to cure any resulting infection and hygienist services on referral from a Doctor in the Insurer Network.

There is no provision for routine Dentistry undertaken outside the Insurer Network in Spain, nor in the second European country shown on the Membership Certificate

**3.28. Ophthalmology.** This includes laser Treatment for medical reasons, (but not to correct long or short sight), and cornea transplants (there is no cover for the costs of obtaining the cornea which must be borne by the Insured). Cover includes one eyesight test per year for each member.

**3.29. Oncology.** Cover includes autologous bone marrow and blood stem cell transplants solely for Treatment of haematological tumours. Cover likewise includes implantable reservoirs used in chemotherapy.

**3.30. Ear nose and throat.**

**3.31. Proctology.**

**3.32. Psychiatry.**

**3.33. Rheumatology.**

**3.34. Traumatology and Orthopaedic Surgery.** Cover includes arthroscopy, hand surgery, percutaneous nucleotomy, chemonucleolysis as well as bone implants of biological materials.

**3.35. Urology.** Cover includes the study and diagnosis of infertility and sterility.

Vasectomies are also included if performed within the Insurer Network in Spain. There is no provision for similar services undertaken outside the Insurer Network in Spain nor in the second European country shown on the Membership Certificate

**3.36. Senior Consultants.** In the Insurer Network in Spain, the Insured may be referred to a Senior Consultant in the relevant speciality, when medically necessary, and only when referred by a recognised Insurer Doctor.

There is no provision for similar services undertaken outside the Insurer Network in Spain nor in the second European country shown on the Membership Certificate

#### **4. Treatments**

**4.1. Oxygen therapy and Ventilotherapy.** The Insured shall be liable for the cost of the drugs.

**4.2. Dialysis.** Dialysis is covered both on an Out Patient and In Patient basis, solely for the Treatment for the required number of days for acute kidney failure. Dialysis for Chronic Conditions is not covered.

**4.3. Lithotripsy for Kidney Stones.**

**4.4. Speech therapy.** Speech therapy is covered when it is medically necessary as part of Treatment for a condition such as a stroke.

In Spain, through the Insurer Network, this Treatment will be covered for a maximum of 6 months each year.

There is no provision for similar services undertaken outside the Insurer Network in Spain nor in the second European country shown on the Membership Certificate

**4.5. Oxygen therapy.** Both when received as an In Patient and Out Patient. Out Patient oxygen therapy is only included for those patients with Chronic Conditions requiring Treatment with oxygen during at least 16 hours a day.

**4.6. Chemotherapy.** The Insured will pay for anti-tumour medication that the Insured may need in as many cycles as necessary. This medication must be prescribed by the Oncology Consultant in charge of the Insured's care.

The Insurer will be liable for the cost of the Treatment, providing that they are provided on an Out Patient or on an In Patient basis should admission to a Hospital become necessary. In all cases the specialist responsible for the care shall be the one to decide what the therapies should be and how they are to be performed.

The Insurer shall only be liable for the expenses corresponding to the cytotoxic drugs that are commercially available in the local market of the country in which the treatment is received (Spain and second European country) and are duly authorised by the local authorities for the indications specified in the product data sheet.

**4.7. Radiotherapy.** Cover for radiotherapy is available, including 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. Rehabilitation.** Rehabilitation will be covered as Out-Patient care exclusively for musculoskeletal disorders. When provided as in-patient care, cover includes post-surgical rehabilitation for musculoskeletal recovery as a secondary process to orthopaedics, and heart rehabilitation for post-surgical recovery.

**4.9. Pain Relief Treatment.** Cover includes implantable medication reservoirs used in pain relief Treatment.

There is no provision for similar services undertaken outside the Insurer Network in Spain nor in the second European country shown on the Membership Certificate

## 5. Other Services

**5.1. Ambulance.** Where transport by road ambulance is medically necessary, expenses may be covered for the following journeys:

- from home or place of work to the nearest Hospital
- from the site of an accident to the nearest Hospital
- from Hospital to home
- between Hospitals
- between an airport or seaport and the nearest Hospital.

To request this ambulance cover in Spain within the Insurer Network, a previous referral by a Doctor included in the Network and an authorisation from the Insurer are needed, save that in an Emergency, authorisation will not be required. This service does not include transfers required for rehabilitation therapies or for performing diagnostic tests on an outpatient basis.

**5.2. Podiatry.** Limited to five sessions a year.

There is no provision for similar services undertaken outside the Insurer Network in Spain nor in the second European country shown on the Membership Certificate

**5.3. Special Home Care/Outpatient Hospice Care.** This will be provided by the recognised health teams, subject to prior referral by a Doctor when the patient's condition requires special care but not going so far as to need hospitalisation, but always subject to prior medical referral. It does not include care for problems of a social nature.

**5.4. Prosthesis.** Only the following prosthetics are covered: prosthetics used in treatment of Trauma and Orthopaedic Surgery: joints, screws and inner fastening plates. It also includes the following vascular and cardiac prostheses: heart valves, vascular by-passes, stents, temporary and final pacemakers and mammary prostheses after mastectomy due to a neoplasm. Cover does not include any kind of orthopaedic materials, external fixing devices, biological or synthetic materials, grafts (except bone grafts), implantable pacemakers or artificial hearts.

In the Insurer Network in Spain, these prosthesis will be provided without any costs for the Insured.

Outside the Insurer Network in Spain and in the second European country shown on the Membership Certificate, the Insurer will reimburse for these prosthesis up to the limit shown in the Benefit Table.

**6. In Patient and Day Case Treatment:** outside the Insurer Network in Spain and in the second European country, In Patient and Day Case Treatments are included on referral by a Doctor. In the Insurer Network in Spain a referral from a Doctor included in the Network is needed.

In Patient and Day Case Treatment is covered at a recognised Hospital, with the patient occupying a Private Room with a bed for an accompanying person, except for In Patient Psychiatric Treatment, Intensive Care and incubator In Patient Treatment.

Cover is not included for additional accommodation charges for an accompanying person in the second European country.

Total or partial reimbursement is included for treatment and accommodation charges, the Insured's meals, nursing care and drugs and dressings, as well as operating theatre expenses and anaesthetic related expenses

**6.1. Medical Hospitalisation.** Medical Hospitalisation is covered subject to prior referral by a recognised doctor and at a recognised Hospital (usually for people over 14 years old).

**6.2. In Patient and Day Case Paediatric Care.** Paediatric Hospitalisation is covered subject to prior referral by a Doctor in a recognised paediatric unit or Hospital (usually for people under 14 years old). It includes conventional and incubator hospitalisation (in the latter case a bed for an accompanying person is not included in Spain)

**6.3. Inpatient and Day Case Psychiatric Treatment.** In Patient Psychiatric Treatment is covered subject to prior referral by a Doctor at a recognised psychiatric unit or Hospital in a Private Room, if the condition so requires, without a bed for an accompanying person. Cover includes the costs of the stay, medication and relevant medical Treatment. There is no cover for chronic psychiatric conditions.

We will only cover up to a collective total of 90 days of Day Case and In Patient psychiatric Treatment during the lifetime of an Insurance held with the Insurer.

**6.4. Intensive Care Treatment.** Intensive Care Unit Treatment is covered subject to prior referral by a recognised doctor at a recognised Hospital or centre, in suitable facilities, not including a bed for an accompanying person.

**6.5. Surgical Hospitalisation.** Surgical operations needing hospitalisation are covered including complications of childbirth and premature childbirth.

**6.6. Obstetric Hospitalisation (normal nursing-home delivery).** There is cover for Obstetric Hospitalisation attended by an obstetrician aided by a midwife, and including delivery room expenses.

## 7. Second Opinion

Cover is included for a second medical opinion on diagnosis or Treatment in the event of a serious Chronic Condition requiring programmed care which requires exceptional diagnostic or therapeutic measures and/or in which survival prognosis is seriously compromised. Such second opinion shall be issued by specialists or healthcare, medical or academic centres of the first order based in any country in the world.

In order to use this service the Insured shall send his/her clinical file to the Insurer, comprising written medical information, x-rays or other diagnostic imaging scans performed, excluding the shipment of any biological or synthetic material. The file shall be delivered in due confidence to the corresponding specialist or centre in accordance with the illness in question.

## 8. SANITAS 24 HOURS

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. EXCLUSIONS

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

- a) **All types of pre-existing and/or Congenital Conditions, defects or deformations, as a result of accidents or diseases existing at the date of the Insured or Beneficiary's enrolment in the Policy; or a condition related to a pre-existing or Congenital Condition, providing that they were known by the Policy-holder or Insured and not declared.**

**At the time of 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 disease, illness or injury, 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 disease, illness or injury. Such conditions will be considered pre-existing and/or congenital and, therefore, excluded from the cover. If there are pre-existing 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 Membership Certificate 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 resulting from them.**

- b) Treatment for any disease, illness or injury 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.**
- c) Treatment for any disease, illness or injury 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.**
- d) Treatment required as a result of industrial and occupational diseases or accidents or ones occurring in sports events, or as a result of 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 the last paragraph of section a) of the chapter "How the services are provided". If you have any other insurance cover for the cost of the Treatment or benefits you have claimed from us, you must write and tell us. If you do have other insurance cover, we will only pay our share of the cost of the Treatment.**
- e) Treatment for chronic alcoholism, drug addiction, intoxication due to abuse of alcohol; misuse of drugs, narcotics or hallucinogens, attempted suicide and self-inflicted injuries, as well as Treatment for any disease, illness or injury suffered by the Insured with fraudulent intent.**
- f) Drugs and dressings provided for out-patient or take home use (except chemotherapy) vaccines of all types and complementary medicines.**
- g) Treatment that is experimental, or has not been proved to be effective, based on established medical practice. This includes the following Treatments 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 Treatment consisting of leisure, rest, comfort or sporting activities (including swimming). Spa therapies and rest cures.**
- h) Treatment, including surgery, aimed at remedying sterility or infertility in both sexes ("in vitro" fertilisation, artificial insemination, etc.) and abortion. Study, diagnosis and Treatment (including surgery) of impotence.**
- i) Transplants of organs, tissues, cells or cell components, except transplant of the patient's own bone marrow and the Treatment of malignant diseases of the blood.**
- j) Treatment for any disease, illness or injury for, or arising from, infection by Human Immunodeficiency Virus (H.I.V.), AIDS.**
- k) 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.**
- l) Hospitalisation for problems of a social type.**
- m) General medical check-ups of a preventive nature, except those specified in the description of the services (Clause One B).**
- 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.**

- o) 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 B).**
- o) Prostheses of any kind or nature, except those prostheses listed in the description of the services (Clause One B). Any type of Osteosynthesis Material, biological or synthetic materials, grafts (except bone grafts of biological materials) and artificial hearts are not included and shall be at the Insured's own expense.**
- p) Dialysis and haemodialysis Treatment for Chronic Conditions.**
- r) Travelling expenses saving ambulances, on the terms specified in the description of the services (Clause One B).**
- s) Surgical techniques or therapeutic laser therapies, saving those services specified in Ophthalmology, surgical laser techniques in peripheral vascular surgery and devices used in musculoskeletal rehabilitation.**
- t) Genetic Screening aimed at ascertaining the predisposition of the Insured or his present or future offspring of suffering from certain genetic conditions.**
- u) Sex change surgery**

### **III. LEGAL NOTICES**

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- 1.** This policy has been agreed on the basis of the declarations made by the Policy-holder and the Insured in the Insurance Application regarding his/her state of health and 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-holder may cancel the policy when the medical staff is altered in the Insurer Network in Spain, providing that it affects the family doctor or the obstetrician or the local paediatrician or half the specialists making up the medical staff provided by the Insurer, 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.** Contestability Period. 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 after one (1) year has passed from the Commencement Date, unless the Policy-holder or the Insured has acted with fraudulent intent.
- 5.** In the event of the Insured not stating their 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 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 that which should have been paid, the Insurer will refund the excess premiums received without interest.

## IV. WAITING PERIODS

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All the benefits assumed by the Insurer by virtue of the Policy shall be provided from the Commencement Date save that eligibility for cover for some Treatment shall be subject to the following waiting periods following the Commencement Date:

- 1. 180 days for tubal sterilization and vasectomy, subject to the restrictions of the policy.**
- 2. 300 days for childbirth care.**
- 3. 2 full years from the Commencement Date for In and Out Patient psychiatric Treatment. This waiting period does not apply for psychiatric Treatment received within the Insurer Network in Spain.**
- 4. 90 days for In Patient and Day-Case Treatment received in Spain but outside the Insurer Network.**
- 5. 150 days for radiotherapy, chemotherapy, cobalt therapy, radioactive isotopes, linear accelerator, CAT scan, MRI scan, nuclear medicine, bone densitometry, lithotripsy, digital arteriography, radio-neurosurgery and transurethral hyperthermic resection of the prostate. This waiting period is only applicable out of network in Spain.**
- 6. 90 days for physiotherapy, rehabilitation, ultrasound, pathology tests and special home care/outpatient hospice care received in Spain but outside the Sanitas Network.**

The above waiting periods shall not apply in the event of accidents covered by the policy or life-threatening illness arising and diagnosed after the Commencement Date of the policy or in the event of premature childbirth.

## V. DURATION OF THE POLICY

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- 1.** The Policy is stipulated for the period of time specified in the Membership Certificate and at the expiry date, in accordance with article 22 of the Spanish Insurance Contract Act, it will be renewed automatically for periods not exceeding one year. Nevertheless, either the Insured or Insurer may cancel the contract by giving the other party written notice of not less than two months before the expiry date of the current period of insurance.
- 2.** The Insurer may not cancel the Policy while the Insured is undergoing Hospital Treatment until discharge, unless the Insured declines to continue with the Treatment.
- 3.** In respect of each Insured, the Policy shall end:
  - a)** due to death of the Insured.
  - b)** if dependents of the Insured living with the Policy-holder who are included in the Policy, move to a separate address, notification should be given to the Insurer. If these persons take out a new policy with the Insurer within one month of this notification, the Insurer shall maintain the policy standing rights acquired by them, providing that they continue with the same level of cover.

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. No cover shall be provided until the first premium has been paid.

## **VI. PREMIUMS**

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1. In accordance with article 14 of the Spanish Insurance Contract Act, the Policy-holder is under the obligation to pay the premium, which shall be effected by direct debit, unless shown otherwise in the Membership Certificate.
2. According to article 15 of the above-mentioned Act, the first premium shall fall due once the contract has been signed. If the Policy-holder has failed to pay, the Insurer is entitled to terminate the Policy or demand payment in an enforcement procedure based on the Policy, and if it has not been paid before a claim is made, the Insurer shall be relieved of its obligation, unless agreed otherwise.
3. If the second and successive premiums are not paid, eligibility for benefits under the Policy shall be suspended one month after the date on which the premiums were due, and if the Insurer does not claim payment within six months of this date, the Policy will be considered to have ended. If the Policy has not ended or been terminated in accordance with these conditions, the benefits become effective again twenty-four hours after the day on which the Policy-holder pays the premium. While the Policy is suspended, the Insured must pay all outstanding premiums for the current contract prior to renewal of the contract for the next year.
4. Premiums must be paid directly to the Insurer, either to the Head Office, a local affiliate office, or a legally authorised representative and supported by receipts issued by the same.
5. At each renewal the annual premium will be determined in accordance with the age reached and the gender of each one of the Insured 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 renewal notice from the Insurer, detailing the premiums due for the next Contract Year, the Policy-holder may choose between renewing the insurance policy and terminating it at the expiry date of the current Contract Year. In this case, the Policy-holder should notify the Insurer in writing of his/her desire to terminate the contractual relationship at its expiry date. Payment of the first premium corresponding to the premium for the next Contract Year shall signify acceptance of the terms and conditions of the new Policy.

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

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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 supply the questionnaire or, even when it does so, if the precise personal circumstances are not connected with the questions in the questionnaire.

The Insurer may terminate the contract in writing to the Policy-holder within one month of the Insurer becoming aware of the omission, or of the Policy-holder's or the Insured's inaccuracy. The premiums for the contract period when this occurs will be retained by the Insurer, in instances of fraud or gross negligence by the Policy-holder or the Insured.

If a claim arises before the Insurer notifies the Policy-holder of the termination, the benefit for this will be reduced according to the level of cover purchased for the agreed premium and the one that would have been applied if the true 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 affect the nature of the risk and are such that if they had been known by the Insurer at the Commencement Date, that it would not have accepted the application or would have included further terms.

The Insurer may propose an amendment to the contract within two months of the day on which it was notified of the increased risk. 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. Within the next eight days, the Policy-holder will be notified of the final cancellation.

The Insurer may also terminate the contract, notifying the Insured in writing, within one month of the day on which it became aware of the increased risk. If the Policy-holder or the Insured has not notified the Insurer of the increased risk when a claim is incurred, the Insurer is not obliged to pay any benefits if the Policy-holder or the Insured has acted in bad faith. If the Insured or the Policy-holder has not acted in bad faith, the benefits payable by the Insurer will be reduced according to the level of cover purchased for the agreed premium and the premium rate that would have been applied if the true 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 accordingly, 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 increase of the risk, however, the stipulations of the preceding letter b) shall be applicable.

**d)** Limit the claim by using all the means at his/her disposal. Non-compliance with this duty with evident intent to harm or deceive the Insurer shall release the latter from all benefit obligations resulting from the claim.

**e)** For the use of the relevant services as described in Clause One, the Insured should present his/her Sanitas Health Plan 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 within forty-eight hours, and 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 the card(s) to the Insurer in the event of cancellation, termination and, in general, ending of the contractual relationship, irrespective of what the cause may be.

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

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**a)** Those listed in the description of the services set out in Clause One letter C).

**b)** The Policy-holder and/or Insured may request the Insurer to correct any errors or to clarify the differences between the actual Policy and the insurance or agreed clauses proposal within one month of delivery, 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 the insurer had been aware of them, the contract would have been agreed 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**

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**a)** As well as satisfying the guarantees, the Insurer should supply 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 signed by the Policy-holder.

**b)** The Insurer shall provide the Policy-holder and/or Insured with the Sanitas Health Plan card(s), stating the emergency services information telephone number.

## **X. DISPUTES AND APPEALS**

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**1.** In the case of a dispute about the nature of an illness or the amount of benefit payable, each Party shall appoint an expert, who shall accept in writing the terms outlined below. If one of the parties has not selected an expert, they may be required to do so eight days following a request to do so, failure to do so shall mean that the advice of the other party's expert shall be considered binding.

**2.** In the case that the Experts reach an agreement, they shall make a report containing the causes of the Claim Event, the valuation or the Benefits, and the other surrounding circumstances affecting the payment of Benefits and the suggested amount of any reimbursement.

**3.** If the experts do not agree, both parties will appoint a third expert by consent, if no agreement is reached about the third expert, the expert will be decided by a Judge of First Instance according to the Civil Law of Arbitration. In this case the experts opinion will be delivered in a way specified by the parties, failing agreement within 30 days of the appointment of the third expert.

**4.** The Experts opinion, whether unanimous or by a majority will be notified to the parties immediately and will be binding on the parties unless judicially challenged by either of the parties within 30 days in the case of the Insurer and 180 days in the case of the Insured, both periods shall be calculated from the date of notification. If neither party takes the aforementioned actions within these time limits the experts' decision shall become final.

**5.** If the decision of the experts is not appealed, the Insurer must make the payment indicated by the experts within five days.

**6.** If the Insurer fails to pay the amount stipulated, the Insured should apply for legal judgement, the corresponding payment shall be increased at the annual rate legally specified and will be calculated from the time that the experts decision became final, and in any case the Insurer shall pay the costs incurred by the Insured in obtaining judgement.

**7.** Each party will pay the costs of their own expert. The third experts costs and any further expenses that the experts deliberations have incurred shall be split between the Insurer and the Insured. Should the need for the expert's decision have been due to a clearly inaccurate valuation of the claim then these costs shall be the sole responsibility of that party.

## **XI. DUPLICATE POLICY**

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If the Policy gets mislaid, at the request of the Insured or, as the case may be, of the Beneficiary, the Insurer will issue a copy or duplicate, which shall have the same value as the original.

The request shall be made in writing explaining the circumstances of the loss, evidence should be supplied of having notified the Policy-holder, and the applicant should undertake to return the original Policy if it is found and compensate the Insurer for any damages occasioned by a third party claim.

## **XII. COMPLAINTS BOOK**

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There is an official complaints book held at the Insurer's offices in Spain where Policy-holders may record complaints.

## **XIII. SUBROGATION**

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If requested the Insured should subrogate their legal rights to the Insurer in cases where the Insurer may wish to exercise a claim against a third party to recover any losses incurred under the Policy.

The Insurer may not exercise the subrogation rights to the detriment of the Insured. The Insured shall be liable for any damages that s/he may cause the Insurer, through his/her acts or omissions, in his/her right to subrogation rights.

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. 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 that contract.

If the Insurer and the Insured both act jointly against a third party, any settlement will be shared between the two in proportion to their respective interest.

## **XIV. PRESCRIPTION**

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The Policy-holder and the Insured have the right to make a complaint, or to bring about a legal claim, for a period of five years after the claim in question was incurred. This right ends once the five years have passed.

## **XV. CONTACTING US**

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- 1.** Communications to the Insurer on the part of the Policy-holder, the Insured or Beneficiary shall be sent to the 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 sent to the address as stated in the Policy, unless the Insurer has been notified of a change of address.
- 3.** 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 Insurer's premium receipt in return.

## **XVI. COMPLAINTS PROCEDURE**

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- 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.

**B.** For the settlement of any claim in relation to the insurance policy, the Policy-holder, Insured, Beneficiary, Aggrieved Third Party or Successor of any of these should write to the following address:

- 1.** The Insurer's Customer Service Department – by means of a letter addressed to Calle Ribera del Loira, 52 (28042-Madrid-Spain) or to fax +34 91 585 24 80 or to the e-mail address [clientes@sanitas.es](mailto: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)** In cases of complaints involving an amount of not more than EUROS 21,000 and that are concerned with the interpretation of the Policy.

N.B. Complaints 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)** In cases where even though the complaint does not meet the above criteria, the Insurer consents to submit to the Insurance Ombudsman.

In order to make a complaint to the Insurance Ombudsman, the claimant should remit a written statement to post office box 50.072 (28080-Madrid-Spain) detailing the grounds for her/his claim. In the light of this, the Ombudsman shall give written acknowledgement of receipt and declare himself/herself either competent or non-competent and, after studying the claim, issue –within 1 month of his declaring himself/herself competent (barring exceptions in which this time limit may be extended to the legal maximum of 2 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.** A complaint may also be brought 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.
- 4.** In any case, a claim may be brought before the relevant Courts and Tribunals in Spain.

## **XVII. CALL MONITORING**

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The Policy-holder and/or the Insured give permission for the Insurer to record telephone conversations that take place in connection with this policy. They may be used in its quality control processes and, when applicable, as a means of evidence for any claim that might arise between both parties, but maintaining 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.

## **XVIII. JURISDICTION**

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The Magistrate competent to hear actions resulting from the Policy shall be the one most local to the Insurer's address. Calle Ribera del Loira, 52 (28042-Madrid-Spain) This Policy shall be governed by Spanish Law.