General Terms and Conditions:

Preliminary Clause

1. This Insurance Contract has been jointly agreed between GNB - Companhia de Seguros, S.A. 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.
2. This contract is personalised in the Specific Terms and Conditions, with, among others, the identification of the parties and their legal domicile, the data of the Insured Person, the data of the Insurance Company's representative for the purpose of claims, and the determination of the premium or the formula for its calculation.
3. In addition to the Conditions provided for in the previous paragraphs and constituting the policy, this contract furthermore consists of the concrete and objective advertising messages that contradict the clauses of the policy, unless these are more favourable to the policyholder, the Insured Person or the beneficiary.
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 of 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** means the spouse or equivalent, their children, stepchildren and adopted children, and ascendants, as long as they live with them as part of the same home. Children shall be considered only if they 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

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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 co-paid by the Insurance Company after excluding the deductible, where applicable.

d) Collateral

- **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 congenital malformation 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:

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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 legal domicile, 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 medication 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 Terms and 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**

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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. **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 Terms and Conditions, this contract may also take effect in the countries indicated in the Specific Terms and 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. **Aesthetic or plastic surgery, except when consequence of an accident occurring or illness manifested during the term of this Contract.**
3. **Obesity consultations, examination/treatment or surgery (including morbid obesity).**
4. **Consultations, examinations/treatments or rejuvenation surgeries or any other treatment of a predominantly aesthetic nature.**
5. **Consultations, tests and treatments for infertility or artificial insemination.**
6. **Expenses with medications, treatments or surgical interventions for contraceptive purposes.**
7. **Haemodialysis.**
8. **Organ and tissue transplantation.**
9. **HIV infection and its implications.**
10. **Check-ups and general health tests.**
11. **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.**
12. **Accidents occurring during participation in motor sport competitions or in related training.**
13. **The practice of professional sports.**
14. **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.**
15. **Injuries or diseases caused by radioactivity.**
16. **Infectious diseases, when part of an epidemic declared by the health authorities.**
17. **Expenses incurred with doctors who are spouses, parents, children or siblings of Insured Persons. Expenses prescribed by a doctor for him or herself.**
18. **Occupational diseases and accidents at work.**

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19. Expenses from acupuncture, homeopathy, naturopathy or any other type of alternative medicine, not officially recognised by the Portuguese Medical Association.
20. Expenses for other services that are not medically necessary.
21. Health and hospitalisation 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.
22. Surgery for the treatment of snoring.
23. 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.
24. Refractive surgery and/or treatments, except for situations above 4 dioptres.
25. 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 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 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 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 with the obligation to provide an initial risk statement

1. In the event of intentional 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 the accident claim that occurs before having become aware of the fraudulent breach referred to in paragraph 1 or during the period provided for in the previous item, following 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 if there has been fraud or gross negligence on the part of the Insurance Company or its representative.

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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 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, 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 accident 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 accident 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 of signing the contract;
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 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

1. Unless otherwise provided, the coverage shall not enter into force for each Insured

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Person until after a grace period has elapsed from their inclusion in the Policy of:

1.1. Three months for the coverage of:

- **Hospitalisation;**
- **Psychiatric Hospitalisation**
- **Extension of provider network - inpatient;**
- **Extension of Provider Network - Outpatient;**
- **Daily Hospitalisation Allowance.**

1.2. Two months for the coverage of:

- **Outpatient;**
- **Psychiatry, psychology and psychotherapy consultations;**
- **Dentistry and Dental Prosthesis (applied to formulas M and L);**
- **Prostheses and Orthotics;**
- **Medicines.**

1.3. Twelve months for the coverage of:

- **Serious illnesses.**

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

2.1. Pregnancy;

2.2. Surgical intervention and treatment of varicose veins;

2.3. Surgical intervention to hernias, whatever their nature;

2.4. Kidney and vesicular lithotripsy;

2.5. Proctological Treatments/Surgeries;

2.6. Surgical intervention to gastroduodenal ulcer;

2.7. Gynaecological intervention for benign pathology;

2.8. Breast surgery for benign pathology;

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

2.10. Thyroidectomy for benign pathology;

2.11. Cholecystectomy;

2.12. Arthroscopy or Arthrotomy;

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

2.14. Consultations, examinations and treatments related to pregnancy;

2.15. Refractive treatments for myopia, astigmatism and hypermetropia;

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

2.17. Prostatectomy or resection for benign pathology;

2.18. 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.**

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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 Termination of Coverage

1. **If the Insured Person takes out the insurance before reaching the age of 55, the Insurance Company may not terminate the policy coverage according to age, except in the case of coverage:**
   - **Medical Assistance: ceases at the expiry date immediately after the person reaches the age of 75;**
   - **Extension of provider network - inpatient: ceases at the expiry date immediately after the person reaches the age of 65;**
   - **Extension of Provider Network - Outpatient: ceases at the expiry date immediately after the person reaches the age of 65;**
   - **Serious illnesses: ceases at the expiry date immediately after the person reaches the age of 65.**
2. **The maintenance of the policy under the terms of the previous paragraph shall not affect changes, over time, to the premiums that may be necessary to meet the risk conditions;**
3. **Coverage ceases to be valid immediately after the person's 70th birthday if the Insured Person takes out insurance after reaching the age of 55;**
4. **Persons over the age of 60 are not allowed to take out insurance.**

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 Terms and Conditions.

Clause 15 - Free Resolution

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 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 clauses 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**

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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. **Inclusion of newborns is automatically accepted, without completing a clinical questionnaire, provided that the entire household is already included in the insurance and is reported within 60 days of the date of birth.**
3. The commencement of coverage for Insured Persons included during the term of the Contract is subject to the grace periods provided for in clause 10, except in the case of inclusion of the newborn in accordance with the previous point.

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. **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 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 Terms and 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

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1. Unless agreed otherwise, the initial premium or its first instalment shall be due on the date of signing the contract.
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 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, together with the reinstatement of the contract 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 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 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**

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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 co-payment request and all documents necessary for settling the claims as referred to in Clause 31(2) of these General Terms and 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 medications 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 expense 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;

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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: children under 1 year of age and dental appointments) they must send clinical information proving the existence of the pathology covered by the insurance, so that the subsequent consultations can 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 pre-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 losses and damages 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.

CHAPTER VIII - Miscellaneous Provisions

Clause 32 - Communications and Notices between the Parties

1. The communications or notices of the policyholder or the Insured Person provided for in this policy shall be considered valid and effective if they are made to the head office of the Insurance Company or branch, as the case may be.

2. Communications and notices 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 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 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

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

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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 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 Terms and 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. 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, except in the case of hospitalisation of children under 13;

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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 Terms and 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.

Pregnancy

1. What is Covered

The Insurance Company shall cover the agreed benefits and fixed pecuniary benefits for medical expenses for normal or caesarean deliveries, provided that they occur during the period of the woman's hospitalisation, in accordance with the limits laid down in the Specific Terms and Conditions.

The medical expenses included in this coverage are:

1.1. Medical fees, including paediatric fees for neonatal care;

1.2. Hospitalisation expenses:

a) Daily rates;

b) Intensive Care Unit;

c) Use of an incubator;

d) Medicines;

e) Complementary diagnostic tests;

f) Birth and operations room floor and material used (anaesthetic gases, oxygen, blood transfusion, etc.);

g) Nursing (non-private);

h) Ambulance ground transportation to and from the hospital.

1.3. Hospitalisation expenses related to Involuntary Interruption of Pregnancy.

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.

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 Terms and Conditions:

1.1. General and specialist consultations;

1.2. 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.

1.3. Medical emergencies:

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

1.4. 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;

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e) Kinesiotherapy, on the basis of agreed benefits;

1.5. 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 Terms and 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
Hepatitis "B" vaccine, if purchased with the Health Service co-payment (in 3 doses, administered over 2 years)	Up to the age of 25
Annual influenza vaccination	From the age of 65; at a lower age, in cases of chronic allergic or respiratory pathology and with the agreement of the Insurance Company

2. Preventive Tests:

Type of test	Age limit
Eye test for early detection of pathologies	Up to the age of 4
Mammogram • Every 2 years • Annual	 From 45 years old From 55 years old
Pap smear • Every 2 years • Annual	 From 45 years old From 55 years old
Cholesterol test • Every 2 years • Annual	 From 40 years old From 50 years old
Faecal occult blood test to prevent gastric cancer. • Every 2 years • Annual	 From 40 years old From 60 years old

Mental Health

1. What is Covered

1.1. Payment of expenses incurred is guaranteed for:

a) Psychiatric hospitalisation in a hospital or clinic, including medical and nursing fees, medicines, diagnostic aids, materials and all products associated with the care provided;

b) Psychiatric Consultations;

c) Psychology and Psychotherapy Consultations.

1.2. Capital, Co-payments, Reimbursements, Deductibles and Co-payments are set out in the Special Conditions.

2. What is Not Covered

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Without prejudice to the exclusions in the General Terms and Conditions applicable to this coverage, the reimbursement of the following is not covered under this Special Condition:

a) **Expenses of a private nature (e.g. food not included in the daily hospital stay and telecommunications costs);**

b) **Vocational psychology and career development;**

c) **Work, social and organisational psychology, such as psychological coaching, community psychology and occupational health psychology.**

Additional Protection Oncology

1. What is Covered

This Special Condition covers:

1.1. Additional capital in the Hospitalisation coverage, for medical expenses from oncological diseases, covered by this policy, in accordance with the limits set out in the Specific Terms and Conditions.

1.2. Additional Payment for Outpatient coverage, arising from oncological medical expenses, covered by this policy, in accordance with the limits set out in the Specific Terms and Conditions.

2. What is Not Covered

2.1. Expenses not covered in inpatient care;

2.2. Expenses not covered in outpatient care;

2.3. Expenses that do not arise from oncological diseases.

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;

1.2. The Insurance Company also covers:

1.1.1. 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 Terms and Conditions;

1.1.2. The reimbursement (fixed pecuniary benefits) of medical expenses for dental appointments or treatments carried out outside the network of providers in Portugal, in accordance with the Specific Terms and Conditions.

1.1.3. 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 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.

Prostheses and Orthotics

1. What is Covered

The Insurance Company covers the co-payment of the medical expenses mentioned below, in accordance with the limits set out in the Specific Terms and Conditions:

1.1. Glasses;

1.2. Bifocal contact lenses;

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1.3. Hearing, ophthalmological and orthopaedic prosthesis;

Rental or purchase of wheelchair, articulated bed and other auxiliary equipment.

2. What is Not Covered

2.1. Sunglasses with less than 4 dioptres;

2.2. Cosmetic contact lenses;

2.3. Dental prostheses;

2.4. Acquisition of orthopaedic tights, elastic stockings and belts;

2.5. Orthopaedic mattresses and pillows;

2.6. Orthopaedic shoes.

Medications

1. What is Covered

1.1. The Insurance Company shall provide co-payment in the form of reimbursement (fixed pecuniary benefits) for medical expenses for the purchase of medication, provided they are prescribed by a doctor and registered with INFARMED, in accordance with the limits set out in the Specific Terms and Conditions;

1.2. The expenses of medication are also co-paid, provided that they are prescribed by a doctor and registered with the respective official bodies of the countries included in the Specific Terms and Conditions of the Policy, and provided that the prescription has been made under the Extension of provider network - outpatient, Extension of provider network - inpatient and Serious Illnesses coverage.

2. What is Not Covered

2.1. Medicines for the treatment of obesity;

2.2. Vaccines, except those recommended in the Preventive Medicine Programme;

2.3. Over-the-counter medications;

2.4. Manipulated medications;

2.5. Hygiene products and dermocosmetic products.

Extension of Provider Network - Inpatient

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 Terms and 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 Terms and 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. 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.

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

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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 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 Terms and 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 Terms and 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;

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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 (paralisis 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 the Specific Terms and 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 doctors 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 the Insured Person, or directly indicated by the latter;

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;

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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 Terms and Conditions applicable to this coverage, 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. Travel costs and accommodation expenses in Portugal and abroad.

Serious illnesses

1. Territorial Scope

The agreed benefits provided for in paragraph 3 are valid only within the Network of Providers Agreed - Best Doctors.

2. Definitions

For the purposes of this special condition, the following serious illnesses or medical conditions shall be covered:

2.1. **Cancer treatment** involving the treatment of a malignant tumour characterised by non-encapsulated and uncontrolled growth and dispersion of malignant cells and tissue invasion, as well as the treatment of leukaemia and Hodgkin's disease.

The following treatments are not covered:

a) Chronic lymphocyte leukaemia;

b) Any tumour histologically described as pre-malignant or that only shows the first malignant transformations;

c) Non-invasive or "in situ" cancers;

d) Tumours in the presence of any human immunodeficiency virus;

e) Skin cancers with the exception of malignant melanoma;

f) Papillary bladder cancer.

For the purposes of point (c), 'IN SITU' malignant neoplasm means a malignant tumour which is restricted to the epithelium from which it originated and which has not invaded the stroma or surrounding tissue. This malignant tumour is pre-invasive when diagnosed at an early stage with favourable prognosis if it is extirpated completely.

2.2. **By-pass surgery** of the coronary arteries (myocardial revascularisation) that involves open heart surgery using by-pass grafts for:

a) Stenosis in the left or right coronary arteries, or;

b) Stenosis near the main coronary branches**.**

Payment of the expenses incurred in this type of intervention shall always depend on the angiographic evidence of the underlying disease.

Surgeries motivated by traumatic lesions or congenital alterations of the aorta are not covered.

2.3. **Interventional Cardiological Procedures** involving any operation or procedure aimed at dilating an artery by filling a balloon located at the tip of a catheter. Payment of the expenses incurred in this type of intervention shall always depend on the angiographic evidence of the underlying disease.

2.4. **Replacement of Heart Valves**, namely the effective total replacement of one or more heart valves for the treatment of a disease.

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2.5. **Specific Neurological Procedures** covering surgical procedures, craniotomy (the surgical opening of the cranium or skull), when it is necessary to extirpate a malignant or non-malignant tumour or to repair an intracranial blood vessel.

Craniotomy is excluded when it is the consequence of an accident or injury.

3. **What is Covered**

In accordance with the provisions of this Special Condition, the insurance contract coverage, in accordance with the limits set out in the Specific Terms and Conditions, the payment of expenses incurred by the Insured Person for diagnoses, treatments, services, provisions or medical prescriptions deemed medically necessary, whenever these are a result or consequence of any of the serious illnesses or clinical situations indicated above and whose first symptoms and first diagnosis have occurred during the term of the coverage.

When there is a serious illness or clinical situation identified in the preceding paragraph, the Insurance Company covers the co-payment of the expenses mentioned below, in accordance with the limits set out in the Specific Terms and Conditions:

3.1. Hospitalisation expenses, in particular:

a) General infirmary service expenses during hospitalisation in a room, lounge or pavilion, or surveillance or intensive care unit;

b) Other hospital services, including services provided in a hospital's outpatient department;

c) Day-to-day expenses of the insured person;

d) Expenses corresponding to the cost of an additional bed or of an accompanying person, if the hospital provides this service.

3.2. Expenses incurred in outpatient or independent surgery centres, as long as the treatment, surgery or prescription would be covered by this Contract when provided in a hospital.

3.3. Medical fees for consultations, treatments, medical care or surgeries.

3.4. Fees for medical appointments made to the Insured Person while in a hospital.

3.5. Expenses incurred for the following medical and surgical services, treatments or prescriptions:

a) Anaesthesia and its application, whenever provided by a professional anaesthesiologist;

b) Laboratory and pathology tests, diagnostic x-rays, radiotherapy, radioactive isotopes, chemotherapy, electrocardiograms, echocardiograms, myelograms, electroencephalograms, angiograms, computed tomography and other similar tests and treatments required for the diagnosis and treatment of a Covered Disease, whenever they have been provided by a doctor, or with the supervision of a doctor;

c) Blood transfusions, plasma and serum application;

d) Oxygen consumption and application of intravenous solutions and injections.

3.6. Expenses from pharmaceutical products or medication applied by medical prescription while the Insured Person is hospitalised, or after discharge, provided that the products in question are prescribed as part of post-operative processes.

3.7. Expenses for travel and transport by land and air ambulance when their use is indicated and prescribed by a doctor.

3.8. Expenses for a round trip on a regular airline for the Insured Person and an accompanying person.

3.9. Accommodation expenses for the Insured Person and an accompanying person.

3.10. In the event of the death of the Insured Person during treatment authorised by the

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Insurance Company due to a serious illness or medical condition covered, the travel expenses of transporting the coffin to the place of burial in Portugal, as well as the minimum mandatory coffin, embalming and administrative formalities.

4. What is Not Covered

Without prejudice to the exclusions provided for in the General Terms and Conditions applicable to this coverage, there is no coverage under this Special Condition for the payment of expenses incurred or caused by any diagnosis, treatment, service, provision or medical prescription in any way related to or resulting from:

4.1. **Any serious illness or medical condition for which the Insured Person has already received treatment before the effective date of the Policy.**

4.2. **Any serious illness or medical condition other than those referred to in paragraph 2 of this Special Condition.**

4.3. **Any serious illness or medical condition caused intentionally or wilfully by the Insured Person or as a result of the Insured Person's reckless actions or gross negligence.**

4.4. **Acquired Immunodeficiency Syndrome (AIDS), any disease that is secondary to or caused by AIDS, as well as any disease that is a consequence of its treatment, including the disease known as "Kaposi's Sarcoma".**

4.5. **Any coronary disease treated with techniques that do not require surgery, except balloon angioplasty.**

4.6. **Organ or tissue transplantation and its consequences or complications.**

4.7. **Expenses incurred for custody services, home health care or services provided in a convalescent home, retirement or nursing home, even when such services are required or needed as a consequence of a Covered Disease.**

4.8. **Any expense incurred outside the framework of international medical providers recommended by the Insurance Company.**

4.9. **Any type of prosthesis, orthopaedic appliances, belts, bandages, crutches, artificial limbs or organs, wigs (even when their use is considered necessary during chemotherapy treatment), orthopaedic shoes, hernia slings and other similar equipment or articles, with the exception of breast implants.**

4.10. **All types of pharmaceutical products and medication which have not been supplied by a licensed pharmacist, or for which no doctor's prescription is required.**

4.11. **Cerebral condition or care and custody expenses derived from cases of senility or brain damage.**

4.12. **Expenses incurred by the use of alternative medicine, even when specifically prescribed by a doctor.**

4.13. **Expenses for the purchase or rental of wheelchairs, special beds, air conditioners, air purifiers, and any other similar items or equipment.**

4.14. **Non-medical expenses incurred by the Insured Person or his/her accompanying persons, with the exception of those expressly covered under this Special Condition.**

5. Pre-Authorisation

In any situation, the payment of the aforementioned expenses shall always depend on their prior assessment by the Insurance Company, and for this purpose, the Insured Person or someone on their behalf must request the Insurance Company's pre-authorisation.

6. Accidents

In the case of a Covered Disease or Condition, the Insured Person or any person acting on their behalf must comply with the following rules:

6.1. Contact the Insurance Company as soon as possible to notify the case, and submit a

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certificate or medical report in which the precise diagnosis of the disease, date of origin, medical history of the Insured Person and the reports and examinations deemed necessary to verify the diagnosis are listed.

6.2. It shall be a precondition of the right to compensation under this coverage that the Insured Person or any person acting on their behalf shall request the Insurance Company for Pre-authorisation before receiving any treatment, service, provision or medical prescription in relation to a disease covered by this coverage.

6.3. The Insurance Company shall issue the Authorisation (Liability Term) which shall include the list of international medical centres authorised by the Insurance Company for the treatment, service, supply or medical prescription of the case. These medical centres shall be selected for the most appropriate treatment for the case using the international medical providers recommended by the Insurance Company.

6.4. If the Insured Person does not comply with the terms of the Authorisation (Liability Term) or does not use the international medical providers recommended by the Insurance Company, s/he shall lose the right to compensation of this coverage.

6.5. Once the claim has been established and the Authorisation (Liability Term) has been satisfactorily fulfilled, the Insurance Company shall with this coverage directly assume the medical expenses incurred by the Insured Person, subject to all other conditions, limitations and exclusions contained therein.

6.6. The Insured Person must strictly follow all the prescriptions of the doctor in charge of the treatment and must give the Insurance Company any information about the circumstances or consequences of the illness.

6.7. The Insured Person shall in all circumstances authorise the doctors and hospitals to which they have recourse to provide the Administrator's or the Insurance Company's clinical services with the clinical reports and any other information that the Insured Person may need to document the case.

Failure to comply with these duties shall be considered an express waiver of the right to compensation by this Policy.

Online Medical Service

This service aims to provide the Insured Party 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 Terms and Conditions.

Medical Assistance

1. Definitions

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

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

2. Territorial Scope

2.1. The coverage in this Contract shall not apply in countries where, for reasons of force majeure not attributable to the Insurance Company, it becomes impossible to provide services under this Contract.

2.2. The assistance guarantees provided for in paragraph 4.2. are valid in mainland Portugal and in the Autonomous Regions of Madeira and the Azores.

2.3. The assistance coverage provided for in paragraph 4.1. is valid throughout the

world, unless stipulated to the contrary in the Specific Terms and Conditions.

3. Duration

The assistance coverage provided for in paragraph 4, in relation to each membership, shall automatically lapse on the date on which the Policyholder ceases to have their habitual residence in Portugal, or if their stay abroad exceeds 60 days per trip, or on the date on which the membership is terminated. They shall also lapse for each Insured Person on the date on which he/she reaches the age of 75.

4. What is Covered

4.1. Assistance to Persons

a) Medical Transportation or Repatriation of the Injured and Sick

If the Insured Person is injured or ill during the period of validity of the Policy, the Insurance Company shall take care of:

- the cost of ambulance transport to the nearest clinic or hospital;
- surveillance by their medical team, in collaboration with the Insured Person's attending doctor, to determine the best measures to follow and the most appropriate means for possible transfer to another more suitable Hospital Centre or to their legal domicile;
- the cost of this transfer by the most appropriate means of transport. If this is to a hospital centre away from home, the Insurance Company shall also take care of the timely transfer to this hospital.

The means of transport used in Portugal, Europe and the neighbouring countries of the Mediterranean, if urgency and severity so require, shall be a special air ambulance.

In other cases, this transport shall be by commercial aircraft or any other means most appropriate to the circumstances.

b) Accompaniment During Medical Transportation or Repatriation

In the case of the Insured Person's condition, the subject of medical transportation or repatriation, the Insurance Company, after consulting their doctor, shall bear the expenses of the trip of a person who is also insured and is in situ to accompany him/her.

c) Accompanying the Hospitalised Insured Person

If an Insured Person is hospitalised and their state of health does not advise repatriation or immediate return, the Insurance Company shall bear the costs of a hotel stay, not initially provided for, of a relative or a person designated by them who is already there, to stay with them, up to the limit established in the Specific Terms and Conditions.

d) Return Transportation Ticket for a Family Member and Respective Stay

If the Insured Person's hospitalisation exceeds 10 days and it is not possible to activate the coverage provided for in point (c) of this article, the Insurance Company shall bear the expenses to be incurred by a family member for a round trip ticket by train in 1st class or by plane in tourist class, departing from Portugal, to stay with the Insured Person, and shall also be responsible for the subsistence costs up to the limit set out in the Specific Terms and Conditions.

e) Hotel Stay Extension

If, after the occurrence of illness or accident, the Insured Person's condition does not justify hospitalisation or medical transport and if their return cannot take place on the date initially foreseen, the Insurance Company shall be responsible for any expenses actually incurred with hotel accommodation by the patient and by a person accompanying him/her up to the

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limit per person set out in the Specific Terms and Conditions.

When the Insured Person's state of health so permits, the Insurance Company shall take care of their return as well as of any accompanying person if they cannot return by the means initially provided.

f) Location and Shipping of Emergency Medication

The Insurance Company shall take care of sending indispensable medication prescribed by a doctor, whenever they cannot be replaced by similar ones. The Insured Person shall be responsible for the price of medications, taxes and customs expenses.

g) Transport or Repatriation of the Deceased and Accompanying Insured Persons

The Insurance Company shall bear the expenses of all formalities to be carried out at the place of death of the Insured Person, as well as those relating to his/her transportation or repatriation to the place of burial in Portugal. If the Insured Persons accompanying him/her at the time of his/her death are unable to return by the means initially provided, or because of the impossibility of using the travel ticket already purchased, the Insurance Company shall pay the travel costs to return to their usual legal domicile or to the place of burial in Portugal.

If for administrative reasons a local burial is necessary provisionally or definitively, the Insurance Company shall bear the travel costs of a relative, if one of them is not already at the place, by providing them with a 1st class return train ticket or tourist class return air ticket to travel from their legal domicile to the place of burial, and shall also pay the subsistence costs up to the limit specified in the Specific Terms and Conditions.

h) Early Return

If, in the course of a trip, the spouse, or person with whom he or she cohabits permanently, ascendant or descendant to the 2nd degree, adopted, sibling, parent-in-law or sister/brother-in-law of the Insured Person dies in Portugal, and the means used for his or her travel or ticket purchased does not allow him or her to return earlier, the Insurance Company shall bear the expenses of the 1st class train ticket or tourist class plane ticket from the place of stay to his or her legal domicile or to the place of burial in Portugal.

This coverage also applies in the event that the spouse of the Insured Person or the person with whom he or she lives permanently, ascendant or descendant to the 2nd degree is the victim of an accident or unforeseeable illness in Portugal whose severity, to be confirmed by the Insurance Company's doctor after contact with the attending doctor, requires his or her urgent and imperative presence. If, as a result of the Insured Person's premature arrival, it is essential to return to the place of stay in order to allow the vehicle or Insured Persons to return by the means initially provided for, the Insurance Company shall make a ticket available to them for this purpose, by the means described above, and bear the respective costs.

i) Responsibility for Children Abroad

In the event of the Insured Person being hospitalised or in the event of death, if the remaining Insured Persons are minors under the age of 15, and do not have a relative or trusted person to accompany them while travelling, the Insurance Company shall bear the expenses incurred by a person travelling with them to the place of burial or their legal domicile in Portugal.

j) Theft of Luggage Abroad

In the event of theft of luggage and/or personal effects, the Insurance Company shall assist the Insured Person, if so

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requested, in reporting this to the authorities. In the event of theft or loss of said belongings, if found, the Insurance Company shall take care to send them to the place where the Insured Person is located or to his/her legal domicile, provided that they are properly packed and transported, up to a maximum of 100 Kg.

k) Advance of Funds Abroad

In the event of theft or loss of luggage or valuables not recovered within 24 hours, the Insurance Company shall advance the sums necessary to replace the missing goods up to the limit set in the Specific Terms and Conditions.

Equal coverage is provided if in the event of breakdown or accident of the insured vehicle funds are required for its repair.

These advance payments shall be reimbursed to the Insurance Company within 60 days.

l) Transmission of Messages

The Insurance Company shall take care of the transmission of urgent messages requested by the Insured Person due to the occurrence of any event covered by this policy.

m) Legal Defence and Complaint Abroad

3. The Insurance Company undertakes to:
   - Claim financial compensation for bodily and/or material damage suffered by the Insured Person, provided that it is the result of an accident in which the vehicle s/he drives is involved and it is the responsibility of a person other than the Insured Persons covered by the Policy or its occupants;
   - Ensure the defence of the Insured Person before any court if s/he is accused of manslaughter or involuntary bodily harm, culpable injury or violation of traffic regulations, as a result of ownership, custody or use of the vehicle s/he is driving;
   - Provide assistance abroad to the Insured Person in the event of a dispute with garages or car repairers concerning the vehicle s/he is driving.
4. The Insurance Company shall be responsible for handling all steps, negotiations and procedures, choosing its experts, doctors, advisers, lawyers, etc.
   The Insured Person may, however, at his/her own expense, appoint and/or associate experts or advisers of his/her choice, whose opinions, however, shall not bind the Insurance Company.
5. The Insurance Company shall not take legal action or appeal against a court decision:
   - When it considers that this does not have a sufficient chance of success;
   - Where, on the basis of information obtained, the third party held liable is insolvent;
   - When the value of the losses does not exceed the amount fixed in the Specific Terms and Conditions;
   - When it considers the proposal made by the third party fair and sufficient.

   The Insured Person may, however, in all cases bring or pursue the action at his/her own expense. If s/he wins it, the Insurance Company shall reimburse them for the amount of expenses legitimately incurred.

n) Advance of Bail Funds

1. Court Costs - The Insurance Company shall provide, as an advance, the bail funds required of the Insured Person, in order to cover the court costs in criminal proceedings brought against him/her as

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a result of a traffic accident, up to the limit set out in the Specific Terms and Conditions;

2. Provisional Release - It shall also provide, as an advance, and up to the limit set, the bail required to cover the provisional release of the Insured Person or his or her appearance at the trial as a result of criminal proceedings resulting from a traffic accident;

3. **These advance payments, either for court costs or to cover provisional release, shall be refunded to the Insurance Company within 3 months or straight after restitution by the court, whichever occurs first.**

   At the same time as the Insurance Company provides bail, the Insured Person must sign a document recognising the debt or provide sufficient coverage in the event that, through his/her fault, the bail is broken or lost.

4.2. Medical and Health Care at Home

4.2.1. Coverage in the event of hospitalisation of the Insured Person or his/her spouse or person cohabiting with him/her in a situation similar to that of his/her spouse:

a) Domiciliary Support

In the event of the Insured Person's hospitalisation, the Insurance Company shall, depending on local availability, arrange for a person to provide domiciliary support:

- to the spouse, children and ascendants up to the 1st degree of the Insured Person during their hospitalisation;
- or to the Insured Person, after his/her return from hospitalisation, during the period of convalescence, in accordance with medical instructions.

The Insurance Company shall bear the costs of domiciliary support up to the maximum limit set in the Specific Terms and Conditions, which must be provided within 30 days of the date of discharge from hospital.

b) Television Costs

During the Insured Person's hospitalisation, the Insurance Company shall bear the costs of renting a television in the hospital, up to the maximum amount fixed in the Specific Terms and Conditions, and on presentation of the respective justifications.

c) Transfer/Travel of Children under 16:

The Insurance Company shall organise and support the costs with:

- one return ticket, by 1st-class train or by plane in tourist class, for one person designated by the Insured Person, from their legal domicile in Portugal to the home of the Insured Person, so that they can look after any children under the age of 16 who are left alone;
- or, one return ticket, by 1st-class train or by plane in tourist class, for each child under 16 years of age so that s/he may travel to the legal domicile of a person designated by the Insured Person who can look after them.

d) Transfer/Care of Domestic Animal (Dogs and Cats)

The Insurance Company shall be responsible for finding an establishment for the safekeeping of domestic animals (dogs and cats) located as close as possible to the Insured Person's legal domicile and for organising the transportation of the animals to this establishment or to the home in

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Portugal of a person designated by the Insured Person.

The Insurance Company shall bear the transport costs, within a radius of 50 km from the Insured Person's legal domicile, as well as the costs of keeping the animals in the kennel or cattery, up to the limit set in the Specific Terms and Conditions.

The provision of this coverage is subject to the conditions of transport and safekeeping of the carriers and the kennels or catteries (up-to-date vaccines, deposits, etc.). In order to be able to provide this coverage, someone, designated by the Insured Person, must be able to deliver the animals to our employees.

4.2.2. Other coverage

a) Home Visit by a Doctor

In the event of an emergency, a doctor should visit the Insured Person's legal domicile for consultation and possible advice as to the treatment to be followed. The cost of travel shall be at the Insurance Company's expense.

The cost of these consultations 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 Terms and Conditions.

b) Transportation by Ambulance

In the event of an emergency, the Insurance Company shall organise and bear the cost of transporting the Insured Person from their legal domicile to the nearest first-aid or emergency post.

c) Medical Information

The Insurance Company shall provide any health information requested of it.

Should the Insurance Company be unable to provide an immediate response, it shall endeavour to search for the information requested and shall contact the Insured Person again to pass on the information.

The Insurance Company shall provide objective answers to the questions posed, based on official documents. It shall not be responsible for the Insured Person's interpretations or possible consequences of these.

The Insurance Company offers the possibility for the Insured Person to contact their medical service. Any advice that may be given should not be understood as a medical appointment but only as a general guideline given by one of the Insurance Company's doctors.

d) Private Clinic Reservation

The Insurance Company shall reserve a place in a private clinic for the Insured Person, subject to a medical prescription and in accordance with availability, the respective costs being paid by the Insured Person.

e) Ambulance Transport to Hospital and Return to Legal Domicile

The Insurance Company shall organise and bear the cost of transporting the Insured Person by ambulance to the designated hospital or clinic, as well as the cost of transporting him/her back to the legal domicile.

f) Accompanying the Hospitalised Insured Person

If the Insured Person is hospitalised more than 50 km from his or her legal domicile, the Insurance Company shall bear the costs of a hotel stay, not initially provided for, of a relative or person designated by him or her, to stay with him or her, up to the limit established in the Specific Terms and Conditions.

g) Expenses from Nurses and Nursing

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As a result of sudden illness or accident happening to the Insured Person, the Insurance Company shall bear the expenses of a nursing professional, as well as all treatments, specific nursing and material required for such, up to the limit stipulated in the Specific Terms and Conditions.

h) Home Delivery of Medications

The Insurance Company shall send the medications prescribed through a prescription to the Insured Person's legal domicile, with the respective cost borne by the Insured Person.

i) Transmission of Urgent Messages

On request of the Insured Person and in the event of hospitalisation, the Insurance Company shall transmit this information to family members designated by the Insured Person and residing in Portugal.

4.2.3. In all cases, the Insurance Company reserves the right to ask the Insured Person for a copy of the hospitalisation or home confinement certificate.

5. What is Not Covered

5.1. The following are not covered by this policy:

a) The consequences of claims occurring prior to the start of the Contract;

b) Claims or consequences caused intentionally or as a consequence of consummated or frustrated suicide of any of the Insured Persons;

c) Damage suffered by Insured Persons as a result of dementia or when they are under the influence of alcohol in accordance with the legislation on driving or have ingested drugs or narcotics without a medical prescription;

d) Claims due to war, riots and public order disturbances;

e) Claims due, directly or indirectly, to the disintegration or fusion of the nucleus of atoms, acceleration of particles or radioactivity.

5.2. Assistance to Persons

Without prejudice to the General Terms and Conditions, the Insurance Company shall also not be liable for services relating to:

a) Medical, surgical, pharmaceutical and hospitalisation expenses in Portugal;

b) Accidents that occur as a result of the practice of competitive, winter, high risk sports such as snow skiing, parachuting, mountaineering and climbing, martial arts and other risky sports, as well as training for competition and betting;

c) Births and complications due to pregnancy, unless unforeseeable during the first 6 months;

d) Spending on a funeral, urn or memorial service;

e) Claims caused by earthquakes, volcanic eruptions, floods or any cataclysms;

f) Expenses for prostheses, glasses, contact lenses and the like;

g) Expenses related to non-urgent physiotherapy.

5.3. Medical and Health Care at Home

Without prejudice to the General Terms and Conditions, the Insurance Company shall also not be liable for services relating to:

a) Expenses incurred without the prior agreement of the Insurance Company;

b) Pathological conditions which do not justify immobilisation at home;

c) Mental illnesses that have already been treated;

d) Recurrences or complications due to a pathological state already declared before the beginning of the Policy;

e) Routine medical appointments;

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f) **Births and complications due to pregnancy, unless unforeseeable during the first 6 months;**

g) **Scheduled hospitalisations;**

h) **Chronic illness.**

6. Accidents

In the event of an accident affecting this coverage, the Insured Person shall:

a) **Immediately contact the Assistance Service, detailing the occurrence and providing all the information necessary to provide the assistance requested;**

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

c) **Satisfy requests for information made at any time by the Assistance Service and promptly send them any warnings, summonses or quotations they receive;**

d) **Collect and provide the Assistance Service with the documents relevant to the enforcement of the liability of third parties, when applicable.**

7. Reimbursement for unused transport

Insured Persons who have used transport services provided for in this contract are obliged to take the necessary steps to recover unused transport tickets, and submit the sums recovered to the Insurance Company.

8. Additional information

The benefits and compensation provided are paid in excess of and in addition to other existing insurance contracts and cover the same risks.

The Insured Person undertakes to take all necessary steps to obtain these benefits and to return them to the Insurance Company in the event and to the extent that the latter has advanced them, as well as co-payments from the Social Security or any other institution to which he/she is entitled.

9. Miscellaneous Provisions

This insurance does not cover benefits that have not previously been requested by the Assistance Service or have been executed without its agreement, except in the case of force majeure or proven material impossibility.

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

2.1. 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 Terms and Conditions of the Policy.

2. What is Not Covered

2.1. 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;**

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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.**

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