Insurance
Dental Care

Because oral health is important for a healthy life, we offer you Dental Care Insurance, which covers your dental and oral healthcare treatment expenses.

Dental Care Insurance gives you access to a nationwide network of dental service providers offering a full range of dental procedures and treatments.

The information below provides guidance on how to make the most of this insurance and sets out the General and Special Terms and Conditions of your Dental Care Insurance.

Your Dental Care Card

- Each insured person will be issued a Dental Care card, which is personal and non-transferable.
- When visiting a provider within the network, you must present your Dental Care Card so that you can be identified as a Mudum Seguros customer. This way, you can take advantage of the benefits this plan offers.
- If you lose your card or do not receive it, please contact the Insurance Helpline at 707 24 7 365* / 218 837 700** to request a replacement.

Benefits of Dental Care Insurance

Some services are free of charge, whilst for others you will only be required to pay the agreed amount. Please refer to the Agreed Price List at www.dentinet.pt.

In addition, you may also benefit from a co-payment towards the cost of non-free services, based on the agreed amount up to an annual *ceiling* .

There is no age limit for signing up or remaining on the scheme, and there are no waiting periods.

The Provider Network

Quality service

- To provide you with a high-qualify service, we offer access to an extensive network of service providers.

Complete peace of mind, with the best professionals

- The network is made up of carefully selected professionals, reflecting our commitment to quality.

How to Use Your Insurance

- Select your preferred provider at www.dentinet.pt or call the Customer Helpline at **707 78 20 70* / 210 114 469**– Option 3 Dental Care** (weekdays from 08:30 to 18:30).
- Book your appointment, treatment or examination directly with your chosen provider, and provide the insured person number shown on your Dental Care card.
- After your appointment or treatment, pay only part of the cost to the provider. Always ask for a receipt so you can claim the deduction on your annual tax return.

You should also know...

When can I start using my insurance?

You can start using your insurance immediately; there is no waiting period.

How much do I have to pay when I use my insurance?

There is a range of treatments which are free of charge (see the Annex to the General and Special Terms and Conditions).

For services that are not provided free of charge, you will benefit from the agreed prices without any limit.

In addition, you also entitled to a co-payment up to a certain *ceiling,* both of which are set out in the Specific Terms and Conditions.

You can view the agreed maximum amounts payable by you in the “Customers” section of the website www.dentinet.pt.

Mudum - Companhia de Seguros, S.A.
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Registered Office: Rua Castilho, nº 26 – 1250-069 Lisbon PORTUGAL - Share Capital €15,000,000 (fifteen million euros) - Sole company and tax registration No. 503 718 092 with the

How does the network work in Spain?

Dental Care insurance can be used in Spain through the Dentyred network.

When using this service, for treatments that are not free of charge, you will be required to pay the full amount. You should then send the receipt to AdvanceCare, which will reimburse you for the portion specified in the contract.

How does the Well-Being Network work?

The Well-Being Network complements your Dental Care Insurance through a network of partnerships designed with your well-being in mind.

The Well-Being Network includes services such as: Acupuncture, Psychotherapy, Osteopathy, Psychology, Nutrition, Homeopathy, and others.

Take advantage of significant discounts on all these services (see the website www.dentinet.pt).



Policy Information and Amendments

For information or to make changes to your policy, please call the **Insurance Hotline at 707 24 7 365* / 218 837 700****



Customer Service Line

For further information about Providers and their prices, please call the **Customer Service Line at 707 78 20 70* / (+351) 210 114 469** – Option 3 Dental Care**, available Monday to Friday, 8:30 to 18:30, or visit the website www.dentinet.pt.

* (Call cost of €0.09/min from a landline and €0.13/min from a mobile network, plus VAT at the prevailing rate).
** (Calls to the national landline)

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Preliminary Article

This Insurance Contract has been jointly agreed between Mudum - Companhia de Seguros, S.A., hereinafter referred to as the Insurance Company, and the Policyholder mentioned in the Specific Terms and Conditions. It is governed by the General, Special and Specific Terms and Conditions of this Policy, in accordance with the statements contained in the proposal on which it is based and which forms an integral part thereof.

Chapter I - Definitions, Object and Coverage of the Contract, Territorial Scope and General Exclusions

Clause 1 - Definitions

The following definitions shall apply for the purposes of this Contract:

a) Parties Involved in the Contract

» Insurance Company: Mudum - Companhia de Seguros, S.A., hereinafter referred to as the Insurance Company, an entity legally authorised to operate the optional health insurance, which subscribes to this contract.

» Policyholder: person or entity in the contractual agreement with the Insurance Company, and responsible for paying the premiums;

» Household: means the spouse or equivalent, children, stepchildren and adopted children, and ascendants, of the Policyholder as long as they live with the Policyholder as part of the same home. Children shall be considered only if they are under 25 years of age and are not in gainful employment and are not married.

» Insured Person: Person designated in the Specific Terms and Conditions, resident in Portugal, in whose interest the Contract is entered into.

» Administrator of the Health Plan: organisation that constitutes and maintains the Network of Providers and that manages the services due under the Contract, in the name and on behalf of the Insurance Company, hereinafter referred to as Administrator.

b) Contractual Documents

» Policy: title document of the Insurance Contract, which contains the respective General, Special, if any, and Specific Terms and Conditions agreed.

» General Terms and Conditions: a series of clauses that define and regulate general and common obligations inherent to an area or type of insurance.

» Special Terms and Conditions: a series of clauses aimed at clarifying, supplementing or specifying the provisions of the General Terms and Conditions.

» Specific Terms and Conditions: document where the specific and individual parts of the Contract are found, which distinguish it from all others.

» Proposal: the document(s) underwritten by the Policyholder and the Insured Persons that contain(s) the information necessary for the acceptance of the insurance by the Insurance Company and that is (are) part of the Policy.

c) Insurance Amounts

» Premium: Amount owed by the Policyholder to the Insurance Company in return for coverage of the Policy. This amount includes all taxes and quasi-fiscal charges imposed by law.

Annual Liability Limit: maximum amount to be paid by the Insurance Company for medical expenses covered by the Policy, per Insured Person and per policy year.

» **Co-payments:** percentage of medical expenses covered by the Policy at the Insurance Company's expense.

d) Coverage

» **Insured Event:** an event or series of events resulting from the same cause that may trigger the coverage provided under the Contract.

» **Illness:** a change in health status, beyond the will of the Insured Person and not caused by an accident, which is revealed by obvious signs or symptoms and is recognised as such by the doctor.

Accident: the fortuitous, sudden and abnormal event, due to an external cause and beyond the control of the Insured Person, which causes him/her a bodily injury.

» **Medical Expense:** the expense incurred by the Insured Person for the purchase of medically necessary services, provided it is prescribed or required by a doctor.

» **Clinically Necessary Services:** goods, services or health care medically accepted by the Insurance Company or the Administrator, and:

a) Necessary for the treatment of an Insured Party's illness or accident; b) Suitable for the situation diagnosed;

c) Of recognised clinical validity and consistent with the patient's clinical condition, in accordance with the protocols and standards recognised by the medical community;

d) Prescribed and/or performed by a doctor or other health professionals;

e) Provided in the most cost efficient way and best suited to the type of service to be provided;

f) Whose main purpose is not the comfort or convenience of the Insured Party, his/her family and the doctor or other healthcare providers;

g) Whose place of provision – whether the Insured Person's legal domicile, medical clinic, outpatient centre, hospital, out-patient or in-patient – is most appropriate to the situation diagnosed.

Healthcare Service Providers: doctors, hospitals, diagnostic centres or other providers that provide clinical services to Insured Persons.

» **Network of Providers:** healthcare service providers who have entered into a service agreement with the Administrator.

» **Doctor:** a graduate of a dental school, legally authorised to practice his/her profession in the country where the medical act takes place and enrolled in the Portuguese Dental Association or equivalent body in that country.

» **Agreed Benefits:** goods, services or healthcare provided within the Network of Providers. The Administrator pays the providers of the Insurance Company's co-payment directly for the medical expenses from the Agreed Benefits.

» **Fixed Pecuniary Benefits:** goods, services or healthcare provided within the Provider Network, where the co-payment for medical expenses is made to the Policyholder/Insured Persons.

» **Official Table of Codes and Nomenclature of the Portuguese Dental Association:** official table of codes and nomenclature published by the Portuguese Dental Association.

Clause 2 - Contract Purpose and Coverage

1. Under this Contract, the Insurance Company covers the

payment of dental and oral healthcare treatment expenses for the Policyholder/Insured Persons, as referred to in the Specific Terms and Conditions, which are designated as agreed benefits or fixed pecuniary benefits, and which result from illness or accident occurring during the term of the contract, in accordance with the General, Special and Specific Terms and Conditions.

2. This Insurance Contract includes the coverage that is expressly contracted, in accordance with that mentioned in the Specific Terms and Conditions.

3. Under the terms of the agreed benefits, the Insured Person only pays the provider the amount for which they are liable, whilst the Insurance Company's co-payment towards these expenses is paid directly to the provider.

Clause 3 - Territorial Scope

In the context of agreed benefits, this Insurance Contract shall only apply to expenses incurred in Portugal; whereas expenses incurred in Spain shall be paid as fixed pecuniary benefits.

Clause 4 - General Exclusions

1. The following are always excluded from any benefit under this contract:

a) Expenses incurred outside the Network of Providers;

b) Hospitalisation expenses, regardless of the causes and circumstances;

c) Medication expenses;

d) Aesthetic or plastic surgery, except when as a consequence of an accident or manifested illness occurring during the term of this Contract;

e) Expenses incurred with doctors who are spouses, parents, children or siblings of Policyholder/Insured Persons. Expenses prescribed by a doctor for him or herself are also excluded;

f) Expenses for other services that are not medically necessary.

Chapter II – Initial and Subsequent Risk Statement

Clause 5 - Obligation to Provide an Initial Risk Statement

1. The Policyholder or the Insured Person is obliged, before signing the contract, to accurately declare all circumstances that they are aware of and reasonably consider to be significant for the risk assessment by the Insurance Company.

2. The provisions set forth in the previous paragraph are also applicable to circumstances whose reference is not requested in a questionnaire eventually provided by the Insurance Company for this purpose.

3. An Insurance Company that has accepted the contract, except in the event of fraud by the Policyholder or Insured Person aimed at obtaining an advantage, may not make use of:

a) The omission of responses to questions on the questionnaire;

b) Inaccurate responses to questions stated in overly generalised terms;

c) Inconsistencies or clear contradictions in questionnaire responses;

d) Any fact that its representative knows is inaccurate or has been omitted at the time of signing the contract;

e) Circumstances known by the Insurance Company, particularly those which are publicly known.

4. Prior to signing the contract, the Insurance Company shall inform the Policyholder or Insured Person of the obligation referred to in paragraph 1, together with the procedure in the event of breach, under penalty of being held civilly liable, in general terms.

Clause 6 - Fraudulent Breach of the Obligation to Provide an Initial Risk Statement

1. In the event of fraudulent breach of the duty referred to in paragraph 1 of the previous clause, the contract shall be cancelled through a declaration sent by the Insurance Company to the Policyholder.

2. If there have been no accident claims, the notice referred to in the above paragraph shall be sent within three months of becoming aware of the breach.

3. The Insurance Company shall not be obliged to cover accident claims occurring prior to becoming aware of the fraudulent breach referred to in paragraph 1, or within the time period referred to in the above paragraph, subject to the general cancellation scheme.

4. The Insurer shall be entitled to the premium due through the end of the time period referred to in paragraph 2, except in the case of fraud or gross negligence on the part of the Insurer or its representative.

5. In the event of fraud by the Policyholder or Insured Person aimed at obtaining an advantage, the premium shall be due until the end of the contract.

Clause 7 - Negligent Breach of the Obligation to Provide an Initial Risk Statement

1. In the event of negligent breach of the obligation referred to in Clause 4(1), the Insurance Company may, via notice sent to the Policyholder within three months of becoming aware of the breach:

a) Propose a contractual amendment establishing a time period of at least 14 days to provide written acceptance or, if admissible, a counterproposal;

b) Terminate the contract, by demonstrating that under no circumstances shall it enter into contracts for the
coverage of risks related to the omitted or inaccurately stated fact.

2. The contract shall become null and void 30 days after sending the notice of termination, or 20 days after the Policyholder's receipt of the proposed amendment, if the latter fails to respond or rejects it.

3. In the case referred to in the above paragraph, the premium shall be reimbursed on a pro rata temporis basis based on the coverage provided.

4. If, before the termination or amendment of the contract, an accident Claim occurs whose occurrence or consequences were influenced by a fact subject to negligent inaccuracies or omissions:

a) The Insurance Company shall cover the claim proportionally to the difference between the premium paid and the premium that would be due if, at the time of signing the contract, the Insurance Company had been aware of the omitted or inaccurately stated fact;

b) By demonstrating that under no circumstances would it have signed the contract if it had been aware of the omitted or inaccurately stated fact, the Insurance Company shall not cover the claim, and shall only be obliged to reimburse the premium.

Clause 8 - Receipt by the Insurance Company of the Initial Risk Statement

Clauses 6 and 7 shall not apply unless the Policyholder or the Insured Person is wilfully misled for the purpose of obtaining an advantage in relation to:

a) Failure to answer a question in the questionnaire submitted;
b) Inaccurate response to a question stated in overly generalised terms;
c) Inconsistency or clear contradiction in the questionnaire responses given;
d) Any fact that the Insurance Company's representative knows is inaccurate or has been omitted at the time the contract is signed;
e) Circumstance known to the Insurance Company, particularly when publicly known.

Chapter III - Start, Entry into Force, Changes to the Network of Providers, Duration, Right of Withdrawal, Termination, Cancellation and Contract Termination Notice

Clause 9 - Start of the Contract

1. This Contract shall take effect on the day and at the time stated in the Specific Terms and Conditions of the Policy, and shall remain in force for the period established therein.

2. The proposal shall be deemed approved on the fourteenth day from the date of its receipt by the Insurance Company, unless in the meantime clinical information, medical reports or any other information necessary for risk assessment is requested, or the refusal, postponement or conditional acceptance of the insurance is not communicated within the same period.

Clause 10 - Entry into Force of Coverage

The insurance contract commences on the date and at the time specified in the policy's Specific Terms and Conditions; no waiting period applies.

Clause 11 - Changes to the Network of Providers

The Insurer may make changes to the network of service providers at any time, and undertakes to ensure that the list of service providers is always kept up to date on the website or through the customer helpline.

Clause 12 - Duration

The insurance has a duration of one year and shall be automatically and successively renewed for equal periods. The Insurance Company covers only the payment of the agreed benefits or the medical expenses made in each year of the term of the Contract.

Clause 13 - Right of Withdrawal

1. The Policyholder has 30 days from receipt of the Specific Terms and Conditions to waive the effects of the Contract, on paper or other durable medium available and accessible to the Insurance Company.

2. The exercise of the right of waiver determines:
2.1. The termination of the contract;
2.2. The annulment, with effect from the date on which the Contract would commence, of all obligations under it;
2.3. The return of the premium already paid.

Clause 14 - Termination of the Contract

1. Termination by the Policyholder
1.1 . The Policyholder may terminate the Contract at any time, provided that notice is given by registered letter at least 30 prior to the date on which termination is intended to take effect.
1.2 . Termination of the Contract by the Policyholder during the term of the insurance, implies reimbursement of the premium for the period already paid and not yet elapsed.

2. Termination by the Insurance Company
2.1. The Insurance Company may only terminate the Contract during its term in the following cases:
a) Failure to pay the premium and in cases provided for by law;
b) Based on the clauses of the Chapter on Risk Declaration, initial and supervening.

2.2. When the termination occurs at the Insurance Company's initiative under the terms of point (b) of the previous paragraph, the Insurance Company shall notify the Policyholder, by registered letter, at least 30 days before the date on which it wishes the termination to take effect.

Clause 15 - Contract Termination Notice

1. Either party may oppose the automatic renewal by terminating the Contract, provided that it is communicated by registered letter, at least 30 days before the end of the current period.

2. In the event that the Insurance Company terminates the Contract, the Policyholder shall be entitled to the benefits contractually due for a period of one year, as a result of illnesses that have manifested or accidents that have occurred during the term of the Contract, until the annual limits of liability in force at the time of Contract termination have been exhausted.

3. This right only applies to manifested illnesses and accidents that occurred during the term of the Contract, which are reported to the Insurance Company up to 8 days after the expiry of this term, except in case of force majeure.

4. In case of doubt, it shall be up to the Policyholder and the Insured Persons to prove their right to the coverage.

Chapter IV - Inclusion and Exclusion of Insured Persons, Transfer of Insurance

Clause 16 - Inclusion of Insured Persons

1. During the Policy Term, the Policyholder may request the inclusion of persons who are part of the household.

2. Coverage for Insured Persons added during the term of the Contract commences on the effective date specified at the time they were included in the Policy.

Clause 17 - Exclusion of Insured Persons

During the term of the Contract, the Policyholder may request an Insured Person to be excluded in writing. The exclusion shall only take effect on the date of renewal of the Contract, except for the death of the Insured Person. In this case, the Insurance Company shall return the premium for the period already paid and not yet elapsed.

Clause 18 - Transfer of Insurance

Adult Insured Persons who wish to be insured under a new Contract may do so, provided that the Policyholder requests this in writing no later than 30 days prior to the intended transfer date.

Chapter V - Determination of Insurance Amounts, Updating of Coverage, Premium Due Dates and Notice of Premium Payments, Failure to Pay Premiums and Alteration of Premiums

Clause 19 - Determination of Insurance Amounts

The co-payment, annual limit on liability, and limits for each medical expense applicable to each contracted coverage are set out in the Specific Terms and Conditions.

Clause 20 - Updating of Coverage

The insurance amounts can be updated on the expiry of the Contract, upon prior notice to the Policyholder at least 30 days in advance.

Clause 21 - Premium Due Dates and Notice of Premium Payments

1. The insurance premium for the initial term is due on the date of signing this contract, and premiums for subsequent terms are due on the dates specified in the

relevant payment notices, which may fall up to eight days prior to the term of the contract the premium is for.

2. For the duration of the contract, the Insurance Company shall notify the Policyholder in writing of the amount payable, payment method and payment location at least 30 days in advance of the

due date of the premium or its instalments.

3. This notice shall include a legible description of the consequences of failing to pay the premium or its instalments.

4. In insurance contracts with premium payments made in instalments of less than three months, and whose contractual documentation specifies the due dates of the premium's instalments and the amounts due, together with the consequences of failing to pay, the Insurance Company may choose not to send the notice referred to in paragraph 1; in such case, the Insurance Company shall be responsible for proving the issuance, acceptance and transmission of the contractual documentation referred to in this paragraph to the Policyholder.

Clause 22 - Failure to Pay Premiums

1. Any failure to pay the initial premium or its first instalment before the due date shall result in the automatic termination of the contract beginning on the date it was signed.

2. Any failure to pay the subsequent annuities premium or its first instalment before the due date shall result in the contract not being renewed.

3. Any failure to pay shall result in the automatic termination of the contract on the due date of:

a) An instalment of the premium over the course of an annuity;

b) An additional premium resulting from a contractual amendment for subsequent aggravation of risk.

4. Any failure to pay an additional premium for a contractual amendment before its due date shall result in the annulment of the amendment, and the contract shall remain in force under the terms and conditions in effect prior to the amendment, unless it is impossible to continue the contract, in which case it shall be terminated on the due date of the unpaid premium.

Clause 23 - Alteration of the Premium

If there is no change in risk, any change

of the premium applicable to the policy may only take effect at the next annual renewal date.

Chapter VI - Obligations and Rights of the Insurance Company, Policyholder and Insured Persons

Clause 24 - Obligations and Rights of the Insurance Company

1. The Insurance Company has the duty to regularly honour the commitments made to the Policyholder and the Insured Persons.

2. The Insurance Company may deduct any outstanding premiums from the benefits due by means of a statement sent to the Policyholder.

Clause 25 - Obligations and Rights of the Policyholder and Insured Persons

1. The Policyholder must pay the insurance premium on the dates and for the amounts stipulated by the Insurance Company.

2. The Policyholder undertakes to notify the Insurance Company in writing of any change of residence. All registered correspondence sent to his/her last place of residence which is listed in the Insurance Company's records and documents shall be deemed to have been received by him/her.

3. The occurrence of an administrative error may not deprive Insured Persons of the benefits due under the

Contract. Nor does the occurrence of an administrative error create the right to non-contracted benefits.

Chapter VII - Accident claims: Obligations of the Insurance Company and/or Administrator, Regularisation Procedures

Clause 26 - Obligations of the Insurance Company in the Event of a Claim

The Insurance Company is obligated to:

1. Diligently and promptly make all inquiries necessary for the correct settlement of claims.

2. In the case of fixed pecuniary benefits, pay the Policyholder/Insured Persons the amount due within fifteen working days of receipt of the co-payment request and all documents necessary for settling the claims, as referred to in Clause 27(2) of these General Terms and Conditions.

Clause 27 - Claims Settlement Procedures

1. Whenever the Policyholder/Insured Persons uses the goods, services or healthcare provided within the Network of Providers, they must:

1.1. Select a provider from the Network of Providers;
1.2. Present their health card when they receive clinical services through the Network of Providers;
1.3. Pay the provider the part of the expense which is to be borne by the provider.

2. Whenever the Policyholder/Insured Persons uses the goods, services or healthcare provided in Spain, they must:
2.1. Submit receipts for the expenses incurred, which must indicate the name of the patient, detail the services provided and comply with legal requirements, particularly those relating to tax matters.
2.2. Present the originals of all expense receipts. If the Insured Person needed to present the originals for the purpose of claiming reimbursement from another body, he/she may submit photocopies which must be accompanied by an original document proving the amount spent and the reimbursement received.
Similarly, if the Insured Person needs to submit the originals for the purpose of claiming reimbursement from another body, they may submit photocopies accompanied by an original document issued by the Insurance Company, proving the amount spent and the reimbursement received;
2.3. Submit receipts for medical expenses within 180 days from the date the expense was incurred.

3. Clinical information:
The Policyholder/Insured Persons must, in all circumstances:

3.1. Truthfully inform the Administrator or the Insurance Company of the circumstances and consequences of the illness or accident;

3.2. Comply with the prescriptions from the doctor they have used;
3.3. Undergo examinations by doctors designated by the Administrator or the Insurance Company, should the latter consider it necessary through the clinical services;
3.4. Authorise the doctors and hospitals they have used to provide the Administrator's or the Insurance Company's clinical services with the clinical reports and any other information that the Administrator or the Insurance Company may need to document the case;
3.5. In the event of an accident, report its occurrence within a maximum of 15 days, giving a description (date, place, time, causes and consequences), the hospital to which s/he has been referred, the witnesses, the authorities who have taken note of it and the identification of the person responsible, if any.

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Chapter VIII - Miscellaneous Provisions

Clause 28 - Communications and Notices between the Parties

1. Any communications or notices from the Policyholder or the Insured Person for in this policy shall be considered valid and effective if they are sent to the Insurance Company's registered office or branch, as the case may be.

2. Communications and notices made pursuant to the terms of the above paragraph to the address of the Insurance Company's representative outside of Portugal related to claims covered by this policy shall also be considered valid and effective.

3. Communications under this contract shall be made in writing or by other means that ensure they are permanently set on record.

4. The Insurance Company shall only be obligated to send the communications provided for under this contract if the recipient is duly identified in the contract; such notices shall be considered valid and effective when sent to the address shown in the policy.

Clause 29 - Confidentiality of Information with the Administrator

The Policyholder and the Insured Persons authorise the Insurance Company to provide the Administrator with all confidential information about this Contract, provided that such disclosure is consistent with the purpose for which the information was collected.

Clause 30 - Subrogation by the Insurance Company

The Insurance Company shall be subrogated, up to the amount paid, to all the rights of the Insured Persons against third parties responsible for accidents or illnesses covered by the Policy, and the Policyholder/Insured Persons are required to provide the Insurance Company with all the information the it needs to exercise this right. Subrogation shall only operate in respect of fixed pecuniary benefits unless otherwise agreed.

Clause 31 – Applicable Law and Arbitration

1. Portuguese law shall apply to this contract.

2. Complaints may be submitted within the scope of this contract to the Insurance Company departments shown in the contract, and to the Insurance and Pension Funds Supervisory Authority (www.asf.com.pt).
3. Any disputes arising from this contract may be settled by arbitration, pursuant to the terms of the law.

Clause 32 - Governing Law

The governing law for settling any disputes arising from this contract shall be that established by civil law.

Clause 33 - International Sanctions

1. Mudum - Companhia de Seguros, S.A., complies with the legislation and rules regarding international sanctions, defined by laws or restrictive measures that impose economic, financial or commercial sanctions (including any sanctions or measures related to an embargo, a blockage of economic assets or resources, restrictions on transactions with natural or legal persons, or related to certain goods or territories) issued, administered or executed by the United Nations Security Council, the European Union, France, the United States of America (including, in particular, measures issued by the Foreign Assets Control Division or OFAC, under the Department of the Treasury) or any other competent authority having the power to issue such sanctions.

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2. No payment may be made in connection with the performance of the insurance contract if this violates the above provisions.

SPECIAL TERMS AND CONDITIONS

The provisions of the General Terms and Conditions shall apply to coverages contained in these Special Terms and Conditions in the parts not specifically regulated.

Dental Treatment and Dental Prostheses

1. What is Covered

1.1. Access to a Network of Dental Service Providers listed in the Specific Terms and Conditions at agreed prices is covered, in accordance with those set out in the annex to the General and Special Terms and Conditions.
1.2. The Insurance Company also covers:
1.2.1. The co-payment (agreed benefits) of medical expenses for dental appointments or treatments carried out within the Network of Providers in Portugal, in accordance with limits set in the Specific Terms and Conditions;
1.2.2. The reimbursement (fixed pecuniary benefits) of medical expenses for dental appointments or treatments carried out within the network of providers in Spain, in accordance with the limits set in the Specific Terms and Conditions.

The medical expenses included in this coverage are:
a) Outpatient treatments, diagnostic tests and other clinical acts as long as prescribed by a dentist/stomatologist;
b) Dental cleaning;
c) Dental prostheses;
d) Orthodontics;
e) Dental surgery.

Well-Being Network

1. What is Covered

The Insurance Company covers access to goods and services such as Psychology, Nutrition, Osteopathy, Homeopathy, Chiropractic, Acupuncture, Shiatsu, Aesthetics, Genetics, Thermalism, Thalassotherapy, Spas, Health Clubs, Birth Preparation Courses, Podology, Speech Therapy, Cryopreservation of Stem Cells, Parapharmacies, Oral and Optical Hygiene supplied by a group of providers at agreed prices.
The service providers in this network, as well as the discounts they offer, can be consulted via the helpline (707 78 20 70) or via the website www.dentinet.pt.

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