General Conditions:

Preliminary Clause

1. This Insurance Contract has been jointly agreed between Mudum - Companhia de Seguros, S.A. and the Policyholder mentioned in the Specific Conditions. It is governed by the General, Special and Specific 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.
2. The individual details of this contract shall be established in the Specific Conditions, including the identification of the parties and their legal domiciles, the information on the insured person, the information on the Insurance Company's representatives for the purpose of claims, the determination of the premium or formula for its calculation, and other details.
3. In addition to the terms and conditions in the above paragraphs comprising the policy, the specific and objective advertising messages contradicting clauses of this policy, unless the latter are more beneficial to the policyholder, insured person or beneficiary, shall be an integral part of this contract.
4. The provisions of the above paragraph shall not apply to advertising messages whose broadcasting ended more than one year prior to signing the contract, or when those messages establish a specific term for the contract and the contract was signed outside of that term.

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,** the spouse or equivalent is considered to be the household;
- **Insured Person,** person designated in the Specific 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 Conditions agreed.
- **General Conditions**, a series of clauses that define and regulate general and common obligations inherent to an area or type of insurance.
- **Special Conditions, a** series of clauses aimed at clarifying, supplementing or specifying the provisions of the General Conditions.
- **Specific 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,** the premium is the amount for the coverage agreed and includes everything contractually owed by the policyholder, namely the cost of covering the risk, acquisition, management and collection costs and charges relating to the issue of the policy. In addition to the

premium, there are tax and parafiscal charges to be borne by the policyholder.

- **Annual Liability Limit,** maximum amount to be paid by the Insurance Company for medical expenses covered by the Policy, per Insured Person and per annuity.
- **Co-payment,** percentage of medical expenses covered by the Policy at the Insurance Company's expense.
- **Deductible for Medical Expenses,** amount that the Policyholder has to pay for each medical expense covered by the Policy, before the Insurance Company's co-payment is calculated. The Insurance Company's co-payment is levied on the amount by which the medical expense exceeds the deductible.
- **Limit per Medical Expense**, maximum amount per medical expense reimbursed by the Insurance Company after excluding the deductible, where applicable.

d) Coverage

- **Claim,** the report, total or partial, of the event that triggers the coverage of the risk specified in the contract.
- **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.
- **Urgent treatment** is considered to be that which must be carried out within a maximum of 48 hours after the accident.
- **Emergency Appointment** is considered to be an emergency consultation, which entails recourse to the emergency services of a clinic or hospital.
- **Elective Surgery,** scheduled surgery, regardless of the origin of the surgical recommendation (as a result of a routine or emergency appointment).
- **Emergency Surgery,** surgery performed during an emergency episode.
- **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.
- **Oncological disease:** Disease characterised by the existence of a malignant tumour resulting from uncontrolled proliferation of malignant cells classified according to the ICD (International Classification of Diseases) and confirmed by histological diagnosis, communicated to the Insurance Company's Doctor by a detailed medical report accompanied by the corresponding auxiliary diagnostic tests
- **Manifested Illness,** any illness which has been unequivocally diagnosed or which has been revealed with sufficient evidence.
- **Sudden Illness,** any illness requiring emergency treatment in hospital, either as an inpatient or outpatient.
- **Congenital Disease or Malformation,** Disease and/or malformation present at birth as a result of hereditary factors or conditions during pregnancy up to the time of birth. The disease and/or malformation congenital may be evident or recognised immediately after birth or be discovered later at any time in a person's life, regardless of its nature.
- **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 Person'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 Person, his/her family and the doctor or other health care providers;

g) Whose place of provision - the Insured Person's home, doctor's surgery, outpatient centre, hospital, out-patient or in-patient - is most appropriate to the situation diagnosed.

- **Grace Period,** the period between the date of inclusion of each person in the Policy and the date of entry into force of the coverage.
- **Clinical Service Providers,** doctors, hospitals, diagnostic centres or other providers that provide clinical services to Insured Persons.
- **Hospital,** a public or private establishment, legally recognised, whatever its name may be (namely hospital or clinic), which has medical, surgical and/or nursing assistance.
  This expressly excludes retirement and convalescent homes, as well as spas, sanatoriums, retirement homes, drug and alcohol treatment centres and other similar institutions.
- **Doctor,** a graduate of a medical school, legally authorised to practice his/her profession in the country where the medical act takes place and enrolled in the Portuguese Medical Association or equivalent body in that country.
- **Agreed Benefits,** goods, services or health care 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 health care given by providers who have not signed a contract with the Administrator. The Insurance Company's co-payment for medical expenses from fixed pecuniary benefits is paid to the Insured Persons.
- **Pre-Authorisation,** the approval of access to clinical services requested by Insured Persons given by the Administrator's clinical services.
- **Health Professional Subsystems,** schemes of protection against disease, covered by any public or private entities, whether or not complementary to the National Health Service.
- **Nomenclature Code and Relative Values of Medical Acts,** official table published by the Portuguese Medical Association, which includes all surgical interventions, valued in numbers of "k" (the more "k" the greater the complexity of the surgery performed).
- **INFARMED,** the National Institute of Pharmacy and Medicines is a Public Institute of the Ministry of Health which is responsible for the evaluation, regulation and control of activities related to medicines for human use, and sanitary products for the protection of Public Health**.**

Clause 2 - Contract Purpose and Coverage

1. **Unless otherwise provided for in the Special Conditions, the purpose of the Insurance Contract is to cover Insured Persons the agreed benefits and fixed pecuniary benefits as a result of manifested illness or accident occurring during the term of the Contract, in accordance with the General, Special and Specific Conditions.**
2. **This Insurance Contract includes the coverage that is expressly contracted, in accordance with that mentioned in the Specific Conditions.**
3. **This contract shall not cover the payment of any medical or pharmaceutical expenses claimed by the network of hospitals and other institutions that are part of or have an agreement with the**

National Health Service, when the Insured Person, being the beneficiary of such service, is assisted there. However, the payment of the corresponding user charges is covered.

Clause 3 - Territorial Scope

1. **The coverage is valid in Portugal, and cover medical expenses incurred abroad in the following cases:**
   1.1. **Accident or sudden illness that occurred during a trip abroad of less than 60 days.**
   1.2. **On the recommendation of a specialist doctor and with the agreement of the Insurance Company.**
2. **By express indication in the Special Conditions, this contract may also take effect in the countries indicated in the Specific Conditions under the terms and conditions referred to therein.**

Clause 4 - General Exclusions

This Contract shall never cover the payment of any benefits arising from:

1. **Surgeries and/or treatments to correct congenital malformations, except when they concern children born during the term of the Contract and are included before they complete 60 days of age.**
2. **Chronic psychiatric illness,**
3. **Aesthetic or plastic surgery, except when consequence of an accident occurring or illness manifested during the term of this Contract.**
4. **Obesity consultations, examination/treatment or surgery (including morbid obesity).**
5. **Consultations, examinations/treatments or rejuvenation surgeries or any other treatment of a predominantly aesthetic nature.**
6. **Consultations, tests and treatments for infertility or artificial insemination.**
7. **Expenses with medicines, treatments or surgical interventions for contraceptive purposes.**
8. **Haemodialysis.**
9. **Organ and tissue transplantation.**
10. **HIV infection and its implications.**
11. **Check-ups and general health tests.**
12. **Alcoholism and treatments for drug addiction, as well as any disease or injury acquired by the Insured Person due to having consumed or acted under the influence of alcohol, narcotics, other drugs or toxic products, when not prescribed by a doctor.**
13. **Accidents occurring during participation in motor sport competitions or in related training.**
14. **The practice of professional sports.**
15. **Accidents that have occurred and diseases contracted due to natural disasters of a catastrophic nature, during revolutions or due to the existence of a state of war, declared or not.**
16. **Injuries or diseases caused by radioactivity.**
17. **Infectious diseases, when part of an epidemic declared by the health authorities.**
18. **Expenses incurred with doctors who are spouses, parents, children or siblings of Insured Persons. Expenses prescribed by a doctor for him or herself.**
19. **Occupational diseases and accidents at work.**
20. **Expenses from acupuncture, homeopathy, naturopathy or any other type of alternative medicine, not officially recognised by the Portuguese Medical Association.**
21. **Expenses for other services that are not medically necessary.**
22. **Health and inpatient expenses, when the treatments to be performed have the clinical purpose of convalescence, psychomotor rehabilitation, recovery or social reasons,**

namely those designated as continuous / palliative care, according to the Insured Person's state of health.

23. **Surgery for the treatment of snoring.**
24. **New techniques and/or technologies, whose evidence of clinical effectiveness is not yet duly proven and/or disseminated to at least two providers in Portugal.**
25. **Refractive surgery and/or treatments, except for situations above 4 dioptres.**
26. **Gender Dysphoria - Consultations, Examinations, Treatments and Surgeries related to Gender Dysphoria and its complications.**

CHAPTER II - Initial and subsequent risk statement

Clause 5 - Obligation to provide an initial risk statement

1 **The policyholder or insured person shall be obliged, prior to signing the contract, to provide an accurate statement of all known circumstances deemed reasonably significant for the Insurance Company's assessment of risk.**

2 **The provisions of the above paragraph shall also apply to any circumstances not specifically requested in the questionnaire provided by the Insurance Company for this purpose.**

3 **An Insurance Company who has accepted the contract, except in the case of fraud by the policyholder or insured person aimed at obtaining an advantage, may not exploit:**

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**

e) **the contract;**

f) **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 - Wilful non-compliance with the obligation to provide an initial risk statement

1. **In the event of wilful non-compliance with the obligation referred to in paragraph 1 of the previous clause, the contract shall be subject to cancellation via notice sent by the Insurance Company to the policyholder.**
2. **If there have been no 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 claims occurring prior to becoming aware of the wilful non-compliance referred to in paragraph 1, or within the time period referred to in the above paragraph, subject to the general cancellation scheme.**
4. **The Insurance Company 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 Insurance Company or its representative.**
5. **In the case 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 5(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 sign contracts to cover 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, a 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 inaccurately stated or omitted 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, Extension, Annulment, Age Limit, Duration, Free Resolution, Termination and Renunciation of Contract

Clause 9 - Start of the Contract

1. This Contract shall take effect on the day and at the time stated in the Specific 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

1 Unless otherwise provided, the coverage shall not come into force for each Insured Person until after a grace period has elapsed from their inclusion in the Policy of:

1.1. <u>Three months</u> for the coverage of:

- **Hospitalisation;**
- **Extension of Provider Network - Hospitalisation;**
- **Extension of Provider Network - Outpatient;**
- **Daily Hospitalisation Allowance.**

1.2. Two months for the coverage of:

- **Outpatient;**

2 The grace period is also extended to twelve months in the event of:

2.1. Surgical intervention and treatment of varicose veins;

2.2. Surgical intervention to hernias, whatever their nature;

2.3. Kidney and vesicular lithotripsy;

2.4. Proctological Treatments/Surgeries;

2.5. Surgical intervention to gastroduodenal ulcer;

2.6. Gynaecological intervention for benign pathology;

2.7. Breast surgery for benign pathology;

2.8. Surgical intervention to the ears, nose and throat for benign pathology;

2.9. Thyroidectomy for benign pathology;

2.10. Cholecystectomy;

2.11. Arthroscopy or Arthrotomy;

2.12. Extraction of birthmarks, moles, dermal cysts and warts, and treatment of eczemas, by benign pathology;

2.13. Refractive treatments for myopia, astigmatism and hypermetropia;

2.14. Intervention Cardiology, namely Electrophysiology Study (with or without ablation), Cardiac Catheterisation, Angioplasty and Pacemaker insertion;

2.15. Prostatectomy or resection for benign pathology;

2.16. Surgery for urinary incontinence treatment.

The grace periods shall not apply in the event of an accident or sudden illness necessitating emergency treatment in hospital, whether inpatient or outpatient.

Clause 11 - Extension of Coverage in the event of Hospitalisation

1. When the hospitalisation has started during the term of the Contract, the Insurance Company shall reimburse the respective medical expenses, even if these occur within 90 days from the date of termination of the coverage.

2. No reimbursement shall be due by the Insurance Company when the termination of coverage is due to non-payment of premiums, the provision of false, inaccurate or incomplete statements or any other cases provided for by law.

Clause 12 - Cancellation of Coverage due to Residence Abroad

1 A stay abroad by the insured person(s) for a period longer than 60 days shall result in the cancellation of the Contract coverage for this person(s) after this period has elapsed.

2 The Policyholder must notify the Insurance Company at least 15 days in advance of any trip abroad, when the planned duration is more than 60 days.

3 The return of this (these) person(s) from abroad makes it possible to resume the Insurance under the previous conditions, in which case it shall not be necessary to fill in the clinical questionnaire again, provided the signing of a new contract occurs no more than one year after the cancellation of the coverage.

Clause 13 - Age limit for subscription, termination of coverage

1. Persons under 55 years of age and over 75 years of age are not allowed to take out insurance.

2. The Extension of Provider Network - Hospitalisation and Extension of Provider Network - Outpatient coverage ceases at the expiry date immediately after the person reaches the age of 65;

Clause 14 - 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, except the provisions of

clauses 11, 12 and 13 of Chapter III of the General Conditions.

Clause 15 - Free Resolution

1. **The Policyholder has 30 days from receipt of the Specific 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 16 - Termination of the contract by the Insurance Company

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 provisions of the Chapter on Risk Declaration, initial and supervening.
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 17 - Renunciation of the agreement

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

2 **If the contract or coverage is not renewed and the risk is not covered by a later insurance contract, the Insurance Company may not, in the following two years and until the capital insured has been exhausted during the last term of the contract, refuse benefits resulting from manifested illness or another event occurring during the term of the contract, provided that they are covered by the insurance.**

3 **This right only applies to manifest illnesses and accidents occurring during the term of the Contract, which are reported to the Insurance Company up to 30 days after the expiry of this term, unless there is a fair impediment.**

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 and Alteration of the Coverage Plan

Clause 18 - Inclusion of Insured Persons

1. During the term of the Contract, the Policyholder may request the inclusion of persons who are part of the household, for which the completion of the clinical questionnaire attached to the proposal is necessary.
2. The start of coverage for Insured Persons included during the term of the Contract shall be subject to the grace periods provided for in clause 10.

Clause 19 - 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 20 - Transfer of the Insurance

1 **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 Contract renewal date.

2 **When the subscription of the new Contract is done within 30 days after the cancellation of the initial Contract, the Insured Person is accepted under the same conditions as the previous Policy, without the need to complete the clinical questionnaire.**

Clause 21 - Amendment of the Coverage Plan

1 During the term of the Contract, the Policyholder may request to change the coverage plan in writing up to 30 days before the Contract renewal date. This amendment shall take effect only on the renewal date, with the grace periods counting from this date in the event of an increase in coverage.

2 In the event of increased coverage, all Insured Persons must again undergo a medical questionnaire, and the Insurance Company reserves the right not to accept such a change.

Chapter V - Determination of Insurance Amounts, Updating of Coverage, Maturity of Premiums, Notice of Payment of Premiums, Unpaid Premiums and Alteration of Premiums

Clause 22 - Determination of Insurance Amounts

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

Clause 23 - 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 24 - Expiry Date

1. Unless agreed otherwise, the initial premium or its first instalment shall be due on the date the contract is signed.

2. The subsequent instalments of the initial premium, the premium for subsequent annuities and the successive instalments thereof shall be due on the dates indicated in the respective payment notices, which may be up to eight days before the period of validity to which the premium relates.

3. The portion of the variable premium to adjust the amount and, when applicable, the portion of the premium for contractual amendments shall be due on the dates specified in the respective notices.

Clause 25 - Notice of premium payment

1. During the term 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.

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

3. In insurance contracts whose premium payments are 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 a case, the Insurance Company shall be responsible for proving the issuance, acceptance and sending of the contractual documentation referred to in this paragraph to the Policyholder.

Clause 26 - 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 prevent the contract from 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 aggravated 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, together with the reinstatement of the contract under the terms and conditions in effect prior to the amendment, unless the contract's continuation is impossible, in which case it shall be terminated on the due date of the unpaid premium.

Clause 27 - Alteration of the Premium

If there is no alteration of risk, the premium applicable to the contract may only be altered after the following annual expiry.

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

Clause 28 - Obligations and Rights of the Insurance Company

1. The Insurance Company has the duty to regularly honour the commitments made by him/her 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 29 - Obligations and Rights of 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. **Doctors, clinics and any other service providers are chosen of the Insured Person's free will. The Insured Person shall, however, only be entitled to agreed benefits when choosing the Network of Providers.**
4. **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 - Claims: Obligations of the Insurance Company and/or Administrator, Regularisation Procedures

Clause 30 - 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 the amount due within fifteen working days of receipt of the claim and all documents necessary for settling the claims as referred to in Clause 31(2) of these General Conditions.**

Clause 31 - Claims Settlement Procedures

1. Whenever they wish to use the goods, services or health care provided by the Network of Providers (Agreed Benefits), Insured Persons 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 they use goods, services or health care carried out by providers that do not belong to the Network of Providers (fixed pecuniary benefits), Insured Persons must:

2.1. Apply for pre-authorisation to obtain the medical services that require it;

2.2. Submit the claims form duly completed;

2.3. Submit a medical prescription for the complementary diagnostic exams and treatments performed, as well as for the medication and glasses/lenses acquired;

2.4. Submit receipts for the expenses incurred, which must indicate the name of the patient to whom they relate, detail the services provided and comply with the legal rules, particularly those regarding tax. The receipts for medical fees must also indicate the medical specialism;

2.5. 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;

2.6. **Submit receipts for medical expenses within 180 days from the date the expense was incurred**.

3. Clinical information

Insured Persons shall in any of the circumstances set out in the preceding paragraphs:

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;

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;

3.6. As of the 9th (ninth) consultation, whatever the specialism (except for the following cases: dental appointments) must send clinical information proving the existence of the pathology covered by the insurance, so that the following consultations may be compensated.

4. Pre-Authorisation

Where paragraph 2.1 of this clause applies, Insured Persons shall:

4.1. Ensure that in the event of hospitalisation, pre-authorisation is requested from the clinical services of the Administrator;

4.2. Apply for pre-authorisation, in the event of hospitalisation, at least 72 hours in advance;

4.3. In case of Hospitalisation due to an emergency situation that prevents the Insured Person from requesting prior authorisation, it must be requested within a maximum of 24 hours from the occurrence.

5. The Policyholder and/or the Insured Persons shall be liable for any loss or damage if the procedures set out in the preceding paragraphs are not followed.
Without prejudice to the right to benefits, whenever the medical act is subsequently authorised by the Administrator.

6. The Administrator shall inform Insured Persons whenever other clinical services require pre-authorisation in the future.
7. Payments due by the Insurance Company are made in Portugal and in Portuguese currency. In the case of expenses incurred in foreign currency, the conversion into Portuguese currency shall be made at the indicative exchange rate published by the Banco de Portugal on the day the expense is incurred.

Clause 32 - Communications and Notifications between the Parties

1. Communications and notifications from the policyholder or insured person as provided for in this policy shall be considered valid and effective when made to the registered office of the Insurance Company or branch, as appropriate.
2. Communications and notifications made under 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 made under this contract shall be done in writing or by other means of permanent recording.
4. The Insurance Company shall only be obliged to send the notifications provided for under this contract if the recipient is duly identified in the contract; such notices shall be considered valid and effective when made to the address shown in the policy.

Clause 33 - 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.

Clause 34 - 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 Insured Persons are obliged to provide the Insurance Company with all the information the latter needs to exercise this right.

Subrogation shall only operate in respect of fixed pecuniary benefits unless otherwise agreed.

Clause 35 - 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

CHAPTER VIII - Other Provisions

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 36 - Jurisdiction

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

Clause 37 – International Sanctions

1. Mudum - Companhia de Seguros, S.A. complies with legislation and rules on international sanctions, defined by laws or restrictive measures imposing economic, financial or commercial sanctions (including any sanctions or measures related to an embargo, the blocking of economic assets or resources, restrictions on transactions with persons - physical or legal, or relating 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 the measures issued by the Office of Foreign Assets Control or OFAC, under the Department of the Treasury), or any other competent authority that has the power to issue such sanctions.
2. No payment may be made in connection with the performance of the insurance contract if this violates the above provisions.

Special Conditions

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

Hospitalisation

1. What is Covered

The Insurance Company undertakes to cover the agreed benefits and fixed pecuniary benefits for medical expenses, **in accordance with the limits set out in the Specific Conditions, in the event of** any:

- Hospitalisation of more than 24 hours;
- Surgery performed in a hospital or clinic on an outpatient basis whose value exceeds 50K per act (in case of association it should be considered the most valued code) according to the values established by the Nomenclature Code and Relative Values of Medical Acts published by the Portuguese Medical Association;
- Outpatient chemotherapy:
  - Antineoplastic drugs administered alone or in association and in the same session;
  - Antineoplastic drugs purchased in a hospital pharmacy, for home administration.
- Radiotherapy and other treatments with radioactive isotopes
- Maxillofacial and/or dental surgery, which results from an accident covered by the contract and requires emergency treatment in hospital, or resulting from a jaw tumour;

The medical expenses included in this coverage are:

1.1. Medical fees;

1.2. Hospitalisation expenses;

a) Day-to-day expenses;

b) Intensive Care Unit;

c) Nursing (not private);

d) Medicines;

e) Complementary diagnostic tests;

f) Operating room floor and material used;

g) Ambulance ground transportation to and from the hospital.

1.3. Hospitalisation motivated by psychiatric illnesses for a maximum of fifteen (15) days per annuity;

1.4. Refractive treatments for myopia, astigmatism and hypermetropia.

2. What is Not Covered

2.1. Expenses of a private nature (telephone, TV rental, etc.);

2.2. Expenses for accompanying persons;

2.3. Private nursing;

2.4. Dental surgery;

2.5. Maxillofacial and/or dental surgery in the event of illness;

2.6. Pregnancy.

3. Limits on Medical Fees

With regard to the fixed pecuniary benefits, the fees of the surgeon, anaesthetist and assistant are limited to the amounts resulting from the application of the "K" value stipulated in the Specific Conditions, in accordance with the Nomenclature Code and Relative Values of Medical Acts in the version chosen by the Insurance Company.

4. Pre-Authorisation

Medical expenses included in this coverage require pre-authorisation.

Outpatient

1. What is Covered

The Insurance Company undertakes to cover the agreed benefits and fixed pecuniary benefits for the following medical expenses, in accordance with the limits set out in the Specific Conditions:

1.1. General and specialist consultations;

1.2. Psychiatric medical appointments up to a maximum of six (6) per annuity;

1.3. Complementary diagnostic tests (if prescribed by a doctor):

a) Clinical analyses, cytohistological examinations;

b) Imaging, including radiography, arteriography, scintigraphy, echotomography, CT, nuclear magnetic resonance and Doppler examinations;

c) Other complementary examinations, such as E.C.G., E.E.G., etc.;

d) Allergy tests.

1.4. Medical emergencies:

a) All expenses related to the episode including ground transportation by ambulance to and from the hospital.

1.5. Treatments (as long as prescribed by a doctor):

a) Physical therapy, in the event of accident or illness, on the basis of agreed benefits;

b) Laser beam treatments;

c) Nursing (except private nursing);

d) Speech therapy, on the basis of agreed benefits;

e) Kinesiotherapy, on the basis of agreed benefits;

1.6. Outpatient surgery:

a) The expenses arising from minor surgery, whose valuation is equal to or less than 50K in accordance with the Nomenclature Code and Relative Medical Acts published by the Portuguese Medical Association, are covered in accordance with the above points.

2. What is Not Covered:

2.1. Dental appointments, treatments and surgery;

2.2. Orthoptic exercises;

2.3. Psychological guidance and support consultations and treatments;

2.4. Private nursing;

2.5. Prostheses and Orthotics;

2.6. Medicines.

3. Amount Limit per Consultation

In the case of fixed pecuniary benefits, the amount for consultations is subject to the limit for each medical expense stipulated in the Specific Conditions.

Preventive Medicine Programme

In accordance with the co-payment schemes and limits of the Outpatient coverage, the Insurance Company coverage the following preventive medicine programme:

1. Immunisation:

Type of vaccine	Age limit
Annual influenza vaccination	From the age of 65; at a lower age, in case of chronic allergic or respiratory pathology and with the Insurance Company's agreement

2. Preventive Tests:

Type of test	Age limit
Mammogram • Annual	From 55 years old
Pap smear • Annual	From 55 years old
Cholesterol test • Annual	From 50 years old
Faecal occult blood test to prevent gastric cancer. • Annual	From 60 years old

Dental Treatment and Dental Prostheses

1. What is Covered

1.1. Access to a Network of Dental Service Providers listed in the Specific Conditions

at agreed prices is covered;

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 the Specific 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 Specific 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.

Extension of Provider Network - Hospitalisation

1. Territorial Scope

The agreed benefits provided for in paragraph 2 shall be valid only within the network of providers provided for in the countries indicated in the Specific Conditions.

2. What is Covered

The Insurance Company undertakes to cover the agreed benefits of medical expenses, in accordance with the limits set out in the Specific Conditions, in the event of any:

- Hospitalisation of more than 24 hours;
- Surgery performed in a hospital or clinic on an outpatient basis;
- Outpatient chemotherapy. The

medical expenses included in this coverage are:

2.1. Medical fees;

2.2. Inpatient expenses;

a) Day-to-day expenses;

b) Intensive Care Unit;

c) Nursing (not private);

d) Medicines;

e) Complementary diagnostic tests;

f) Operating room floor and material used;

g) Ambulance ground transportation to and from the hospital.

2.3. Hospitalisation expenses related to Involuntary Interruption of Pregnancy.

3. What is Not Covered

3.1. Expenses of a private nature (telephone, TV rental, etc.);

3.2. Expenses for accompanying persons, except in the case of hospitalisation of children under 13;

3.3. Private nursing;

3.4. Dental or maxillofacial surgery, except if it is the result of an accident and illness that requires emergency treatment in hospital, either inpatient or outpatient, covered by this contract and occurred during its term;

3.5. Treatment of varicose veins, including sclerosing injections and laser treatment;

3.6. Pregnancy;

3.7. Any consultations, treatments or examinations directly related to pregnancy, except those provided for in paragraph 2.3.

4. Pre-Authorisation

Medical expenses included in this coverage require pre-authorisation.

Extension of Provider Network - Outpatient

1. Territorial Scope

The benefits provided for in paragraph 2 shall be valid only within the network of providers provided for in the countries indicated in the Specific Conditions.

2. What is Covered

The Insurance Company undertakes to cover the agreed benefits for the following medical expenses in accordance with the limits set out in the Specific Conditions:

2.1. Medical fees:

a) General and specialist consultations;

b) Medical acts.

2.2. Complementary diagnostic tests (if prescribed by a doctor):

a) Clinical analyses, cytohistological examinations;

b) Imaging, including radiography, arteriography, scintigraphy, echotomography, CT, nuclear magnetic resonance and Doppler examinations;

c) Other complementary examinations, such as E.C.G., E.E.G., etc.;

d) Allergy tests.

2.3. Medical emergencies:

a) Medical fees;

b) Operating room floor and material used;

c) Complementary diagnostic tests;

d) Ambulance ground transportation to and from the hospital.

2.4. Treatments (as long as prescribed by a doctor):

a) Physiotherapy, in the event of an accident requiring emergency treatment in hospital, either inpatient or outpatient, post-surgical situation, stroke, or kinesiotherapy caused by respiratory disease;

b) Radiotherapy and other treatments with radioactive isotopes;

c) Laser beam treatments;

d) Nursing (except private nursing);

e) Speech therapy, in case of post-surgical situation or stroke.

3. What is Not Covered

3.1. Dental appointments, treatments and surgery;

3.2. Orthoptic exercises;

3.3. Psychological guidance and support consultations and treatments;

3.4. Private nursing;

3.5. Prostheses and Orthotics;

3.6. Medicines;

3.7. Any consultations or treatments directly related to pregnancy, with the exception of involuntary termination of pregnancy;

3.8. Treatment of varicose veins, including sclerosing injections and laser treatment.

4. Pre-Authorisation

The expenses that require Pre-Authorisation are:

4.1. Fluorescence angioscopy and Retinography;

4.2. MRI / CAT scan;

4.3. Cardiological diagnosis;

4.4. Echocardiogram, Holter, Ergometry, Doppler;

4.5. Clinical Analysis (specifically karyotypes);

4.6. Special anatomopathological studies;

4.7. Extraction of moles, cysts and nevi by appointment;

4.8. Physiotherapy;

4.9. Vascular Radiology;

4.10. Radiotherapy;

4.11. Chemo and Cobalt therapy;

4.12. All Neurophysiology Techniques;

4.13. Radioactive isotopes;

4.14. Outpatient surgery.

Second Medical Opinion

1. Definitions

For the exclusive purpose of this Special Condition,

Serious Illness shall mean any of the following diseases, whether or not they develop in parallel with another type of disease:

1.1. Carcinogenic diseases;

1.2. Cardiovascular disease;

1.3. Neurological and neurosurgical diseases, including strokes;

1.4. Chronic renal failure;

1.5. Parkinson's disease (paralysis agitans);

1.6. Alzheimer's disease;

1.7. Multiple sclerosis;

1.8. Any other illness, considered to be serious by the Administrator or the Insurance Company, taking into account the specific case of the Insured Person using the services.

2. What is Covered

2.1. Under this Special Condition, when provided for in Specific Conditions, the Insurance Company shall, in the event of a serious illness of the insured person, take the necessary actions to collect a Second Medical Opinion from the best specialists worldwide in relation to the diagnosis of the pathology and its appropriate treatments;

2.2. For this purpose, the Administrator or the Insurance Company shall coordinate the collection of the information, requesting, if necessary, new medical examinations, clinical analysis and/or x-rays, and shall send it to the specialist physician whom it considers to be the most appropriate, taking into account the pathology of the Insured Person. In possession of all the information, the issue of the Second Medical Opinion shall take place within a maximum of 30 working days.

In addition to obtaining the Second Medical Opinion, when the Insured Person takes the initiative to carry out medical treatment abroad, the Insurance Company shall provide the following services:

a) Select and provide references to the Insured Person about foreign specialist doctors and hospitals selected by the Administrator or the Insurance Company at the request of, or directly indicated by, the Insured Person;

b) Obtain estimates and costs with fees and hospitalisation related to the medical service to be undertaken abroad;

c) Make medical appointments with specialists selected abroad by the Administrator or the Insurance Company or with those appointed by the Insured Person;

d) Book transport and accommodation reservations abroad for the Insured Person and his/her family, within a maximum of 10 working days;

e) Formalise the prior procedures necessary for the admission of the Insured Person to the hospital;

f) Deliver and guide the Insured Person at the hospital where s/he is admitted and coordinate the medical care to be provided;

g) Review, check and analyse the invoices corresponding to the treatments/consultations made;

h) Perform complete audits of all invoices and medical expenses supported by the Insured Person;

i) Negotiate discounts on behalf of the Insured Person with specialist doctors and hospitals.

3. What is Not Covered

Without prejudice to the exclusions in the General Conditions applicable to this cover, the following are not covered under this Special Condition:

3.1. Any services requested from the Administrator or the Insurance Company when the Insured Person is not suffering from a serious illness as defined above;

3.2. Services not requested from the

Administrator or the Insurance Company;

3.3. Any medical expenses for fees, medication and/or hospitalisation abroad;

3.4. Transport and accommodation expenses in Portugal and abroad.

Online Medical Service

This service aims to provide the Insured Person with access to remote (video) consultations by specialist doctors in General and Family Medicine, Paediatrics and Travel Consultation.

Access to this service shall be made through the Customer Care Line through the specific option for this purpose, who shall evaluate access to it.

The cost of the consultation shall be borne by the Insurance Company and the Insured Person, who shall pay the amount of the deductible that is considered to be fixed in the Specific Conditions.

Medical Assistance

1. Definitions

For the purpose of covering this risk, the following definitions shall apply:

Insured Person - the person or persons in whose interest the insurance contract is entered into, and in whose favour the coverage contracted must be provided, in accordance with this Policy. Only those who are domiciled in Portugal are eligible as Insured Persons under this Policy.

2. Territorial Scope

The coverage foreseen in this Policy is valid in Portugal, regardless of each individual item covered.

3. What is Covered

In the event of a claim, covered by any of the Policy's coverages when contracted, occurring at the Insured Residence, the Assistance Service shall, up to the Policy's Capital Limits, provide the following coverage:

3.1. <u>Sending a Doctor to the Insured Residence</u>

a) The Assistance Service ensures that a general practitioner is sent to the Insured Residence for consultation and possible advice regarding the direction to take.

b) The cost of travel per visit shall be paid by the Assistance Service, while the consultation fee is set out in the Specific Conditions and is borne by the Insured Person. All prescribed treatments shall be paid by the Insured Person.

3.2. <u>Medical Advice</u>

On request, the Assistance Service's team of doctors provides medical advice by telephone to the Insured Person, under conditions that are compatible with the rules of the profession.

The responses issued are based on the information provided by the Insured Person and the Assistance Service is not responsible for interpretations of such responses.

The medical support requested and provided by telephone implies, solely and exclusively, the appropriate responsibility arising from this type of intervention, within the context in which it is practised.

This medical advice is not a substitute for the use of hospital emergency services and is not in itself a medical consultation.

3.3. <u>Home Convalescence</u>

Following a claim and by request of the Insured Person, the Assistance Service will organise and support the sending of qualified professionals to your Home, to help in the recovery or convalescence of your state of health, up to the Capital Limit established in the Policy, for the following services:

- Speech Therapy;
- Physiotherapy (provided that the necessary conditions are met to practice it);
- Nursing service.

These services must be requested at least 48 (forty-eight) hours in advance and can be requested between 09h00 and 21h00, from Monday to Friday.

3.4. <u>Domiciliary Support Staff</u>

In the event of a claim and at the request of the Insured Person, the Assistance Service shall organise and support the sending of qualified professionals to support the following hygiene and personal well-being tasks for which the Insured Person is not in a stable clinical condition to perform:

- Get out of bed;
- Personal hygiene, bathing, nail cutting and simple hair care;
- Help with food;
- Changing personal clothes and bedding;
- Short walks, wheelchair help, mobility exercises.

This service must be requested at least 48 (forty-eight) hours in advance and may be requested between 09h00 and 21h00, from Monday to Friday.

3.5. Transportation by ambulance or taxi

The Assistance Service organises and supports the cost of transport by ambulance or taxi from the Insured Residence to the nearest first aid or emergency post within a 30 km radius.

4. What is Not Covered

In addition to the exclusions provided for in the General Conditions, charges or benefits in connection with the following shall also be excluded:

a) **Claims that occurred prior to the start date of the Policy, even though their consequences extend or are manifested beyond that date;**

b) **Claims occurring outside the period of validity or coverage of the Policy;**

c) **Claims and their consequences, caused by the Insured Person's criminal actions or omissions, whether wilfully or grossly negligent;**

d) **Claims and their consequences caused by suicide, attempted suicide or self-injury by the Insured Person;**

e) **Claims arising from causes already existing at the start of the Policy;**

f) **Actions or omissions by the Insured Person, while using toxic products, narcotics or other drugs off prescription, and when found to have a blood alcohol level higher than 0.5 grams per litre, or after having refused to undergo tests for alcohol or narcotics;**

g) **Claims caused by natural cataclysms, such as earthquakes, volcanic eruptions, floods, tsunamis and any other similar phenomena, including lightning strikes;**

h) **Claims derived from events of war, declared or not, hostility between countries, sabotage, rebellion, revolution, acts of terrorism, riots, insurrection, labour disturbances, strikes, lockouts, acts of vandalism, implementation of martial law and usurpation of civil or military power, other public order disturbances and similar phenomena;**

i) **Claims caused by explosive or incendiary devices;**

j) **Claims derived, directly or indirectly, from the disintegration or fusion of the nucleus of atoms, acceleration of particles and radioactivity;**

k) **Claims and damages not proven by the Insurance Company;**

l) **Rescue operations, primary medical assistance and initial emergency transportation, whenever they exist and public means can be activated for this purpose;**

m) **Expenses from therapies and long-term treatments.**

5. Procedures in the event of a claim

5.1. In the event of a claim, and without prejudice to the obligations specifically provided for in the applicable Special Conditions, it is an indispensable condition for the operation of the coverage in this contract that the Policyholder or the Insured Person:

a) Immediately contact the Assistance Service, detailing the occurrence and providing all the information necessary to implement the coverage in question, explain the circumstances of the claim, possible causes and respective consequences;

b) Follow the Assistance Service instructions and take all necessary measures possible to prevent the consequences of the claim from deteriorating;

c) Obtain the agreement of the Assistance Service before bearing any cost or expense;

d) Comply with the requests for information and documentation formulated by the Assistance Service / Insurance company at any time, and promptly send all the necessary documents for the case to progress;

e) Collect and provide the Assistance Service with the documents relevant to the enforcement of the responsibility of third parties, when applicable.

5.2. Failure to comply with the obligations laid down in the preceding paragraphs shall give rise to a reduction in the Assistance Service provided in view of the harm caused to it by failure to comply with the obligations laid down in this Article.

5.3. Intentional failure or defective performance of the duties set out in the preceding paragraphs and which have resulted in harm or loss to the Assistance Service shall result in loss of cover.

5.4. The Insured Person is responsible for proving the veracity of the claim reported, and the Assistance service / Insurance company may require all appropriate means of proof within their power.

6. Material Impossibility

6.1. This policy does not cover costs or reimbursement of expenses incurred by the Insured Person with provision of assistance that has not previously been requested by the Assistance Service or has been implemented without its prior agreement, except in cases of force majeure or demonstrated material impossibility.

6.2. If it is not possible for the Assistance Service to organise the benefits due within the defined territorial scope, the Assistance Service shall reimburse the Insured Person for the expenses s/he has incurred, within the limits defined by this Policy shall and the applicable coverage.

6.3. The processing of any reimbursement by the Assistance Service is subject to the submission by the Insured Person of the original documentation proving the expenses incurred.

7. Insurance Company medical team

7.1. In the settlement of claims under the coverage involving medical assistance, health care, transportation of claimants, the decisions of the Assistance Service shall always take into consideration the opinion of the respective medical team, which shall prevail over any others, in the choice of procedures to be followed and the selection of means of transportation.

7.2. Under the penalty of exclusion from the coverage of the Policy or impossibility of the Assistance Service to settle the claims reported, the Insured Person must authorize and assure the Assistance Service medical team of the availability and access to the relevant clinical information.

7.3. The Insured Person expressly consents to the processing of his/her health data for the purpose of managing the coverage of this insurance.

8. Rescue and loss of coverage

8.1. In the event of a claim, the Policyholder or Insured Person must employ the means at their disposal to prevent or limit harm.

8.2. Failure to comply with the duty laid down in the preceding paragraph shall give rise to a reduction in Assistance

Service provision in view of the harm caused to it by failure to comply with the duty laid down in this Article.

8.3. The Policyholder or Insured Person forfeits the benefits of this contract if they have:

a) Voluntarily or intentionally aggravated the consequences of the claim;

b) Used fraud, deception or any other malicious means, including false documents, to justify making a claim.

9. Expiry

The assistance coverage provided for in paragraph 3 shall cease to have effect on expiry in the following cases:

a) Change of Domicile of the Insured Person out of Portugal;

b) The Insured Person begins regular work abroad;

c) Absence of the Insured Person from Portugal for more than 60 consecutive days.

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.advancecare.pt.

2. What is Not Covered

The Insurance Company does not cover the granting of the discounts referred to in the previous paragraph, when the respective suppliers are not part of the Network of Providers managed by the Administrator.

Daily Hospitalisation Allowance

1. What is Covered

During the period of an Insured Person's Hospitalisation, the Insurance Company covers the payment of a daily allowance, under the terms and in accordance with the limits set out in the Specific Conditions of the Policy.

2. What is Not Covered

The Daily Allowance shall be excluded:

a) When the hospitalisation is due to childbirth;

b) When the hospitalisation of the Insured Person is not covered by the terms of the contract;

c) When the hospitalisation occurs in the first three months after the inclusion of the Insured Person in

this Insurance or inclusion in this Special Condition.

This document is available in Portuguese and English. In case of any discrepancy, the Portuguese version shall prevail