The BBVA Salud Autónomos Con Copago is a product mediated by **BBVA MEDIACIÓN, OPERADOR DE BANCA-SEGUROS VINCULADO, S.A.,** with corporate domicile in Madrid, Calle Azul nº 4, 28050, recorded in the Madrid Companies Register under Volume 24602, Section 8, Sheet M-62255 with Tax Code A/78581998, and the special administrative register of insurance agents at the Directorate General of Insurance and Pension Funds, an organisation that reports to the Spanish Ministry of Economic Affairs and Digital Transformation, code OV-0060. It is not obliged to perform insurance mediation activity exclusively for SANITAS, S.A. and does not give advice based on the obligation to provide a fair analysis which is imposed on insurance brokers. The advice provided is to take out an insurance policy and it may seek information about the insurers for which it mediates.

BBVA MEDIACIÓN, OPERADOR DE BANCA-SEGUROS VINCULADO, S.A. has taken out Civil Liability Insurance and established a financial surety. It belongs to the business group whose parent company is Banco Bilbao Vizcaya Argentaria, S.A. whichowns 100% of its share capital and to which group the insurer BBVASEGUROS, S.A., DE SEGUROS Y REASEGUROS also belongs.

GENERAL TERMS AND CONDITIONS

BBVA Seguros

BBVA SEGUROS Sociedad Anónima de Seguros y Reaseguros.

Entered in the Register of the Directorate General of Insurance and Pension Funds, with code C-0502

Entity domiciled in Spain and recorded in the Biscay Companies Register, volume 3,678, section 8, folio 38, sheet BI-854

Corporate address: Gran Vía Don Diego López de Haro nº 12, 48001 Bilbao

ID NO. A-48051098

Sanitas Sociedad Anónima de Seguros

Recorded on 10 February 1958 in the Register of the Directorate General for Insurance and Pension Funds, code C-320.

Organisation domiciled in Spain, Ribera del Loira, 52 - 28042 Madrid.

Companies Register of Madrid, sheet 4,530, volume 1,241, book 721, section 3, Entry 1.

ID NO. A-28037042

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General terms and conditions

Preliminary clause

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

Clauses restricting the rights of Insured shall be applicable when highlighted in bold letters and specifically accepted.

Glossary of terms

For the purposes of this document of the **BBVA Salud Autónomos Con Copago** insurance product, the following definitions apply:

INSURANCE TERMS

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

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

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

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

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

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

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

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

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

DEDUCTIBLE
Sum of medical and/or hospital expenses not included in the insurance cover that, according to the corresponding cover, is payable by the Policyholder or the Insured to the care provider.

PARTICIPATION IN COSTS
Prior to access to certain cover, the Insured must pay a single payment to the Insurer, which is specified according to the degree of difficulty of the cover.

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

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

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

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

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

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

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

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

POLICYHOLDER
The physical person or body corporate that, together with the Insurer, signs this contract and who may be the same as or different to the Insured and to whom the obligations arising there from correspond, particularly the payment of the premium, except those that, due to their nature, are the obligation of the Insured.

HEALTH TERMS

HEALTHCARE
Act of assisting or caring for the health of a person.

HOSPITAL HEALTHCARE/WITH ADMISSION TO HOSPITAL
This is the care provided in a medical centre or hospital under admission to hospital, recording admission and the insured being admitted as a patient for at least one night in order to undergo medical treatment, diagnosis, surgery or therapeutic treatment.

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

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

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

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

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

CONSULTATION
Assistance and examination of a patient by a doctor, performing the necessary examinations and medical tests to obtain a diagnosis or prognosis and prescribe treatment.

DIAGNOSIS
Medical opinion on the nature of a patient's disease or injury, based on assessment of his/her signs and symptoms and on the performance of additional diagnostic tests.

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

ILLNESS
Any alteration of the state of health of an individual who suffers the action of a pathology that is not the result of an accident, which is diagnosed and confirmed by a legally recognised doctor or dentist and which requires professional medical care.

CONGENITAL DISEASE
A disease that exists at the time of birth as a result of hereditary factors or disorders acquired during pregnancy up to the time of birth. A congenital disorder may become manifest and be recognised immediately after birth, or be discovered later, at any time of the individual's life.

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

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

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

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

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

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

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

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

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

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

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

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

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

COMPLEX THERAPEUTIC PROCEDURES
A complex therapeutic method is any method requiring technical equipment, a specially designated area and specialised health professionals in a healthcare or hospital setting.

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

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

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

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

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

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

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

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

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

EMERGENCY CARE SERVICES

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

TREATMENT

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

EMERGENCY

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

LIFE-THREATENING EMERGENCY / MEDICAL EMERGENCY

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

Clause I: Purpose of the Insurance

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

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

Clause II: Benefits

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

PRINCIPAL BENEFITS

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

In general, with the limitations and exclusions highlighted in the terms and conditions of this policy, the healthcare benefits covered correspond to the following specialties:

1. Primary care

1.1. General Medicine

This includes medical care in a healthcare centre, indication and prescription of basic diagnosis tests and procedures (analysis and general radiology)during the days and times established for this purpose by the doctor. It includes also home services when, for reasons attributable only to the Insurer's illness, he/she is prevented from attending the consulting room.

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

1.2. Paediatrics and Childcare

This includes the care of children **until they are 15 years old** in consulting room and at home, the indication and prescription of tests and basic diagnosis procedures (analysis and general radiology), being applicable all other regulations mentioned for the benefit of General Medicine.

1.3. Nursing Service

Includes healthcare at the healthcare centre and at home.

2. Emergencies

It includes healthcare in the event of emergency. It will be provided in the permanent emergency centres agreed with the Insurer and listed in the User Guide to Doctors and Services corresponding to this product.

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

Sanitas 24 Hours

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

3. Medical specialities

3.1. Allergology

It includes determination of complete allergen-specific IgE (natural extracts) but **excludes specific IgE determinations for recombinant allergens and IgG4. Molecular diagnosis of the allergy (microarrays) is excluded.**

3.2. Clinical Analysis

Intestinal dysbiosis tests are excluded.

3.2.1. Genetic Studies

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

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

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

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

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

It excludes HLA DQ2 / DQ8 molecule study, HLA class I and II DNA typing, PCA3 study, genome sequencing, full gene clinical exome study, microarray, pharmacogenetics (except for the study for diagnosing dihydropyrimidine dehydrogenase deficiency) and gene therapy.

3.3. Anatomic Pathology

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

requires that such targets be determined. These criteria also apply to the speciality of genetic testing.

3.4. Anaesthesiology

3.5. Angiology and Vascular Surgery

Varicose vein treatments with foam or microfoam are excluded.

3.6. Digestive System

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

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

MR-enterography is included.

3.7. Cardiology

Includes a cardiac MRI scan and a cardiac stress perfusion MRI, and the medication required for these tests.

Excludes implantable loop recorder.

3.8. Cardiovascular Surgery

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

3.9. General and Gastrointestinal Surgery

Includes laparoscopic surgery.

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

3.10. Maxillofacial Surgery

Includes the diagnosis and surgical treatment of diseases and trauma involving only the jawbone, maxilla and facial bones.

Dentistry treatments are excluded, as are cosmetic treatments and/or treatments targeting functional issues of the patient's mouth or teeth, such as orthognatic, pre-implant and pre-prosthesis surgery.

3.11. Traumatology and Orthopaedic Surgery

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

3.12. Paediatric Surgery

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

3.13. Reconstructive Surgery

All operations with a cosmetic component, such as septorhinoplasty or diastasis recti surgical treatment are excluded.

3.14. Chest Surgery

3.15. Dermatology

3.16. Endocrinology

3.17. Geriatrics

3.18. Haematology and Haemotherapy

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

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

3.19. Internal Medicine

3.20. Nuclear Medicine

Contrast agents are paid for by the Insurer.

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

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

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

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

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

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

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

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

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

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

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

Any radiotracer other than 18FDG is excluded.

3.21. Nephrology

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

3.22. Pneumology

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

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

3.23. Neurosurgery

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

for intracranial processes and for spine surgery.

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

3.24. Clinical Neurophysiology

3.25. Neurology

3.26. Obstetrics and Gynaecology

Includes laparoscopic gynaecological surgery.

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

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

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

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

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

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

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

3.26.1. Breast Surgery

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

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

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

3.26.2. Neonatology Care

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

3.26.3. Newborn care

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

3.27. Ophthalmology

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

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

3.28. Medical Oncology

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

Includes specifically cytotoxic medicines **that are authorised for sale in the Spanish market and provided that they are used in accordance with the indications set out in the product datasheet and whose administration is via parenteral in as many cycles as necessary, or via bladder instillation.**

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

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

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

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

It excludes experimental treatments, treatments for compassionate use, and treatments carried out for indications not included in the product datasheet of the medicine.

3.29. Ear, Nose and Throat

Includes CO2 laser surgery and radiofrequency surgery.

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

3.30. Psychiatry

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

3.31. Radiodiagnosis/Imaging Diagnosis

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

It also includes:

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

- Screening of colon cancer and colon polyposis in patients without a known clinical history of colon cancer, polyposis orinflammatory intestinal illness, as long as they present family background of these pathologies or are candidates to screening for age reasons (from the age of 50).

- Screening of colon cancer and colonpolyposis in patients in which the conventional colonoscopy is contraindicated due to their clinical situation or entails a higher risk.

- As a complement to conventional colonoscopy when this has been unable to reach the full length of the colon.

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

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

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

Assessment of the calcium score is excluded.

3.32. Radiotherapy

The radiotherapy cover includes oncological processes only **and only the following methods: Intensity modulated radiotherapy (IMRT), stereotactic body radiotherapy (SBRT), interoperative radiotherapy and brachytherapy.**

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

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

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

3.33. Rehabilitation

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

3.34. Rheumatology

3.35. Urology

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

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

- PSA>10 and/or ratio lower than 0.13. Involves Multi-parametric MRI.
- Therapeutic monitoring.

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

Includes Fusion biopsy of the prostate in cases of suspected clinical risk (a positive previous Multi-parametric MRI with a negative previous conventional biopsy, a maximum of 1 year before this test was requested, and the well-founded suspicion of prostate cancer persists the PSA level continues to increase).

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

Includes laser photo-vaporization and enucleation of the prostate.

Includes laser endourethral and vesical lithotripsy.

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

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

4. Other care services

4.1. Ambulance

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

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

4.2. Special Care in the Home of the Insured

This will be carried out by the healthcare teams designated by the Insurer, provided that it is possible to arrange the service when the patient's illness requires special care but does not require admission to hospital nor specialised equipment, **always under the prescription of the doctor. Does not include care for social problems.**

4.3. Obstetric-Gynaecological Nursing (Midwifery)

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

4.4. Physiotherapy

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

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

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

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

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

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

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

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

4.5. Speech and Phoniatric Therapy

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

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

Only the following are covered:

Organic processes associated to the larynx and vocal cords:

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

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

4.6. Nutrition

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

4.7. Podiatry (Chiropody exclusively)

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

4.8. Prostheses

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

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

1. Ophthalmology: Monofocal intraocular lens, **excluding toric, used for cataract surgery.** Also includes corneal tissue **exclusively from national tissue bank for cornea transplant.**

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

3. Cardiovascular Area: the following vascular prostheses: stents, peripheral or heart bypasses, medicalised or non-medicalised, aortic endoprothesis, which will require express authorisation **from the Insurer** after assessing the medical report; heart valves, **excluding percutaneous or transapical implants** and aortic valve ducts provided they are associated with aortic valve surgery; pacemakers, **excluding any kind of defibrillator or artificial heart**; coils and/or embolization materials.

4. Chemotherapy or Pain Treatment: reservoirs.

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

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

4.9. Mother and Baby Programme

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

4.10. Psychology

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

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

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

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

4.11. Home-based respiratory therapy

Exclusively comprises the following treatments:

a) Oxygen therapy: liquid, concentrator-based and gaseous.

Liquid oxygen therapy must be prescribed for administration for at least 15 hours a day. The Insurer shall only pay for one type of oxygen therapy treatment.

Portable oxygen concentrator is excluded.

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

c) Partial BiPAP ventilation therapy and aerosol therapy.

5. Hospital admission

Hospitalisation in a clinic or hospital.

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

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

Excludes care for social reasons.

6. Preventive medicine

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

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

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

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

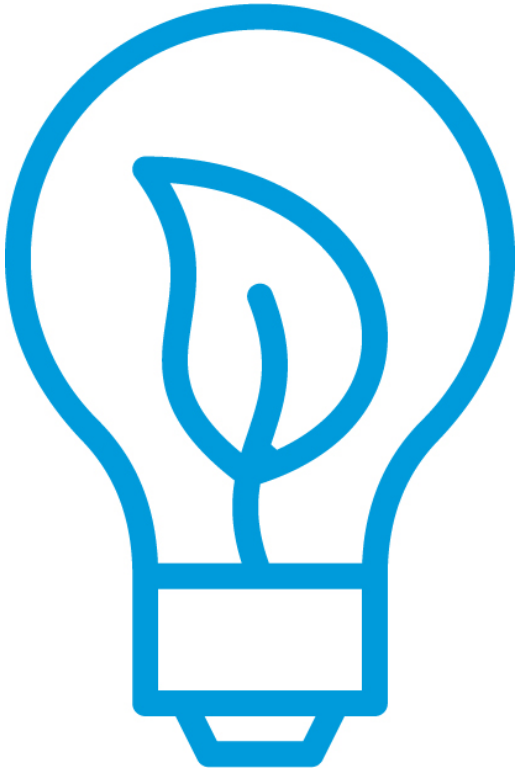
6.4. Pneumology: Includes consultation with a specialist and a physical examination as well as basic diagnostic tests (e.g., chest x-ray).

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

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

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

ADDITIONAL COVERAGES OF YOUR INSURANCE



BBVA Seguros

Traffic and Occupational Accidents Cover

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

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

Overseas emergency healthcare cover

What is it? Use of services and time limit

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

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

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

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

What is not included?

- **medical expenses abroad under €3.**
- **costs arising from the diagnosis or treatment of a physiological condition (e.g. pregnancy) or an illness that was known about before the trip began, unless it is a clear or unforeseeable complication; treatments arranged in Spain;**
- **pregnancy costs incurred after the first 150 days.**
- **mental and chronic illnesses causing alterations in the Insured's health.**

What services are included?

1. Medical Costs

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

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

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

Limits

€12.000 per person and year.

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

What is included?

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

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

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

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

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

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

5. Transport in the event of death

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

6. Early return of insured accompanying relatives

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

7. Accompanying children

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

8. Search and retrieval of luggage and personal belongings

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

9. Dispatch of documents and personal belongings overseas

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

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

10. Advance of funds

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

11. Legal advice

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

12. Advance of the amount for bail demanded abroad

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

13. Dispatch of medication

What is included?

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

What is not included?

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

14. Transmission of urgent messages

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

Total Protection cover

1. PURPOSE OF THE COVER

Total protection is a complementary cover to the healthcare policy with guarantees that are covered when the insured needs to be **hospitalised for more than 72 hours** or is immobilised at home for more than 72 hours for convalescence with **medical leave or an equivalent certified document**.

Description of Temporary Incapacity: This is the temporary physical situation motivated by illness or accident that determines the incapacity of the Insured to exercise his or her professional or work activity. Temporary Incapacity covered by the policy must be diagnosed by a competent physician employed in the social security system or similar and is calculated as of the date the incapacity certificate is issued by the competent physician.

2. TERRITORY COVERED

The total protection guarantees will apply **throughout Spain for insured parties domiciled in Spain**, even if the accident or illness is produced outside of Spain. In any case, the services covered in the guarantees

described below are **provided exclusively in Spain**.

3. USE OF THE SERVICES

To use the services the insured must be up to date with his or her premium payment obligations. The services will be provided by the Insurer. The insured must contact the provider by calling 91 353 63 48 as soon as possible after learning of the hospitalisation or immobilisation.

4. GUARANTEES INCLUDED FOR INSURED MEMBERS AGED OVER 16

4.1. Home help

the Insurer will send a person to the insured's home to help with basic household tasks (cleaning, washing, ironing, meal preparation, etc.) f up to a **maximum of 30 hours at a ratio of a minimum of 2 continuous hours per day** starting from the first day.

These hours will be distributed throughout a **maximum period of 1 month**. The number of hours of service provision will be assigned on the basis of an objective assessment of the applicant's degree of autonomy, considering aspects such as the effective time of invalidity to perform basic tasks, the seriousness of the insured's injuries and the number of dependent family members, etc.

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

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

4.2. Home help to care for the insured's children under 16 years of age or with disabilities.

the Insurer will arrange and cover the cost of home help to care for the insured's children under 16 years of age or with disabilities, establishing the number of hours based on the actual time of immobilisation and the severity of the insured's injuries, according to the results of the questionnaire completed by the insured, in which the degree of severity of the injuries will also be determined; **the daily minimum being 2 continuous hours per day as of the first day of the incident, and up to a total maximum of 30 hours distributed over the maximum period of one month**.

4.3. Dispatch of medication

the Insurer will collect medication and send it to where the insured is in Spain, **with a maximum of twice per week, distributed over the first two weeks as of the start of the service**.

the Insurer takes no responsibility regarding delays in delivery or state of medication for causes not imputable to it.

The cost of the medication is excluded from provision and must be paid for by the insured upon delivery.

the Insurer will provide this service in line with applicable legislation. The insured undertakes to collaborate with the service provider by facilitating any documentation required for this purpose.

4.4. Technical assistance by phone or online

This TECHNICAL ASSISTANCE BY PHONE OR ONLINE is designed to resolve incidents related to the private use of a home computer.

If during the period of temporary incapacity of the insured described in the purpose of this cover (point 1), the insured requires technical assistance by phone or online, this will be

provided under the following terms during the period of temporary incapacity.

Type of Services:

Trouble-shooting: Resolution of technical problems the insured has with their computer.

Assistance in the use of applications and of the computer: The help menu showing the applications that are covered is complemented by more direct and specific interactive assistance.

Configuration of computers: Configuration, in all its senses, of devices, options in the operating system, Internet options, email accounts, etc.

Assistance is available for the following applications and systems:

1) OS: all versions of Windows.

2) Hardware: PC, monitor, external storage devices, webcam, printers, PDAs, scanners.

3) Office programs: Microsoft Office Suite (Word, Excel, PowerPoint, Frontpage and Access).

4) Internet programs: Internet Explorer, Netscape Navigator, Mozilla Firefox, Outlook and Outlook Express, Eudora, MSN Messenger and Yahoo Messenger.

5) Multimedia programs: Acrobat, Windows Media Player, Real Audio and main codecs on the market.

6) Zip programs: Winzip, Winrar.

7) Copiers: Nero.

8) Peer to Peer: emule, Kazaa, edonkey.

9) Antivirus and firewalls: Panda, Norton, Symantec, McAfee.

10) Management of drivers of any of the devices mentioned above.

The insured may request **assistance for legitimate programs only, with valid licences**, without in any way contravening intellectual property rights. The insured must make a back up of the information stored on their computer so it cannot be lost, and thereby exonerating the Insurer from any responsibility for this circumstance, in addition to responsibility arising from the incorrect handling by the insured, attacks by viruses, malware or similar, and generally for any other incidents that are beyond their control.

4.5. Mobility cover

the Insurer will arrange and cover the cost of 2 taxi services (including a return journey in each service) **per week within a 30 km radius from the insured's home** so they can travel to the office to perform professional activities, **during the first two weeks of their immobilisation**.

4.6. Delivery of post

the Insurer will arrange and cover the cost of 2 taxis **per week within a 30 km radius of the insured's home**, to collect post from the office and deliver it to the insured's home **during the first two weeks of their immobilisation**.

The insured must provide written authorisation to the service provider at the time of provision to access their place of work and/or to collect their correspondence on their behalf.

4.7. Early recovery

the Insurer will oversee the selection, dispatch and cost of a physiotherapist to the insured's home for therapies prescribed by the insured's physician due to an accident or illness, up to a **maximum of 20 hours per annuity and per insured**.

In any case the Insurer reserves the right to ask the insured for the medical report and tests that have been performed.

4.8. Protection of payments

The Insurer will settle to the Policyholder an amount equivalent to one monthly premium as of the third day the insured is in a situation of temporary incapacity or hospitalisation. If the situation of temporary incapacity is prolonged for more than 2 consecutive months, the insurer will settle a new amount of the monthly premium and continue to do so for each complete monthly premium in which the situation of temporary incapacity or hospitalisation is prolonged, **with the maximum insurable capital per policy and annuity being €200 or 3 monthly premiums**.

- Age of termination of cover: **The last day of the month in which the Poilicyholder turns 75**.
- **The Policyholder and Debtor of the insurance premium, by signing the back of this application, authorises Sanitas S.A. de Seguros to collect, on the card also indicated overleaf, the amount corresponding to the insurance premium of the policy hereunder and any other amount whose payment corresponds to the Policyholder by virtue of the policy. They also authorise the card issuer to settle these due payments by way thereof as instructed by Sanitas, S.A. de Seguros**

QUALIFYING PERIODS BETWEEN CLAIMS:

- **For accident:** no qualifying period.
- **For the same disease:** 6 months.
- **For a different disease:** 1 month.

5. GUARANTEES INCLUDED FOR INSURED MEMBERS AGED UNDER 16

5.1. Transfer of a relative to care for the insured's children under 16 years of age or with disabilities

the Insurer will arrange and cover the cost of transferring a relative of the insured to their home by scheduled flight (economy class), train (1st class) or taxi, as decided by the Insurer, or the person designated by the insured for the care of their children.

This service is incompatible with provision numbers 4.2 and 5.2.

5.2. Transfers of the insured's children under 16 years of age or with disabilities to the home of a relative

the Insurer will arrange and cover the cost of a form of travel (economy class flight, first class train fare or taxi, as decided by the Insurer) for the insured's children under 16 or with disabilities to the home of the relative designated by the insured in Spain.

This provision is incompatible with provisions 4.2 and 5.1.

5.3. Childminder to take the insured's children under 16 years of age or with disabilities to school and back.

the Insurer will arrange and cover the cost of selecting and dispatching a childminder for a **maximum of 4 times per day for up to 10 days, if no relative is available, and for a maximum period of 1 month**.

5.4. Home tuition service for children under 16 years of age or with disabilities.

In the event of immobilisation of children aged under 16 occurring during the school year **(except school holidays)** for more than 10 days, the Insurer will arrange and cover the cost of a private tutor for such children for a **maximum of 3 hours per day** as of the first day; the minimum 72-hour period indicated in the purpose of this cover (clause 1) not being applicable.

These hours will be distributed throughout **a maximum period of 3 months**.

6. GRACE PERIODS

For the provision of the guarantees described above, it will be necessary for two months to have passed from the date of the present supplementary cover taking effect in relation

to the insured who requests a service covered herein.

EXCLUSIONS

In addition to the exclusions established general for all exclusions in this policy, in these terms and conditions the following exclusions apply to temporary incapacity and hospitalisation cover.

The following claims are not considered temporary incapacity or hospitalisation:

a) Maternity leave;

b) Surgical operations and medical treatments demanded by the Insured exclusively for aesthetic reasons, so long as they are not consequences of an accident, as well as injuries or illnesses caused voluntarily by the Insured; AIDS and HIV;

c) Those occurring when the Insured is under the influence of alcohol to the extent that alcoholism or drunkenness is considered to exist, when the level of alcohol, as per the methods of determination or measurement established in Spanish legislation applicable at the time, exceeds the legally permitted levels by such legislation;

d) Those occurring due to the consumption of toxic drugs or narcotics that are not medically prescribed;

e) Those that occur from mental disorders, somnambulism or from challenges, struggles or arguments, except in a proven case of self-defence; as well as those resulting from a legally determined criminal action on the part of the Insured;

f) Claims occurring directly or indirectly as a result of a disease prior to the arrangement of the insurance, as per our terms and conditions;

g) Backache, save where there is proven evidence from complementary medical studies (radiology, scintigraphs, scans, CAT scans, etc.) and which cause temporary incapacity;

h) Headaches and nervous mental illnesses, including depression and stress, even where medical evidence exists;

i) Those voluntarily provoked by the Insured;

j) Attempted suicide occurring during the first year of membership of the insurance;

K. Those occurring from the professional practice of sport;

l) Those occurring due to nuclear reaction or radiation or radioactive contamination;

m) The following claims covered by the Consortium: natural phenomena, earthquakes and tsunamis, extraordinary floods (including battering by the sea), volcanic eruptions, atypical cyclonic storms (including extraordinary winds with gusts exceeding 135 km/h and tornados), and meteorite impacts. Those occasioned violently as a result of terrorism, rebellion, sedition, riots, and rioting. Events or acts of the armed forces or police and security forces in peacetime.

Second medical opinion cover

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

To use this service, the Insured can call 902 19 97 24 or 93 25 40 538 for an explanation of the procedure to follow and the documentation to supply, which shall include written medical information, X-rays or other image diagnoses, excluding dispatch of any biological or synthetic materials. The dossier shall be sent, with due confidentiality, to the specialist or centre concerned, according to the disease being treated.

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

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

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

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

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

Dental 21

The benefits insured by this policy are specified in the document Insured Dental Benefits, attached to the Particular Terms and Conditions and forming an integral and inseparable part of them and of these General Terms and Conditions. They are classified as follows:

1. Without excess: The Insured does not have to pay any amount to the dentist unless the policy provides for copayments, which shall be specified in the Particular Terms and Conditions.

2. With excess: The Insured must pay the excess amount determined in the Insured Dental Benefits document, attached to the Particular Terms and Conditions of this policy, for the service performed.

If there is any change to the insured benefits or the amount of excess, the Insurer shall notify the Insured of the new amounts to pay with two months' notice of the date of effect. Payment of the premium implies acceptance of such changes.

Clause III: Exclusions from cover

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

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

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

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

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

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

D. Hospitalisation for problems of a social nature.

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

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

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

within the limits established in said communication.

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

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

H. Any type of service relating to:

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

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

• Voluntary interruption of pregnancy.

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

• Heterologous transplants.

• Any surgical procedure on unborn babies.

• Any surgical technique using robotic surgery equipment.

• Genetic studies for ascertaining the predisposition of the insured or their current or future ascendants or descents of suffering diseases related to genetic alterations. Tumour and liquid biopsy genetic studies are expressly excluded, except: BCRA1 and BCRA2 determination, the genetic panel for studies of hereditary breast and ovarian cancer and genomic tests for breast cancer (ONCOTYPE; MAMMAPRINT and PROSIGNA) under the conditions detailed in previous sections. It excludes HLA DQ2 / DQ8 molecule study, HLA class I and II DNA typing, PCA3 study, genome sequencing, full gene clinical exome study, microarray, pharmacogenetics (except for the study for diagnosing dihydropyrimidine dehydrogenase deficiency) and gene therapy.

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

• Operations, infiltrations and treatments, as well as any other action that is purely for questions of appearance or of a cosmetic nature. In terms of breast surgery, only those caused by tumour disease are included, the following being expressly excluded: prophylactic operations, except those that meet the criteria detailed in the breast cancer section; and those performed to correct breast hypertrophy and/or gynecomastia. Any kind of disorder or complication which may occur subsequently and which is directly and/or mainly caused by the

Insured's undergoing an operation, infiltration or treatment of a purely aesthetic or cosmetic nature are also expressly excluded.

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

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

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

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

• Alternative medicine, naturopathy, homeopathy, acupuncture, mesotherapy, hydrotherapy, pressotherapy, ozone therapy, chiropractic, etc. All care provided in integrative medicine medical centres or clinics or that combine medical care and non-conventional therapies recognised as pseudo-therapies by the Spanish Ministry of Health and the Spanish Medical Association is excluded.

• Services or techniques that merely consist of leisure, rest, comfort or sporting activities, similarly treatments at spas and health farms.

• Orthosis, orthopaedic products, anatomical products, glasses, contact lenses, hearing devices, and others.

• All treatments with hyperbaric chamber are excluded.

• Any radiofrequency treatment at musculoskeletal level, except vertebrae.

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

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

• Corneal cross-linking for keratoconus treatment.

• Haemorrhoid treatments.

• Clinical (not cosmetic) peripheral vascular surgery.

• Ear, nose and throat CO2 laser.

• In musculoskeletal physiotherapy.

• Laser endourethral and vesical lithotripsy.

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

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

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

L. The following human medicines:

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

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

- **The following special medicines:**
  - **Vaccines/autogenous vaccines and other biological medicinal products**
  - **Medicines of human origin**
  - **Advanced therapy medicinal products (gene and cell)**
  - **Medicinal plant products**
  - **Homeopathic medicinal products**
  - **Radiopharmaceuticals for therapeutic purposes (for example**

yttrium (90Y) chloride, ibritumomab tiuxetan (90Y), radium-223 dichloride, lutetium (177Lu) oxodotreotide, etc.) except those mentioned in Medical Oncology, such as sodium iodide I 131 for treating overactive thyroid and thyroid cancer, as well as the use of 90Y-Yttrium Citrate for radioisotopic synoviorthesis.

- **Adoptive cell transfer therapies (for example CAR T-cell therapy, adoptive transfer of autologous tumour infiltrating lymphocytes (TIL)) and any other therapies not expressly mentioned, are excluded, unless the Insurer has informed the policyholder in writing that it is included in the cover.**

All pharmacokinetic studies are excluded.

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

N. Bariatric surgery is excluded in obesity and metabolic surgery is excluded in diabetes.

Ñ Radiosurgery is excluded.

O. Parkinson surgery is excluded.

P. Epilepsy surgery is excluded.

Clause IV: Qualification periods

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

Qualification Periods for the modality of Contracted Medical Network:

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

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

Clause V: Form of service provision

1. Through the contracted medical network

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

On receiving applicable services, the Insured must present his/her the Insurer card. Also the Insured must show his/her National Identity Document, if such was required. Each time the Insured receives a service covered by this policy, he/she must pay, in the concept of participation in the cost of such service, the amount that is established in the Particular Terms and Conditions.

The Insurer must provide insured cover under the terms established in the policy and is not bound by the decisions that professionals may make, whether or not they belong to its medical network or are included in this insured cover.

The care may be provided in different ways, depending on the service to be given:

1.1. Free access.

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

1.2. Prior prescription for the performance of the service

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

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

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

As a general rule, for surgical operations, inpatient treatment and counselor professionals, prior express authorisation by the Insurer shall be needed, after the written prescription of the professionals belonging to the Insurer network. Such authorisation shall be also needed for certain therapeutic methods, diagnosis tests and other care services, whenever such is said in the General Terms and Conditions of the policy. The authorisation voucher shall not be valid if at the moment of receiving the service, the Insured is not fulfilling all the requirements established in the General Terms and Conditions of his/her policy to access to the full insured coverage relating to the service indicated in such authorisation voucher (i.e. no being current on payments of the premium, preexisting condition not declared, etc.).

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

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

1.5. Prior authorisation and express designation of the physician

More particularly, for surgical procedures of great complexity, as indicated below: neurosurgery, heart surgery and backbone surgery, surgery requiring robotic equipment,

assisted navigation equipment or any other restricted implementation technology, that are covered by this policy, the Insurer shall appoint the healthcare centre and the professionals to perform the surgery in each individual case and prior to the specific surgical procedure.

1.6. Services at the Insured's home.

The Insurer undertakes to provide home services in those localities where it has an arrangement for the provision of this service. **Any change of the Insured's home address must be reliably notified** with a minimum of eight days' notice before requiring any service.

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

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

1.7. Care in case of temporary displacement to Cantabria and Navarra.

In case of temporary displacement of the Insured to the mentioned Autonomous Regions the service included in the coverage shall be performed through the medical network of the Entities expressly contracted by the Insurer for such performance. The Insured must present his/her the Insurer card in the Offices of the contracted Entities, accepting the administrative steps of these Entities.

1.8. Emergencies

As specified in article 103 of the Insurance Contract Act, the Insurer provides the necessary care of an **emergency** nature in accordance with the policy Terms and Conditions and that in all cases shall be provided through the resources designated by the Insurer, expressly indicated in the User Guide to Doctors and Services for this product.

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

1.9. Care in providers not recognised by the Insurer.

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

Clause VI: Other features of the insurance

1. Basis and loss of rights of the policy

1.1. The **present agreement** has been closed on the basis of the **declarations made by the Policyholder and the Insured in the health questionnaire included in the insurance application, where questions are made referring to the state of health of their health, profession, Insured's sport practices and in general those habits of life that can be of relevance for a correct assessment of the risk that is the object of the insurance by this policy being it essential that the Policyholder/Insured provides with complete truthful about the questions posed since these constitute the basis for the acceptance of the risk of the present agreement,** being the mentioned Insurance Application a constituent part of it.

1.2. The Policyholder's duty, before the conclusion of the contract, to declare the Insurer, according to the questionnaire it will submit all the circumstances known to him that might affect the valuation of risk. He is relieved of this obligation if the Insurer did not submit questionnaire or even when the Insurer did, there are circumstances that may influence the risk assessment and that are not included in it.

The Insurer may terminate the contract by declaration addressed to the Policyholder within a month, as of knowledge or inaccuracy of the Policyholder. They correspond to the Insurer except willful misconduct or gross negligence on its part, the premiums for the current period to the time to make this statement.

If the incident occurs before the Insurer makes the statement to which the preceding paragraph refers, the provision will be reduced proportionally to the difference between the agreed premium and that which would have applied had the true risk been known. If there was fraud or gross fault on the part of the Policyholder, the Insurer will be released from payment of the benefit (Art. 10 of the Insurance Contract Act).

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

1.4. The Policyholder can terminate the agreement when the medical network is changed, providing the change affects to 50% of the consultants that are part of the national medical network of the Insurer, who will have available for the Insured, at all times, in the Insurer Offices, the complete and updated list of such consultants, for the Insured's information.

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

1.6. Remote subscription of Insurance: As specified in Article 10 of the Distance Marketing of Financial Services Act 22/2007 of 11 July, the Policyholder shall have a term of fourteen calendar days to terminate the remote subscribed contract, without having to indicate any reasons and incurring in no type of penalty.

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

2. Duration of insurance

2.1. The Insurance Contract expiry date shall be established in its particular terms and conditions and, at its expiry, in accordance with Article 22 of the Insurance Contract Act, it shall be extended tacitly for periods of one

year. Nevertheless, either of the parties may repudiate extension by giving the other party due written notice not less than two (2) months before the date of expiration of the current period, if it is SANITAS that gives this notice and one month if it is the Policyholder who gives it.

2.2. If the insurance policy is terminated unilaterally at the discretion of the Insurer, it may not suspend the provision of cover while the Insured is undergoing hospital treatment, until discharge, unless the Insured waives to continue the treatment.

If the insurance policy is terminated by the Insured, the covers will cease to have effect on the expiry date specified in the Particular Terms and Conditions of the policy, and the provisions of the preceding paragraph will not apply. Therefore, if the Insured is receiving some kind of insured benefit at the time the policy expires, the cover insured by the Insurer shall cease on said expiration date and it will not be obliged to pay for any cost as of said date, even those arising from a claim occurring during Insurance validity unless the policy is terminated due to fraud or gross negligence on the part of the insured.

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

a) To death.

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

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

2.4. Persons under 14 years of age can only be included in the insurance if the persons that hold their custody or guardianship are also insured, unless the parties agree otherwise.

3. Insurance premiums

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

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

3.3. The Policyholder can apply for the division of the payment of the annual premiums in biannual, quarterly or monthly periods.

In these cases, the corresponding surcharge shall be applied. The division of the premium does not exempt the Policyholder of his/her obligation to pay the complete annual premium.

3.4. If, due to the Policyholder's fault, the first premium is not paid, the Insurer is entitled to terminate the contract or legally demand payment based on the Policy. Where payment is not received before the claim arises, the Insurer shall be freed from its obligation, except where otherwise agreed and duly indicated in the Particular Terms and Conditions of the policy.

In the event of non-payment of the second or successive premiums or their divisions, the Insurer coverage shall be suspended one month after the due date of the premium.

Where the Insurer does not claim payment within the six months following said due date, the contract shall be considered terminated.

If the contract is not terminated or discharged according to the above mentioned conditions, the cover shall once again become effective twenty-four hours following the day on which the

Policyholder pays the premium or, where applicable, suitable part payments thereof.

The Policyholder shall lose any agreed right to pay part of the premium in the case of non-payment of any receipt and shall, from that moment, be required to pay the full premium agreed to for the remaining Insurance period.

For premiums paid in installments, in the event of a claim, the Insurer may deduct from the amount payable or reimbursable to the Policyholder or Insured any premium installments for the current annual period not yet collected by the Insurer.

3.5. Where the parties stipulate the application of co-payments for certain benefits insured by this policy, the amounts corresponding to said co-payments shall be specifically established in the Particular Terms and Conditions of the policy. Their amount shall be established each year by the Insurer. The provisions of this Clause in the event of non-payment of the second or successive premiums or part payments thereof shall apply in the case of non-payment of the amount of co-payment.

3.6. Except where otherwise specified in the Particular Terms and Conditions, the place of payment of the premium and co-payments, where applicable, shall be as indicated in the bank debit account order form.

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

3.7. The Insurer is only bound by the invoices issued by the Management or by its legally authorised representatives.

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

The premiums to be paid by the Policyholder will vary according to the age achieved by each of the Insured, the geographical zone corresponding to the place of performance of the services, the tariffs established by the Insurer on the date of renewal of each policy being applicable. Such variation of premiums shall be communicated in writing by the Insurer to the Policyholder with at least two months' notice with respect to the renewal date.

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

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

4. Registering newborns

Newborn children can be included in the policy with all its rights since their date of birth if the care provided to the mother whilst the child delivery has been provided by the Insurer within the coverage of the mother's policy and if the inclusion of the father as an insured in the policy has taken place at least 240 days prior to the child delivery. For this to be effective, the Policyholder must communicate to the Insurer such circumstance within the 30 natural days following the date of birth, by means of completing an Insurance Application.

In any case, **the Insurer will only cover the newborn's healthcare when and if he/she is included as Insured in the Insurer.** If the

inclusion of the newborn is communicated once the term mentioned above has elapsed or without fulfilling all the requirements indicated in the paragraph above this, the Insurer by virtue of the information provided by the Policyholder in the Insurance Application can deny the inclusion of the newborn as Insured member.

5. Provision of reports

The Policyholder and Insured must provide the Insurer, whenever expressly required so to do, medical reports and/or providers cost estimates enabling the Insurer to determine whether the requested care is covered by the policy. The Insurer is under no obligation to cover the requested care unless and until it is supplied with such reports and cost estimates if the Insured is expressly required to supply them.

6. Complaints

6.1. **Complaints control and procedure**

a) Supervision of the business activity of the Insurer lies with the Spanish State and is exercised through the Directorate General for Insurance and Pension Funds of the Ministry of Economic Affairs and Digital Transformation.

b) In case of any type of complaint in relation to the Insurance Policy, for the settlement thereof the Policyholder, Insured, Beneficiary, Aggrieved Third Party or Successor of any of these should proceed to address:

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

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

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

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

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

7. Other important legal points

7.1. Subrogation

Once payment of the covered benefit has been assumed, the Insurer may exercise the rights and actions corresponding to the Insured due to the claim caused with regards to the persons responsible for it, up to the limit of compensation paid.

The Insured must sign the necessary documents for subrogation in favour of the Insurer.

7.2. Notifications

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

7.2.2. The policyholder accepts the full validity and effectiveness of any notification sent by the Insurer to the policyholder's physical or email address or to the telephone number they provided in the insurance application form, until notification of any change to this information is received.

The policyholder authorises the Insurer to use their mobile phone number and email address to send notifications, information associated to their policy, such as the annual review of the premium, changes to the insurance contract, etc.

8. Data Protection clause

The contract is entered into under a coinsurance arrangement pursuant to which the insurers are BBVASEGUROS, S.A. de Seguros y Reaseguros and SANITAS, S.A. de Seguros.

The Data Protection policy of the two entities is given below:

8.1 SANITAS, S.A., de Seguros

8.1.1 Personal data controller

SANITAS, SOCIEDAD ANONIMA DE SEGUROS, whose registered address is C/ Ribera del Loira, 52, 28042, Madrid, (hereinafter, "**Sanitas**").

8.1.2 Personal data processing

Personal data, including data referring to identification and health (hereinafter, "Personal Data"), provided through insurance applications and during the term of the contract will be processed. Personal data is confidential and appropriately protected.

The Applicant, Policyholder and the Insured Party undertake that the information relating to the Policyholder and the Insured Party(ies) provided to Sanitas is true and no information has been omitted on each Insured Parties' state of health.

8.1.3 The purpose for which their Personal Data is processed

(a) Formalising, developing, and implementing the insurance contract. Processing Personal Data is necessary for formalising the contract between the Policyholder/Insured Party and Sanitas, as well as for the maintenance, development and execution of the contractual relationship.Sanitas will therefore process the Policyholder's/Insured Party's Personal Data in order, among other reasons, to assess, select and price the risks associated with insurance, manage the relationship with them, manage the policy, etc. Furthermore, it may, in certain cases make automated decisions based only on the analytical procedures carried out to improve the service provided which is the aim of their contract with Sanitas. During execution of the contract Sanitas will process their Personal Data to assess their financial solvency, carry out statistical or quality reviews or technical analyses, even conducting satisfaction surveys, as well as managing coinsurance/reinsurance where appropriate.

(b) Provision and coverage of the health care service covered by the insurance contract, being in a position to request and obtain information about their health from healthcare professionals. Sanitas will process the Policyholder's/Insured Party's Personal Data to provide the contracted services. This involves, among other things, making appropriate payment to healthcare providers or reimbursing health care costs to the Insured Party or their beneficiaries. To this end Personal Data may be reciprocally shared with and transmitted to the medical professionals providing the healthcare service, even asking and obtaining from the healthcare professionals information concerning their health to assess the cover and the appropriate payment for or reimbursement

of the services provided. If they wish, as part of the service Sanitas places at the disposal of the Policyholder/Insured Party we have a "Health Folder" (accessible via "MiSanitas") so that they can apply to transfer to and file Personal Data (e.g. medical reports or diagnostic tests) generated by Sanitas health providers in a tool for the exclusive use of the Policyholder/Insured Party.

(c) Research for designing health care models covered by the insurance contract. Processing the Policyholder's/Insured Party's Personal Data is necessary in order for Sanitas to perform analysis allowing it to design healthcare models for the purpose of healthcare prevention for the Policyholder/Insured Party.

(d) Offering and managing the insurance contract assistance and prevention programs. As a consequence of the analyses and profiling carried out, Sanitas will design healthcare models that it may offer to the Policyholder/Insured Party, taking into account their characteristics and specific needs. Sanitas therefore needs to process their Personal Data in order to be able to deliver and manage various healthcare models that are specifically suited to the Policyholder/Insured Party.

(e) Providing the healthcare promotion service which is the purpose of the insurance contract. Sanitas needs to process the Policyholder's/Insured Party's Personal Data in order to design and refine specific healthcare management plans for each Policyholder/Insured Party. Forth is purpose, as result of processing the Policyholder's/Insured Party's Personal Data, Sanitas will draw up personalised healthcare plans and proactive follow-up programs to allow for the management of complex cases (such as serious illness or prolonged hospitalisations), provide assistance to chronic patients and also emergency care.

(f) Managing access to and the use of the "Mi Sanitas" tool. Sanitas will process the Policyholder's/Insured Party's Personal Data in order to manage and provide access to "Mi Sanitas" (an insurance management portal), as well as ensuring its correct operation, either through the website or the app developed for this purpose. Sanitas, in the context of the use of "Mi Sanitas", will process their Personal Datain order to, among other things, offer health recommendations or place at the Policyholder's/Insured Party's disposal receipts and refunds, manage their appointments, etc.

(g) Providing the Sanitas video-consultation service. Sanitas will process the Policyholder's/Insured Party's Personal Data, and where appropriate, outsource it to third parties designated by the Policyholder/Insured Party, in order to provide a video consultation, chat or other service made available by Sanitas insofar as this service forms part of the Policyholder's/Insured Party's insurance service. In this way, through the programs and applications downloaded for that purpose, the Policyholder/Insured Party may contact medical personnel remotely and provide documentation in order to resolve any queries that may arise for the Policyholder/Insured Party in the context of the healthcare services provided by Sanitas.

(h) Actuarial risk management. Sanitas will need to process the Policyholder's/Insured Party's Personal Data in order to carry out a statistical-actuarial analysis for the determination of associated risk as well as for assigning tariffs for customers' and potential customers' policies prior to the signing of the insurance contract or during the term of the latter, taking into account any new circumstances affecting the Insured Party or any changes to the actuarial grounds.

(i) Compliance with any mandatory legal obligations corresponding to Sanitas. On certain occasions, Sanitas will need to process the Policyholder's/Insured Party's Personal Data to comply with certain legal obligations. Among other things, Sanitas will process Personal Data in order to comply with the obligations laid down in the

legislation on insurance, tax laws and the existing Personal Data protection regulations.

(j) Profiling. Sanitas processes the Policyholder's/Insured Party's Personal Dataso that their experience with Sanitas can be as personalised as possible and so that Sanitas can continue customising it while performing the service covered by the insurance contract. To do this, Sanitas will conduct an analysis of their interests and needs in order offer information tailored to the specific characteristics of each Policyholder/Insured Party, among other things. To conduct this analysis, in some cases,Sanitas may make decisions based solely on automated processing, including developing a profile. This means that Sanitas may use automated analysis procedures to recognise their interests and needs based on the type of interaction the Policyholder/Insured Party may have with Sanitas and thus enable them to receive personalised information with advice and tips, among other things.

Likewise, any processing that Sanitas may carry out of the Policyholder's/Insured Party's Personal Datawill be performed in order to improve the services that we offer,whereby Sanitas anticipates the Policyholder's/Insured Party's health requirements and the necessary increase in resources to provide personal services to them. Sanitas will carry out Personal Data processing for scientific research purposes with the ultimate aim of improving their health as much as possible.

(k) Profiling for offering new products and services. Sanitas will process the Policyholder's/Insured Party's general Personal Data in order to offer them new Sanitas products and services adapted to their needs and interests, improve such products and services, provide an enhanced response to their expectations and improve customer satisfaction levels.

(l) Sending commercial communications over any channel, including electronically. As described above, Sanitas will process the Policyholder's/Insured Party's Personal Data to provide them with tailor-made information and advice, taking into account their particular interests and needs for Sanitas's products and services. Thus, Sanitas will process the Policyholder's/Insured Party's Personal Data for sending commercial communications relating to financial products and services, insurance, health and social services and/or healthcare or welfare services by any means, including electronically on custom offerings responding to their interests. In addition, Sanitas may send them commercial communications by any means, including electronically, from third parties with whom Sanitas has cooperative links.

(m) Carry out Personal Data anonymisation and pseudonymisation procedures. Occasionally, Sanitas may apply certain procedures to the Policyholder's/Insured Party's Personal Data either to make it impossible to find a relationship between an identified or identifiable natural person and the Personal Data processed or so that the afore said Personal Data cannot be attributed to a certain person without using additional information listed separately.

(n) Transferring their Personal Data to Group Companies. Sanitas may transfer the Policyholder's/Insured Party's Personal Data to Group Companies for sending commercial communications by any means, including electronically, as well as for scientific or statistical research purposes so that, among other things, Sanitas can anticipate the Policyholder's/Insured Party's healthcare requirements.

(o) Transferring Personal Data to third-party companies. Sanitas may transfer the Insured Party's Personal Data to any other entity with which it has established cooperative links for the effectiveness of the contractual relationship with the Insured Party arising from risk reinsurance as well as for sending commercial information relating to products and financial services, insurance, social healthcare services and/or any others

relating to health and/or well-being. In particular, the categories of recipients who will receive the Insured Party's Personal Data are identified in www.sanitas.es/RGPD (Sanitas Seguros) and these include other co/insurance and reinsurance entities, insurance brokers, entities with which a commercial link has been established, health professionals, medical centres and hospitals.

Sanitas may merely share the Policyholder's/Insured Party's identifying data with social networks with the aim of cross-checking them with the information contained on the afore mentioned social networks to understand the way in which the Applicant or Policyholder/Insured Party uses Sanitas's websites and applications, i.e., which pages and information they consult, and therefore provide them with personalised information regarding the companies of the Sanitas Group.

In addition, Sanitas may carry out other Personal Data processing activities, in which case the Applicant and/or Policyholder/Insured Party will receive the necessary information in relation to this processing and Sanitas will request their consent if necessary.

8.1.4 Legitimacy for processing the Policyholder's/Insured Party's Personal Data

- The **legal basis** for processing data for purposes (a), (b), (c), (d), (e), (f) and (g) is **performing the service provision contract**.

- The **legal basis** for processing data for purposes (h) and (i) is the requirement **to fulfil a legal obligation applicable to Sanitas**.

- The **legal basis** for processing data for purposes (j), (l), (n) and (o) is the **consent** requested from the Applicant and/or Policyholder/Insured Party, without withdrawal of the latter affecting in any way the performance of the service provision contract.

- The **legal basis** for processing data for purpose (k) is **satisfying the legitimate interest** pursued by Sanitas to be able to anticipate the Policyholder's/Insured Party's needs and to offer the latter the products and services best suited for the purpose.

- The **legal basis** for processing data for purpose (m) is **the need to process for scientific research or statistical purposes**.

The Policyholder is responsible for communicating to all the Insured Parties covered by the policy all the information contained in this clause on Personal Data processing so that together with the Policyholder themselves they can exercise the rights described in the section "Policyholder's/Insured Party's rights".

Likewise, the Applicant/Policyholder declares that they are acting on their own behalf and those of the Insured Parties when they consent to the processing described in this clause. In addition, the Applicant/Policyholder declares that the Insured Parties understand and accept that they have provided or may provide their Personal Data to the Insurer, since the Insurer provides the Applicant/Policyholder with the identifying information about the Insured Parties' medical services covered by the policy, unless the Policyholder, releases the Insurer in writing from its legal duty to inform them, or this is requested by any of the Insured Parties.

8.1.5 Personal Data conservation period

Sanitas **will retain** the Policyholder and/or the Insured Party's Personal Data for the duration of the contractual relationship between Sanitas and the Policyholder and/or the Insured Party and, in any event, during the period that is necessary to formulate, exercise or defend potential claims, to comply with the obligations for the conservation of clinical documentation and/or in any case where the applicable law permits. Once this deadline has ended, Sanitas agrees to cease processing all Personal Data, as well as to properly block access to it. However, Personal Data may be retained for longer periods when it is necessary whenever it is

processed exclusively for healthcare, medical, scientific research or statistical purposes.

8.1.6 Accessing Personal Data

The optimal service delivery offered by Sanitas may require that other **Sanitas third-party service** providers may access the Policyholder's/Insured Party's Personal Data as data processors. The Policyholder/Insured Party understands that some of these service providers are **in countries outside the European Economic Area or which do not offer security levels equivalent to those in Spain**. Such international transfers are made under the authorisation of the Director of the Spanish Data Protection Agency and/or are covered by contractual clauses complying with appropriate security measures. International transfers can be checked using this link www.sanitas.es/RGPD (Sanitas Seguros). To obtain a copy of this documentation, please contact Sanitas using the contact details set out in paragraph "**Policyholder's/Insured Party's rights**".

In addition to the national or international access third-party providers may have to the Personal Data for which Sanitas is responsible in their capacity as data processors within the service provision framework, Sanitas **will transfer** Personal Data to other entities, as specified in paragraph III. -The purpose for which your Personal Data is processed.

In addition to the above, the Policyholder/Insured Party understands that Sanitas may transfer or communicate Personal Data to meet its obligations with public administrative bodies in cases in which it is required to do so in accordance with the legislation in force at any given time, and, where appropriate, also to other bodies such as state security and the judiciary.

Likewise, the Policyholder/Insured Party understands that Sanitas may request, require, and share personal and health data with professionals or health centres, hospitals and, on the other hand, entities with which it has a co/reinsurance or co-operative relationship. It is therefore understood that it will be necessary to reciprocally provide their Personal Data, for the purpose of managing reinsurance, coinsurance, comprehensive care program management, a better understanding and assessment of the risks to be covered, fraud prevention, the determination of healthcare, payments to healthcare providers or reimbursement to the Insured Party of health care expenses and in order to attend to claims filed by the Insured Parties themselves.

8.1.7 The Policyholder's/ Insured Party's rights

Sanitas informs the Policyholder/Insured Party about the possibility that they may exercise the rights of **access, rectification, objection, erasure, portability and limitation of processing** as well as rejecting **automated processing** regarding the Personal Data collected by Sanitas.

These rights may be exercised free of charge by the Policyholder/Insured Party, and as the case may be, by any person representing them, by making a written and signed request, accompanied by a copy of their National ID or equivalent document accrediting their identity, to the following address: Calle Ribera del Loira no. 52, 28042, Madrid, Spain Att. Personal Data Protection Law insurance or through Mi Sanitas at http://www.sanitas.es/misanitas/online/clientes/contacto/index.html. Representatives must prove their powers of representation by a written document accompanied by copy of the National ID or equivalent document attesting to the identity of the represented party or any other supporting documentation set out in www.sanitas.es/RGPD (Sanitas Seguros).

In addition to the above rights, the Policyholder/Insured Party will have the right to **withdraw any consent granted** at any time by following the procedure described above, without the aforesaid withdrawal of consent affecting the lawfulness of any processing prior to withdrawal of the latter. Sanitas may continue to process the Policyholder's/Insured Party's Personal Data insofar as permitted by applicable law.

Sanitas reminds the Policyholder/Insured Party that it has the right to **file a complaint with the relevant supervisory authorities**.

The Policyholder/Insured Party may contact the Sanitas Group Data Protection Representative (hereinafter, "DPR") via email"dpo@sanitas.es" or at the postal address: Calle Ribera de la Loira 52, 28042 Madrid, Spain, for any query or requirement falling within the field of data protection.

8.1.8 Unsubscribing from the commercial communications service

As mentioned in the previous section, the Policyholder/Insured Party has the right at any time to revoke their consent for receiving commercial communications by notifying Sanitas that they do not wish to receive them. To do this, the Policyholder/Insured Party may either revoke their consent as described in the previous section or click on the link provided in each commercial communication, thereby cancelling the sending of electronic advertising.

8.1.9 Minors

In General, Sanitas will only process the Personal Data of children under eighteen when their parents or legal guardians have given their consent to such processing, and it is necessary for the execution of the insurance contract or to comply with a legal obligation and/or to satisfy a legitimate interest of Sanitas.

However, in accordance with the regulations currently in force, those over the age of 14 (or the age which may be legally established for these effects) will have the right to access their own medical information and may exercise those rights recognised for them by law.

8.1.10 Amending the privacy policy

Sanitas may amend its privacy policy in accordance with the legislation applicable at any given time. At all events, the Policyholder/Insured Party will be duly notified of any amendment of the privacy policy, so they can be up to date with any processing changes affecting their Personal Data and, should the regulations require it, the Policyholder/Insured Party can consent to this.

8.2. BBVASEGUROS, S.A. de Seguros y Reaseguros

8.2.1 Controller

The data controller for the personal data provided in the taking out of this Insurance Contract is BBVASEGUROS, S.A. de Seguros y Reaseguros, with registered address in calle Gran Vía de Don Diego López de Haro, 12, 48001 Bilbao and with its main office in calle Azul, nº4 28050 Madrid. Email address: seguros@bbvaseguros.es (hereinafter, “BBVA Seguros”).

8.2.2 Data Protection Officer

The Data Protection Officer of the BBVA Group may be contacted at the following email address: dpogrupobbva@bbva.com

8.2.3 Personal Data Categories

For the aforementioned contractual relationship, BBVA Seguros can process the following categories of personal data (hereinafter, the “**Personal Data**”):

- Identifying and contact details (including postal addresses and/or electronic addresses)
- Data relating to the Insured asset. **In accident, illness and life insurance, and in the event of claims, BBVA Seguros will collect health-related data, with your prior informed consent**.
- Sociodemographic data (such as age, family situation, residence, education and occupation)

The Personal Data must be duly updated to ensure that it is accurate at all times. Any modification must be communicated to BBVA Seguros so that the data corresponds to the current situation.

8.2.4 Purposes

The Personal Data will be used to (i) manage the taking out of the insurance contract applied for and the full development of the insurance contract, (ii) administer common files with other insurers and institutions collaborating with the insurance sector for statistical, actuarial and fraud prevention purposes, as well as prepare insurance technique studies, (iii) manage reinsurance contracts, where appropriate, and (iv) create statistical profiles for actuarial and market research purposes, with the aim of being able to offer products that we consider fit the customer's profile, as well as personalised offers at more affordable prices.

8.2.5 Legal Basis

The legal basis that allows BBVA Seguros to process the Personal Data for the purposes indicated in the previous paragraphs is:

(i) and (iii) fulfilment of the contract and additionally fulfilment of the obligations imposed by law, including the Organisation, Supervision and Solvency of Insurance and Reinsurance Undertakings Act 20/2015, the Insurance Contract Act 50/1980, the Insurance Distribution regulations and the Prevention of Money Laundering and Terrorism Financing Act 10/2010.

(ii) the legitimate interest of BBVA Seguros. The Organisation, Supervision and Solvency of Insurance and Reinsurance Undertakings Act 20/2015 permits insurance undertakings to establish shared files for the settlement of claims and actuarial statistical cooperation, with the purpose of enabling fees to be prepared and risks to be selected. Act 20/2015 also grants authority to create common files whose purpose is to prevent fraudulent activities designed toobtain illicit enrichment from, principally, claims for damages or losses that were not incurred. These files fulfil a social function as state law enforcement agencies are allowed access to them. Inclusion in this file will be duly notified.

(iv) the legitimate interest of BBVA Seguros in its ability to meet the expectations of our customers better and thus enable us to increase their degree of satisfaction, as well as to obtain statistics for actuarial purposes, surveys or market research. The aforesaid legitimate interest respects the right of the Policyholder/Insured party to protection of their personal data, honour, and personal and family privacy.BBVA Seguros considers that customers have a reasonable expectation that their data will be used to be able to offer them products and services corresponding to their profile and enjoy a better customer experience.

In both cases, based on legitimate interest (ii) and (iv), you can exercise your right to objection at the following address: derechosprotecciondatosbbvaseguros@bbvaseguros.es

8.2.6 Conservation of Personal Data

The Personal Data will be kept for the term of the contractual relationship. Applications for insurance which is not taken out will be kept by BBVA Seguros for a maximum period of ninety (90) days, unless a greater period is agreed in the application, to prevent procedures from being duplicated in the event of new applications. Once the contractual relationship has terminated, BBVA Seguros will keep the Personal Data blocked for the legal limitation periods, which in general are for 10 years under the regulations on the prevention of money laundering and the financing of terrorism. On expiry of the legal limitation periods, the Personal Data will be destroyed.

8.2.7 Communications of Data

We will not transfer the Personal Data to third parties, unless the law requires us to do so or except under the reinsurance agreements, as a result of the contractual relationship itself.

In order to be able to successfully provide a service and manage the contractual relationship, the link indicated in the final section of this clause provides a list by categories of the companies that process Personal Data on behalf of BBVA Seguros, as part of the services we have contracted them to provide.

8.2.8 Rights of the Data Subject

The data subject to whom the Personal Data relates can exercise certain rights at any time vis-à-vis BBVA Seguros. In this respect, data subjects may access, rectify, erase, object to, limit the processing of or request the portability of their Personal Data by writing to BBVA Seguros. Their request should be accompanied bya copy of their National ID or equivalent document accrediting their identity and they should state the right they wish to exercise. The request should be sent to the following address:

- BBVA Seguros. Quality Department. Calle Azul, 4. 28050 Madrid
- Or by email to derechosprotecciondatosbbvaseguros@bbvaseguros.es

The exercise of these rights is free of charge.

If the data subjects consider that the processing of their Personal Data has not complied with the regulations, they can write to the Data Protection Officer (Delegado de Protección de Datos) of the BBVA Group at the following address: dpogrupobbva@bbva.com. They may also, where appropriate, file a complaint with the Spanish Data Protection Agency (Agencia Española de Protección de Datos)(www.agpd.es).

Additional information about the BBVA Seguros Data Protection Policy can be found by following this link:www.bbvaseguros.com

9. Others

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

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

10. Jurisdiction

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

11. Concurrent insurance

If the Insured is entitled to receive payments from other compulsory or private healthcare insurance policies, or from compulsory accident or pension insurance policies, the Insurer shall only be liable to pay the expenses that exceed those covered by these policies.

To the extent that compensation can be claimed under other insurance contracts in the event of an insured event occurring, these payment obligations prevail.

This policy cover shall be deemed to apply in last place with respect to any other policy or policies of similar cover for which insureds may also have cover. In the event that the insureds are covered by any other policy or policies with similar cover, the insurer's liability will be limited, always within the indemnity limit, to the amount in excess of what would have been paid under the other policy or policies if this insurance had not been effective, except in cases in which the other policy or policies were specifically taken out as policies in excess of this policy.

12. Prevention of money laundering and financing of terrorism

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

13. Coinsurance clause

The benefits guaranteed by the present policy are covered under coinsurance, with the percentages indicated, by the following entities:

SANITAS S.A. de Seguros	50 %
BBVA SEGUROS S.A. de Seguros y Reaseguros	50 %

This coinsurance is established in a single policy, made out by SANITAS S.A., hereafter SANITAS, and which shall be signed by the Policyholder and/or Insured and by all the Coinsurers, therefore being fully valid for them all. In the event of the issue of supplements or appendices, SANITAS shall issue a single document which shall also be signed by all the Coinsurers, except for premium regularisation and those cases which do not modify the contractual economic conditions, which shall be signed solely by SANITAS on behalf of all of the coinsurers. Therefore, the Policyholder and/or Insured shall only sign the contractual documents that have been issued by SANITAS S.A.

For the effectiveness of the premiums, SANITAS S.A. shall issue and submit for collection a single receipt for the totality of the stakes in the coinsurance.

Its payment shall have the effect of releasing the Policyholder from responsibility before each of the coinsurers, without prejudice to any settlements between said coinsurers that may subsequently take place.

In their relations with the Policyholder and/or Insured, the Coinsurers shall always be represented by SANITAS S.A., including when it involves declaring, processing or settling any claims that may occur. The Policyholder and/or Insured must only address SANITAS to report the contingencies it must relay to its insurers and all communications from them to the Policyholder and/or Insured shall be performed in the same fashion.

Furthermore, in the event of a claim, the decisions which must be adopted for the common defence of the interests of the Insured and the Insurers, a previous agreement between the latter and SANITAS S.A. shall be taken except in the event of it being delegated to another coinsurer in special circumstances and by mutual accord.

Without prejudice to SANITAS S.A.'s powers, when the technical complexity and economic importance of a claim make it recommendable, in its opinion, it shall consult with the Coinsurers that represent at least 50% of the stake in the coinsurance.

SANITAS's representation does not extend to possible court or arbitral proceedings that may arise by cause of this contract, and which are filed by the Policyholder and/or Insured or injured party, and therefore all the Coinsurers must be sued, for their respective quotas, without prejudice to them being able to subsequently commission the management of the process to the leading insurer. When the purpose of the lawsuit is exclusively to demand the quota of compensation that corresponds from one or more Coinsurers , this having already been settled by the others, the suit shall be addressed exclusively against the provision's debtor companies.

The present contract may be terminated:

1. By SANITAS on behalf of all of the Coinsurers in all cases where the Law and the present contract award the power of termination to the insurers.

2. By the insurance Policyholder in the cases provided for under the Law and in this contract, addressing SANITAS S.A. solely.

The action of settling or not extending the contract is indivisible and can only be exercised by the leading insurer on behalf of all the Coinsurers. Consequently, separation or exclusion from the network of one coinsurer may only take place by reason of extending the contract, under the terms set in the paragraph below:

The insurance Policyholder may oppose the extension of the present contract, whether

fully or in respect to one or more of the coinsurers, in both cases addressing SANITAS S.A. and the affected Coinsurers. SANITAS S.A. shall have the same entitlement, and must notify the full or partial termination of the contract to the Policyholder and the affected companies. Likewise, each of the Coinsurers may oppose the extension of its participation in the contract, notifying the Policyholder and SANITAS with the two months' notice anticipated under the Law.

In all cases, communication of settlement or refusal to extend must be made with the notice provided for in this contract.

The insurance Policyholder and the coinsurers of this risk, lend their consent to the content of the present contract by signing it, understanding that the matters established in the foregoing clauses do not mean that the Coinsurers respond jointly to compliance with the obligations assumed by this policy. The responsibility of each of them is their own and independent of that of the other Coinsurers, and is determined in accordance with the percentages set forth in the coinsurance network and no party can, for any reason, demand the payment of compensation which exceeds that which results from the application of said percentages.

This is part of the coinsurance framework.

Executed in duplicate in Madrid, 28 December 2020

For Policyholder / For the Insurer

Iñaki Peralta
Sanitas, S.A. de Seguros

Eugenio Yurrita
BBVA Seguros S.A.
de Seguros y Reaseguros