

INSURANCE POLICY - GENERAL AND SPECIAL CONDITIONS

Médis Health

Ocidental seguros
Millenniumbcp Fortis
GRUPO SEGUADOR

Médis Health

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GENERAL CONDITIONS

CLAUSE 1 - DEFINITIONS

Definitions of useful terms and expressions for a better understanding of the concepts and contents of the contractual conditions of the current insurance contract:

1 - Regarding the entities involved in the health insurance contract:

Insurance Company

Entity that is legally authorised to conduct insurance business, and who agrees an insurance policy with the Policyholder.

Médis

Exclusive trademark brand of products developed by Médis - Companhia de Seguros de Saúde, S.A., insurer, reinsurer, who manages an in-network healthcare insurance system, covering: health, assistance and accidents, through policies issued by itself or by other authorised Insurance companies.

Policyholder

Entity that signs the insurance contract with the Insurance Company, responsible for payment of the premium.

Insured Person

The Person identified in the Special Conditions, that holds an Individual Insurance Certificate, whose health or physical integrity is hereby insured, and who is entitled to benefits covered by the policy.

Household

Group of people identified in the Special Conditions or in the Individual Certificate, who live together economically, which includes - besides the 'Insurance Holder', in the case of individual insurance policies, and besides the 'Member', in the case of group policies - his/her spouse, or the person who lives with him/her in legal partnership for over two years, as well as his/her offspring or ancestors, whether directly related or up to a second degree, and who are economically dependant of the Insurance Holder or of the Member.

2 - Regarding the documents that regulate and are part of this contract:

Policy

Document that seals the contract between the Insurance holder and the Insurance Company, which includes the agreed General, Special, and Specific Conditions, as well as additional proceedings to the contract.

General Conditions

Clauses that define and regulate the general and common obligations covered by the insurance contract.

Special Conditions

Clauses that - whether complementing or specifying the General Conditions -, are generally applicable to certain coverage, when those have been contracted.

Specific Conditions

Document where you can find the specific elements of each insurance contract, reflected in an Individual Certificate.

Additional Proceedings

Document where a modification to the Policy is reflected.

3 - Regarding the subscription to the Insurance Policy:

Médis Health Insurance

Health Insurance Contract agreed between the Insurance Company and the Policyholder, set out in an issued Policy document, whereby the Insurance Company provides the Insured People with access to the Médis healthcare network, under the agreed terms and limits, where specific financial criteria, or the partial refund of medical expenses from out-of-network providers, are expressly stated.

Médis Health Insurance Proposal

Insurer's document which is filled out and signed by the Policyholder or Member (Membership form), in which the information elements, essential for the acceptance of the insurance contract or individual membership are stated. This document is an integral part of the Policy and binds all parties, i.e.: Policyholder, each Member, and the Insurance Company.

Individual Health Questionnaire

A form that contains a range of indicators regarding health information, so as to form a profile and medical history that allows for a correct risk assessment, on behalf of the Insurance Company, whose filling and signing - by the Member - is equivalent to a precise personal declaration of his/her medical information.

4 - Regarding the amounts referred to in the Health Insurance Contract:

Premium

The amount paid by the Policyholder to the Insurance Company, for covering the risk contracted through the Insurance Policy. In contributory group Insurance Policies, the premium may be supported -whether in full or partially - by the Insured People.

Insured Capital

The capital insured represents the maximum amount contribution that the Insurance Company will pay for a claim or the insurance annuity, whichever is established in the contract.

Deductive Item

Amount that - in case of an accident - will be paid by the Insured Person, according to the coverage and the capital, and whose value is set out in the Specific Conditions or the Individual Certificate.

Co-payment

An amount that the insured person will pay for each health claim(s) or medical act, as per the terms set out in the Specific Conditions or the Individual Certificate.

Indexation

Amendments, if contracted, to the guaranteed capital and the corresponding Premium, according to an index

specified in the Specific Conditions or the Individual Certificate.

Cost-sharing Amounts

Amounts met by the Insurance Company under the in-network care provision, which are paid directly to the healthcare provider, without prejudice to rights to a co-payment contribution from the Insured People.

Refund/Reimbursable Amounts

Amount returned to the Insured person, by the Insurance Company, after having deducted the applicable Deductive Items and Co-payments, or paid by the healthcare provider when 'Direct Billing' has been issued.

Direct Billing

A document issued by the Insurance Company, which expresses the assumption of responsibility for the costs incurred in certain medical action or procedure, under the applicable terms and limits of the coverage of the Insurance, up to the maximum available guaranteed capital.

5 - Regarding the guarantees of the Health Insurance Contract:

Membership Conditions

These are established under the Individual Specific Conditions or in the Individual Insurance Certificate, for each Insured Person, Family Unit or Insured Group.

Approved Provision

Approved Provision implies the Insured Person's automatic access to a network of doctors and healthcare providers, set out on a supplied list and/or through the Médis Line, with the freedom of choice and wise access is subject to criteria set out in the Médis guide, namely: appointment with a medical assistant or referral to a medical specialist or authorisation for doctor's visits and procedures.

Out-of-network

Benefit that involves partial refund of costs incurred from an event covered by the Policy.

Event/Claim

All and any event likely to activate the cover provided by this Policy.

Accident

Fortuitous, abnormal and sudden event, attributed to external causes, against the will of the Insured People and which provoke bodily harm.

Illness

All and any involuntary change in the person's state of health, not caused by an accident, and diagnosed by a doctor.

Pre-existing condition

Pre-existing conditions excluded from the coverage are: any illness or injury of which the Insured Person was aware or, or should have been aware of, before the date on which the contract was signed, as a result of having undergone a clinical assessment, doctor's visit and/or prior treatment and whose signs or symptoms were evident at the time of subscription.

Congenital Disease

A disease that is present at birth, as a result of hereditary factors, or conditions raised during pregnancy and up to the moment of birth. The congenital disease may be evident or recognised immediately after birth, or discovered much later during the lifetime of the person, without prejudice to its nature.

Doctor

A Graduate of a Faculty of Medicine or a Faculty of Dental Medicine, licensed to practice in Portugal, and whose specialty and membership have been recognised by the Portuguese General Medical Council or General Dental Council, or by similar entities in the countries where they practice their activity.

Healthcare Unit

Establishment within or without of the National Health Service, legally licensed to provide medical services and other medical care. This covers establishments offering inpatients' treatment, recovery wards, general hospitalisation, in and outpatient services and specialist units for outpatient and supplementary diagnostic and therapeutic resources, independent of the designation and legal means used, including hospitals, clinics and supplementary diagnostic and therapeutic centres.

Medical treatment

Medical treatment provided by a doctor who is legally licensed by the respective Medical Council and who promotes health, the prevention and treatment of the illness, as well as the rehabilitation of the persons treated and who may determine additional procedures to be executed by other health professionals.

Clinically Required Services

Services consistent with the clinical condition of the patient in terms of protocols and standards recognised by the medical community, that justify medical treatments performed under the Insurance Policy.

Eligible health insurance expenses

Expenses directly related to medical and/or surgical treatment, both diagnostic and/or therapeutic, performed by duly licensed healthcare professionals after clinical diagnosis, and always under medical supervision and guidance, and which will determine and limit the scope of responsibility of those involved.

Excluded healthcare expenses

Expenses not considered under the Policy, such as those related to treatments without medical prescription, acquisition of goods - even when medically prescribed -, whose usefulness is not exhausted during its therapeutic use, such as: cosmetics, mattresses, chairs, cushions, dehumidifiers, vacuum cleaners, air conditioning units, bicycles, body-building equipment, hydro massage units, sunglasses, amongst others. Also excluded are: all consumer articles whose usefulness is exhausted during their own use, but have no therapeutic purpose or are not objectively justifiable by medical prescription. Unless otherwise expressly stated, non-surgical prosthetic devices and orthoses are excluded. Likewise, the co-payment or excess related to another Médis policy in use, for the same insured person, is excluded up to the limit of the counterpart co-payment for the policy claim invoked.

Individual Insurance Policy

Individual Insurance Policy that may include cover for a household not included under a Group Policy.

Group Insurance Policy

A Policy that covers a group of people associated with each other and the Policyholder, through some link or common interest, other than to insure oneself.

Contributory Group Policy

Group insurance in which the Insured Persons/Subscribers pay, in full or in part, the amount corresponding to the premium owed by the Policyholder.

Non-contributory Group Policy

Group Insurance Policy where the Policyholder is entirely responsible for paying the premium.

Insurable group

A group of people associated with each other and the Policyholder, through some link or common interest other than that of arranging insurance coverage.

6 - Regarding the Médis Health Integrated Healthcare System:

Médis Health Integrated Healthcare System

An organisation that channels the direct funding, via an approved network - available to the Insured Person -, of healthcare providers, namely: doctors, hospitals, clinics, supplementary diagnostic and therapeutic laboratories.

Médis Line

Permanent telephone support line through which an Insured Person can be referred to the most appropriate healthcare, seeking to improve his/her health, and, when necessary, providing the medical doctor's advice through the telephone.

Médis Card

Personal and non-transferrable card, identifying the respective holder to the Insurance Company and the Médis network, so as to grant him/her access to the healthcare system, registering the appointments, medical treatments and other means used, when such healthcare system is equipped with the necessary device for that effect.

Referrals

Requisition necessary for making specialty appointments, for the execution of complementary means of diagnosis and therapeutics within certain specialties, which consists in the Médis Doctor's - or another within the Médis network - express indication. That same network doctor may refer him/herself, indicating that same specialty, with the objective of following-up on the patient, within the limits set out in the Specific Conditions.

Authorisation

Act whereby the Insurance Company's clinical services authorise the access to hospitalisation coverage, some therapeutic acts, and some complementary means of diagnosis, as well as assistance services, to the Insured Person, without which he/she cannot be financed or refunded.

Médis Network

A range of agreed service providers within the Médis healthcare integrated system, covering healthcare professionals, either as personal entities or as corporations that manage healthcare units.

Doctor associated to the Médis Network

A doctor specialised in any of the specialties recognised by the General Medical Council, who has been hired by Médis for providing healthcare within the scope of his/her specialty.

Associated Doctor for Primary Care

A Doctor who has joined the Médis Network of healthcare providers and who is trained in the following specialties: Medical and Family Medicine, Internal Medicine, Obstetrics and Gynaecology, Paediatrics, Ophthalmology, Stomatology and Dentistry.

Associated Specialist Doctor

A Doctor trained in specialties other than those that integrate the network of primary healthcare, and who has joined the Médis Network of healthcare providers.

Médis Medical Assistant

A doctor specialised in General, Family, or Internal Medicine, accessible and available as a result of proximity to the Médis Client, with a deep knowledge of the Médis procedures, and who - along with the Médis Line - helps the Médis Clients to rapidly and adequately use the benefits of the health plan, guaranteeing the most adequate management of their healthcare needs.

CLAUSE 2 - AIM

Through the current contract, the Insurance Company guarantees the coverage to the Person Insured, in terms of healthcare, integrating - solely or jointly - agreed payments, claims refunds, and assistance services, identified in the Specific Conditions of the Policy, and whose scope is defined in the respective Special Conditions and the current General Conditions.

CLAUSE 3 - BASIS OF THE CONTRACT

1 - The Insurance Proposal or the Individual Membership application, the Individual Health Questionnaire for each insured person, as well as the clinical documentation required for acceptance of coverage, or individual membership application of the Insurance Company, are incorporated into, and form the basis of, the current Insurance Contract.

2 - The validity of the coverage guaranteed is based upon, and dependent of, a truthful and accurate statement of the Insurance Holder, the Person Insured, or its representative, regarding facts or circumstances known to themselves, and that - within reason - should be considered as significant for the Insurance Company's risk assessment, and that may influence the existence or conditions of the contract.

CLAUSE 4 - TERRITORIAL SCOPE

1 - Unless otherwise specified in the Special or Specific Conditions, the current contract's territorial scope is limited to the national territory.

2 - Healthcare expenses that have or will take place abroad, are only covered in the case of accidents or sudden illness, duly justified in a medical report, and which take place during an occasional stay abroad, no longer than 45 days.

3 - The guarantees of the insurance contract are suspended for the respective period in which the Insured Person is abroad for more than 45 days. This suspension will take effect as from its beginning, even if the stay abroad is only known to the Insurance Company after it has taken place.

CLAUSE 5 - INSURED PEOPLE

1 - The guarantees offered in the current contract are granted to those Insured People who cumulatively satisfy the following conditions at the date of their inclusion in the policy:

- a) Fill out the Individual Health Questionnaire, truthfully and accurately;
- b) Be accepted by the Insurance Company in conformity with its criteria of acceptance, as per the risk evaluation parameters in force;
- c) Accept the rules of activation of the insured guarantees and that of the usage of the Médis Integrated Healthcare System.

2 - The Insurance Company confirms the acceptance of the Insurance, for each Insured Person, through the issuance of a Policy or Individual Certificate, who will afterwards send a Médis Card.

3 - In the signing, execution and termination of the insurance contract, the Insurance Company's own practices and techniques for the evaluation, selection and acceptance of risk, will be considered. These will be based on rigorous statistical and actuarial data, considered to be relevant.

CLAUSE 6 - COVERAGE AND MODALITIES

1 - The coverage is defined in the Special Conditions, and the coverage referred to in the Specific Conditions will be integrated into the Insurance Contract.

2 - The coverage integrates the modalities for agreed payments, refunds, and assistance

services, under the terms of the following numbers and respective Special Conditions.

CLAUSE 7 - APPROVED PROVISION

1 - Under the scope of agreed provision, the Insurance Company guarantees the Insured People with direct access to doctors, hospitals or healthcare units, centres for complementary means of diagnosis, and other healthcare services that, at each moment, are part of the Médis Integrated Healthcare System, whose conditions of use are established in the Policy.

2 - Regarding the services that are not contracted with the healthcare providers mentioned in the previous number, the refund arrangement observed in the next clause is applied.

3 - The financing conditions integrate maximum limits, as do the Co-payments, of the Policyholder's responsibility, regarding specific medical acts, regardless of the capitals guaranteed or available at each given moment.

4 - The activation of the coverage agreed to in the Specific Conditions, is subject to clinical process analysis and dependent on express authorisation of the clinical services of the Insurance Company, who exclusively follows criteria of the medical nature, as per the principles of good medical practice.

5 - The Insurance Company provides the Insured Person with a list of the service providers who, at each given moment, are part of the Médis Network, and it is up to the Insured Person to choose the adequate entity for his/her condition.

6 - When the Insured Person seeks an entity that is not part of the Médis Network, the arrangement set out in the next clause, applies.

CLAUSE 8 - REFUND PAYMENTS

1 - The Insurance Company is obligated to refund the Insured Person with the expenses incurred with healthcare providers outside of the Médis Network, under the terms and limits settled in the General, Special and Specific Conditions. These are subject to the scoring parameters of the medical acts, according to the table of relative values established by the Medical Association.

2 - When the Insured Person seeks an entity that is part of the Médis Network, but with the option of refund payment, (s)he will benefit from the application of the agreed prices, without

prejudice to only being reimbursed by the Insurance Company for the amount agreed in the Specific Conditions.

CLAUSE 9 - ASSISTANCE

The Insurance Company, under the terms and within the limits of this contract's territorial scope, and in compliance with the Special Conditions, agrees to provide assistance services abroad, for illness or accident benefits covered by this Policy.

CLAUSE 10 - EXCLUSIONS

1 - Benefit is always excluded from the current contract, when derived from:

- a) Pre-existing illness or accidents occurred before the date of acceptance for coverage under the Policy;
- b) Car accident, accident at work or occupational disease, as well as accidents and illnesses covered by compulsory insurance;
- c) Infectious and contagious diseases, where health authorities declare an epidemic;
- d) Any pathology directly or indirectly arising from the human immunodeficiency virus;
- e) Any mental health problem, unless expressly otherwise agreed to, regarding psychiatric appointments under the terms established in the Specific Conditions. Any benefit resulting from psychological assistance, appointments or psychoanalytical treatment, hypnosis and sleep therapy, is excluded;
- f) Problems resulting from alcohol intoxication, use of drugs or narcotics not prescribed by a doctor, or the abusive use of medication;
- g) Illness or injury resulting from any deliberate or seriously culpable act of the Insured Person, self-inflicted or resulting from an illegal act practised by the Insured Person;
- h) Any method of birth control and family planning, and voluntary pregnancy termination, as well as all medical acts related to it;
- i) Sexual dysfunctions, whichever the cause;
- j) Appointments, treatments and tests for infertility, as well as artificial insemination methods and their consequences;
- k) Any treatment:
 - And/or surgical intervention that takes place with the intention of improving one's personal appearance and/or remove healthy body tissue, and their consequences;
 - Obesity correction, slimming treatments, and other similar treatments, and their consequences;
 - And surgery of an aesthetic and/or reconstructive nature, and their

consequences, except if resulting from an accident that takes place during the Policy lifetime;

- l) Treatments, surgery, and other acts destined to correct congenital anomalies, diseases or malformations, unless otherwise expressed in the terms set out in the Specific Conditions regarding newborns, included in the Policy since their birth;
- m) Haemodialysis;
- n) Organ transplants and their implications, unless otherwise stated in the terms of the additional coverage, when specifically contracted;
- o) Treatments in sanatoriums, health spas, nursing homes, old age homes, and other similar establishments, appointments and treatments for: hydrotherapy, complementary medicine, homeopathy, osteopaths, and chiropractors, and other similar practices, as well as any medical or therapeutic act that is not recognised by the Portuguese Medical association;
- p) Medication whose introduction into the market has not yet been authorised by the competent entity;
- q) Accidents occurred, and diseases caught, as a result of:
 - The professional practice of sports, and amateur participation in sporting events integrated in championships, and their training;
 - Taking part in sporting competitions and respective training, in vehicles with or without motor (skate, all-terrain bike, rafting, hang-glider, paraglide and ultra-light included);
 - The practice of snow and water ski, surf, snow-board, underwater fishing, deep-sea diving, boxing, martial arts, parachuting, bullfighting, horse jumping, caving, canoeing, rock-climbing, abseiling, mountain-climbing, bungee-jumping, and other similarly hazardous sports;
 - The use of motorized two-wheel or three-wheel vehicles, or quad bikes;
 - Natural calamities, acts of war, declared or otherwise, acts of terrorism, sabotage, public order disturbances, and the use of chemical and/or bacteriological weapons;
 - Consequences of exposure to radiation.
- r) Expenses incurred with doctors who are: a partner, a parent, children or brothers of the Insured Person;
- s) Private nursing care;
- t) Experimental procedures, as well as any diagnostic and therapeutic procedures whose clinical safety and efficiency have not yet been scientifically proven, according to the medical practice;

- u) Hospital treatment and assistance, for social reasons;
- v) Expenses for services not clinically required;
- w) Expenses involved in the transport of the Insured Person, related to rehabilitation, physiotherapy and dialysis;
- x) Consequences of the unjustified delay or negligence attributable to the healthcare provider or the Insured Person whilst seeking medical assistance, or the refusal or failure to comply with treatments that have been prescribed to him/her.

2 - Within the scope of the Hospital and Surgical Assistance, the following surgeries are still, and always will be, excluded from the current contract:

- a) All and any surgery technique that seeks to correct eyesight refraction errors, including:
 - I. Radial keratotomy;
 - II. Photo-refractive keratotomy (keratotomy with *laser excimer/lasix*);
 - III. Laser-Assisted *In Situ* Keartomileusis;
 - IV. Intraocular contact lens insertion.
- b) Surgical treatment for ronchopathy;
- c) Breast enhancement or reduction surgery and their consequences, whichever the surgical indications, or removal of breast implant material.

3 - Unless otherwise agreed to in the Specific Conditions, in the Individual Certificate, or under the Special Conditions, benefit resulting from the following is also excluded:

- a) Stomatology and dental medicine, except surgery as a consequence of an accident covered by this contract and which took place during its lifetime;
- b) Implantology, unless otherwise agreed to in the Specific Conditions;
- c) Medication;
- d) Non-surgical Prosthetic devices and Orthoses;
- e) Childbirth;
- f) General health check-ups;
- g) Co-payment or Deductive items resulting from medical acts or procedures guaranteed by another Médis Policy in force, for the same Insured Person, presented to the Insurance Company for out-of-network payment, up to the co-payment limit for the same medical procedures or interventions covered by the same policy.

CLAUSE 11 - WAITING PERIODS

1 - The waiting periods between the date of beginning of the Insurance - or in the case of Group Insurance: the date of becoming a Member -, and the date in which the respective guarantees can be activated, are stated in the

applicable Special Conditions and Specific Conditions.

2 - Without prejudice to that described in the previous number, a 12-month (365 days) waiting period is still enforced for coverage regarding benefit or medical acts resulting from:

- a) Sclerosis and/or surgical treatment of varicose veins;
- b) Surgical treatment of herniated disk;
- c) Haemorrhoidectomy and other haemorrhoid treatments;
- d) Arthroscopy;
- e) Septoplasty.
- f) Tonsillectomy, adenoidectomy, myringotomy with or without ventilating tubes;
- g) Rhinoseptoplasty;
- h) Surgical removal of benign skin lesions;
- i) Laser treatments of benign skin lesions;
- j) Surgical treatment for sleep apnoea.

CLAUSE 12 - BEGINNING AND DURATION OF THE CONTRACT

1 - The Policy or Membership, once accepted, will be valid from 00h on day 1 or 15 of the month following receipt of the proposal by the Insurance Company, provided this occurs respectively up to the 15th day after day 15 of any given month, whose benefit for the Insured People are activated from the start date stated in the Specific Conditions, without prejudice to waiting periods or other suspenseful periods.

2 - The duration of the contract is that which is established in the Policy's Specific Conditions, and which may be for a determined fixed period, or for a year with the possibility of being renewed annually.

3 - When the contract is signed for a fixed period, its effect is terminated at the 24th hour of the last day of the established period.

4 - When the contract is signed for a year with the possibility of future annual renewals, its renewal will be considered as being automatic and will be successively renewed for another year, except if either party repudiates it, by registered mail or by another means which produce a written record, at least 30 days before the end of the annuity.

5 - Benefits provided by the Insurance Company are valid exclusively for the period of the Insurance. There is no provision for prolonging or extending benefit beyond such date, without prejudice to the provisions regarding the non-renewal of the Policy or Membership.

CLAUSE 13 - TERMINATION OF THE CONTRACT

1 - The guarantees stated in the current contract, automatically cease to produce effects in relation to each Insured Person - unless otherwise expressly stated -, in the following cases:

- a) When the expiry date of the annuity in which the Insured Person reaches the age limit, set out in the Specific Conditions, is reached;
- b) In the case of Household members: when they become no longer dependant in terms of the definition stated in Clause 1;
- c) When the end of the annuity in which the Insured Person ceases to be a Member or a member of the group through which (s)he joined the insurance Contract, is reached;
- d) In the case of failure to pay the premium as legally required;
- e) In the case of non-renewal of the Contract or Membership.

2 - The current Contract - or, in the case of a group contract: the Membership -, may be repudiated by either party, on its annual expiry date, through registered mail or another means that produces a written record, sent to the other party within a minimum of 30 days of the expiry date.

3 - In the case of non-renewal of the Contract or Membership, the Insurance Company's responsibility terminates on the expiry date, without prejudice to that stated in the following number.

4 - In the cases set out above, the Insurance Company will honour the benefits guaranteed, for a two-year period and until the capital insured in the last period of the contract's effectiveness is exhausted, with regards to illnesses manifested while the policy was in force, or accidents and other factors generating claims, which took place during that same period, provided these are covered by the contract and declared until 30 days prior to its termination, with the exception of *force majeure*.

5 - The Médis Card is property of the Insurance Company, and its holder is forbidden to use it, and must return it immediately, as soon as the respective Insurance Contract terminates, otherwise, (s)he may be charged with civil and criminal responsibility -, depending on the situation. In case the card is lost, taken advantage of, robbed, or stolen, the Holder is obligated to communicate it to Médis, within a maximum of 72 hours of the event, otherwise (s)he may be held responsible for its improper use.

CLAUSE 14 - PREMIUM PAYMENT CONDITIONS

1 - The risk coverage depends on the previous payment of the Premium.

2 - The Premium corresponding to each duration period of the insurance contract is owed in total, without prejudice to it being split for the effects of payment, if agreed to by the Insurance Company and the Policyholder.

3 - Unless it has been previously agreed that the Insured Person will pay the Premium to the Insurance Company directly, the obligation to pay the Premium is of the Policyholder.

4 - The Premium, or its first instalment, is due on the date that the contract is signed. In the case of group contracts, the Premium or first instalment corresponding to each member is due on the date of its acceptance.

5 - The following instalments of the initial Premium, the Premium for successive annuities, and their successive instalments, are due on the dates established in the contract.

6 - The variable part of the Premium regarding the adjustment of the amount and, when that's the case, the part of the Premium that corresponds to alterations made to the contract, are due on the dates indicated in the respective notifications.

7 - In the event of an early termination of the insurance contract, for whichever reason, the Premium or instalment owed by the Policyholder will be calculated in proportion to the period of time that took place until the termination. If the Policyholder has already paid the Premium in full, or partially through an instalment, (s)he will be refunded for the remaining period of time.

8 - The Policyholder or the Insured Person, when that's the case, indicate in the membership proposal that they submit, their bank account identification number where they want the amount of their Premium to be withdrawn from, and credited for the amount of the Insurance Company's benefits.

CLAUSE 15 - NOTICE OF PAYMENT OF THE PREMIUM

1 - During the duration of the contract, the Insurer must notify the Policyholder or Insured Person in writing, in case it was agreed that the latter must pay the premium directly to the Insurer, of the amount to be paid, as well as the form and place of payment, with an advance notice of at least 30 days in relation to the date on which the Premium, or fractions thereof, fall due.

2 - The notification must contain - in a legible form - the consequences of the non-payment of the Premium or its instalment.

3 - In Insurance Contracts where the Premium has been agreed to be paid in instalments, in periods equal to or less than three months, and in whose contractual documentation the dates of the successive instalments of the Premium and respective amounts due are indicated,

as well as the consequences of its non-payment, the Insurance Company may choose to not send the notification mentioned in Nr. 1, in which case it is responsible for proving that the contractual documentation mentioned in this number, was issued, accepted and sent to the Policyholder.

CLAUSE 16 - FAILURE TO PAY THE PREMIUM

1 - Failure to pay the initial Premium, or its first instalment, until its expiry date, results in the automatic termination of the contract as from the date of its signing.

2 - Failure to pay, results in the automatic termination of the contract, on the expiry date of:

- a) an instalment of the Premium within an annuity;
- b) an additional Premium resulting from modification to the contract, based on a supervening aggravation of the risk.

3 - In the contributory group policy, when the Insured Person does not provide the Policyholder with the amount destined to pay the Premium, or when it has been agreed that the Insured Person will pay the Premium directly to the Insurance Company, and such payment does not happen, the Insured Person is excluded from the Insurance coverage.

4 - Failure to pay the Premium of subsequent annuities, or the first instalment of it, on its expiry date, prevents the extension of the contract or the coverage of the Insured Person in question.

5 - Failure to pay - until its expiry date - an additional Premium resulting from a contractual modification, will invalid the modification, maintaining the contract or coverage set out in the conditions that were in force before the requested modification, unless that is impossible, in which case its respective termination will take place, on the date of expiry of the unpaid Premium.

CLAUSE 17 - ACCESS, PROCEDURES AND BENEFIT PAYMENTS

1 - In case of need for medical care guaranteed in this contract, and depending on whether it is the case of agreed benefits or refund benefits, the Insured Person may access the Médis Integrated Healthcare System, or seek - at its choice - any doctor, hospital, or clinic, in case of the need for hospitalisation, but must - in either case - take into consideration the prescriptions of the doctor who assists him/her and the procedures set out in the following numbers.

2 - In the case of in-network healthcare, the Insured Person may:

- a) Choose an examining doctor from the Médis network;
- b) Consult a doctor from the Médis Integrated Healthcare System or contact the Médis Line who will indicate a doctor or health service appropriate to each case. If necessary, either of these contacts will indicate a specialist doctor or a healthcare unit of the Médis Network;
- c) Contact the Médis Line where a nurse will register the information regarding the complaints presented, as well as the susceptibility of the situation requiring medical assistance and its level of urgency, suggesting the most appropriate means for the situation, and also alerting for signs and symptoms that may require another action, not constituting in any circumstance a medical act or a clinical diagnosis.

3 - In any of the cases stated in the previous number, and so as to allow for the use of the maximum amount of the respective coverage, the Insured Person must take the following procedures into consideration:

- a) Identify him/herself as a Policyholder of the Médis Insurance or show his/her Médis Card to the service providers of the Médis Network;
- b) Supply the necessary information for the correct evaluation of his/her health status;
- c) Obtain a referral - when required - under the health plan, to consult a Médis in-network specialist or for any supplementary diagnostic and therapeutic treatment in a Médis in-network healthcare unit;
- d) Make sure the medical assistant obtains clearance from the Insurance Company where funding is required, to ensure benefit is available for procedures and medical acts.

4 - The use of out-of-network doctors, when the services sought do not exist in the in-network services or there aren't any in-network doctors licensed for such services, will be considered as benefit outside of the Médis Integrated Healthcare System, and will be reimbursed as refund benefits, under the terms and with the limits of the coverage expressed in the applicable Specific Conditions.

5 - In the case of refund benefits, the Insured Person must:

- a) Ask the Insurance Company - through the assistant doctor - for the necessary authorisation for the effects of coverage of the corresponding procedures and medical acts;
- b) Inform the Insurance Company of the clinical situation and rendered medical acts, attaching the doctor's report where those are listed;
- c) Submit him/herself to an examination by a doctor appointed by the Insurance Company, if the latter finds that necessary.

6 - The expenses that take place under the terms of this contract, will be reimbursed after submitting the supporting documents, valid according to the legal norms in force, and the following procedures taken into account:

- a) Mention, in the case of accident, the date, time, place, causes and consequences of the event, witnesses, the authority that recorded the event, and identification of the alleged culprit;

- b) Present, within a maximum of 120 days of the expense - subject to losing the right to be reimbursed - all the original documents for the expense incurred. These must specify the services rendered, and include the medical prescription. However, the Insurance Company may accept photocopies if the Insured Person requires the originals for reimbursement from other authorities where the Insured Person must show proof of the amounts spent and the refund received.

7 - In any of the cases set out above, the Insurance Company's clinical services are authorised by the Insured Person, to obtain information at any moment, from the doctors who assisted him/her, and obtain copies of clinical reports or any other documents regarding the rendered assistance, with strict obligation to observe confidentiality and the legislation in force.

8 - Without prejudice to the provisions set out in the Policy's Special Conditions, the reimbursement of the medical expenses will be for the actual amount supported by the Insured Person and not for anything else, as long as the following procedures are taken into consideration:

- a) When the original documents for proof of any expense are presented, the reimbursement percentage will be applied over the total of their value;
- b) When documents from another unit are presented, proving the expense and respective co-payment that the Insured Person had previously sought, the reimbursement percentage will apply only over the remaining of the expense not eligible for co-payment.

9 - The reimbursement of the medical expenses may be subject to maximum limits of co-payment, regardless of the capital guaranteed and available, under the terms of the applicable Specific Conditions.

CLAUSE 18 - OBLIGATION TO PROVIDE INFORMATION

1 - The Policyholder or Insured Person's failure to fulfil its obligation to declare with accuracy all of the circumstances known to him/herself to which s(he) gave significance, within reason, for the appreciation of the risk, will determine the annulment, alteration of termination of the contract, under the terms of the law.

2 - In the case of fraud on behalf of the Policyholder or the Insured Person, with the purpose of gaining advantage, the Premium is still due until the end of the contract.

3 - The Policyholder must inform the Insured People about the contracted coverage and its exclusions, the obligations and rights in case of accident, as well as the alterations to the contract, in conformity with the specimen produced by the Insurance Company, otherwise s(he) will be subject to liability under the general terms.

CLAUSE 19 - SUBROGATION

Up to the amount of claims paid by reimbursement, of the value of benefit used for in-network care provision, the Insured Person's rights regarding third parties responsible for accidents or illness occurring under this policy, are subrogated to the Insurance Company. The Policyholder and/or Insured Person must supply the Insurance Company with all the information to enable it to exercise these rights. If not, damages and losses incurred will be at their expense.

CLAUSE 20 - MODIFICATIONS TO THE TERMS OF THE CONTRACT

1 - The Insurance Company may propose the modification of the coverage, the capitals insured, the Deductive Items, Co-Payments, and the Premiums, as well as the criteria for use of the financing or reimbursement of the healthcare expenses, to be included in the contract's following annuity, as long as these modifications are communicated to the Policyholder or Insured Person's Insurance Company within 30 days before the date of the contract or coverage renewal.

2 - The modifications are considered as having been accepted if the Policyholder or Insured Person says nothing within 15 days after having received the proposal.

3 - In case the modifications proposed by the Insurance Company are not accepted, the contract will be terminated on the date mentioned in Nr. 1 of this Clause.

4 - The insured capitals, Premiums and Deductive Items, may be subject to an annual indexation, which will be automatically considered at the expiry date of the Policy, under the terms set out in the Specific Conditions.

5 - Whenever they are based on age ranges, the Premiums corresponding to the Insured Person's changes in range, will be demanded on the date of the contract's next renewal.

6 - The Insurance Company will put the modifications to the contract, in writing.

CLAUSE 21 - CO-ORDINATION OF PAYMENTS

1 - The Insured Person must inform the Insurance Company of other policies of identical nature to this one, as soon as such is known, as well as when communicating an accident, so as to allow for the coordination of the in-network payments or reimbursement payments, under the various contracts, if that is the case.

2 - The fraudulent omission of the information mentioned in the previous number, exonerates the Insurance Company from its payment.

3 - For the effects of this clause, the systems of reimbursement or co-payment of expenses similar to the current contract, of which the Insured Person benefits, are compared to the insurance policies.

CLAUSE 22 - ARBITRATION

1 - In exclusively clinical matters, if there is any disagreement about the right of the Insured Person to healthcare accessed through the Insurance Company, the parties may go to arbitration.

2 - In the case set out in the previous number, each party will appoint a doctor to represent them. These two doctors will appoint a third one to chair the arbitration board. (S)he will hold a qualifying vote.

3 - The arbitration costs will be supported by each party in relation to their own representative, and shared equally for the presiding arbiter.

CLAUSE 23 - COMMUNICATIONS AND NOTIFICATIONS

1 - The communications and notifications foreseen in this Policy are considered valid and fully effective if sent, by registered mail or by any other means of which a written record is kept, to the head office of the Insurer or the address of the Policyholder or Insured Person stipulated in the contract.

2 - If the Policyholder or the Insured Person changes Head-Office or home address, they should notify the Insurance Company within 30 days of such change, by registered recorded mail. Otherwise, the Insurance Company's communications and notifications will continue to be delivered to the last known address and remain legally enforceable.

3 - All documentation containing clinical information may only be made available through doctors, or parties holding specific power of attorney for that purpose, in order to safe keep the confidentiality of personal health data.

CLAUSE 24 - PERSONAL DATA

1 - The personal data is treated by the Insurance Company and its sub-contracted personnel, with the undeniable consent of the holder. This data treatment is necessary for the execution of the insurance contract and for managing the supply of healthcare or medical treatment or managing the healthcare services, and are carried out by health professionals who are obligated to secrecy, or by people who are equally obligated to secrecy.

2 - The Insurance Company is responsible for the treatment and guarantee of the data's appropriate safety measures, for the purpose mentioned in the previous number, and the Insured People have the right to access and rectify that data.

CLAUSE 25 - APPLICABLE LAW AND JURISDICTION

1 - When the parties have not chosen - within the legal limits - another law applicable to it, this contract will be governed by the Portuguese law.

2 - The competent jurisdiction for any litigation that may arise from this contract is that which is determined in the civil law.

SPECIAL CONDITIONS

SPECIAL CONDITION - IN-PATIENT MEDICAL CARE

1 - Under the terms of this Special Condition, the Insurance Company is obligated to:

- a) Fund the Insured Person's access to the Médis network's healthcare service providers in terms of hospitalisation, under the terms and with the limits set out in the Specific Conditions;
- b) In terms of refund benefits, to reimburse the Insured Person for the expenses related to clinical assistance that requires specific means and services in a hospital environment, under the terms and with the limits set out in the Specific Conditions.

2 - This coverage covers the benefit for healthcare within a hospital, including outpatient hospital assistance, as long as its need for a hospital environment is clinically proven.

3 - Eligible expenses under in-patient cover through the Médis network, is that related to payment for medical treatment, surgery or laboratory analysis that require resources and specific services that can only be provided and performed as an in-patient in a hospital environment, namely:

- a) Fees related to treatment carried out in the hospital, such as the fees for doctors/surgeons, anaesthetists, assistants and instrumentalist;
- b) Complementary means of diagnosis and therapeutic associated to acts undertaken in hospital environment;
- c) Medications, when administered during the period of hospitalisation;
- d) Materials, equipments and products, when associated with the treatment carried out in the hospital environment;
- e) Nursing fees related to in-patient treatment;
- f) Resources used in in-patient treatment (operating theatres, recovery ward, private room, or recovery ward);
- g) Ambulance or other means of transportation to and from the hospital, providing the Insured Person's health requires it;
- h) Surgically implanted Prosthetic Devices;
- i) Other medical treatment or procedures set out in the fixed price regime, where applicable.

4 - The coverage for Clinical Assistance for In-Patient medical care is subject to a 90-day waiting period.

5 - The partial reimbursement, refunds, capitals, Deductive items, co-payments and waiting periods are stated in the Specific Conditions.

SPECIAL CONDITION - OUTPATIENT MEDICAL CARE

1 - Under the terms of this Special Condition, the Insurance Company is obligated to:

- a) Finance, under the agreed benefits, the Insured Person's access to the Médis network healthcare service providers, as an outpatient, under the terms and with the limits set out in the Specific Conditions;
- b) In terms of refund benefits: to reimburse the Insured Person for expenses related to outpatient medical care, under the terms and with the limits set out in the Specific Conditions.

2 - Eligible expenditure under the in-network healthcare service provider cover is that related to payment for medical treatment, surgery or laboratory analysis, that does not need to be provided and performed as an in-patient, namely:

- a) Medical visits;
- b) Medical fees related to outpatient care;
- c) Complementary means of diagnosis and therapeutic, done outside of a hospital;
- d) Materials and equipments associated to specific acts and used during these;
- e) Nursing fees related to outpatient treatment;
- f) Home nursing care;
- g) Ambulance transportation to and from healthcare centres, providing the Insured Person's health condition so requires.

3 - The coverage for OutPatient Medical Care is subject to a 60-day waiting period.

4 - The partial reimbursement, refunds, capitals, Deductive items, co-payments and waiting periods are stated in the Specific Conditions.

SPECIAL CONDITION - STOMATOLOGY AND DENTAL MEDICINE

1 - Under the terms of this Special Condition, the Insurance Company is obligated to:

- a) In terms of the agreed benefits, finance the Insured Person's access to stomatology and dental clinics within the Médis network, under the terms and with the limits set out in the Specific Conditions;
- b) In terms of the refund benefits, to reimburse the Insured Person for the expenses with stomatology and dental care, under the terms and with the limits set out in the Specific Conditions.

2 - Reimbursable expenses, under policy cover, with healthcare providers within the approved network, relate to:

- a) Visits;
- b) Dentistry (restoration and filling of cavities);
- c) Periodontology (removal of tartar);
- d) Minor oral surgery;
- e) Prosthetic Devices;
- f) Orthoses (corrective apparatus);
- g) Complementary means of diagnosis and therapeutic.

3 - For the purpose of the above, the following must be taken into account:

Prosthetic Devices - all clinically conceived and/or recommended instruments whose purpose is to replace, totally or partially, a member or an organ;

Orthoses - all clinically conceived and/or recommended instruments whose purpose is to, totally or partially, help a member or organ to function.

4 - The coverage for Stomatology and Dental Medicine is subject to a 60-day waiting period.

5 - The guarantees covered in this Special Condition are subject to the establishing of Waiting Periods and Deductive Item, as well as minimum and maximum refundable amounts, duly stated in the Specific Conditions.

SPECIAL CONDITION - MEDICATION

1 - Under the terms of this Special Condition, the Insurance Company is obligated to reimburse the Insured Person - within the terms and limits set out in the Specific Conditions - for the expenses incurred for the acquisition of medication, and, as such: officially qualified and eligible for contribution from the National Health Service.

2 - Refundable expenses are the amounts that are not subject to contribution from the National Health Service, in relation to the medication's public sale price.

3 - Payment for the following are not considered to be refundable expenses:

- a) Non-prescription medication;
- b) Vaccines;
- c) Baby food;
- d) Dietary products, natural products, and health supplements and manipulated products;
- e) Aesthetic and cosmetic products, general hygiene products, including dental and mouth products;
- f) Sanitary articles, and antiseptics;

g) Bandaging material.

4 - Reimbursable expenses are only paid after the assumptions below are verified:

- a) Medication should be prescribed by a registered doctor and be for the treatment of lesions resulting from clinical situations covered by the contracted benefit;
- b) Depending on the case, the original copy of the medical prescription, countersigned by the supplying pharmacy and including the price tag and/or barcode, or prescribed medication registration number and corresponding receipt, should be sent to the Insurance Company. The claim should clearly and legibly list the medication supplied, and their values, following the deduction of the reimbursement amount where applicable, paid by the Insured Person, under the terms set out for the coordination of benefits.

The Insurance Company will not reimburse expenses whose documentary proof has not been provided.

5 - The coverage for medication is subject to a 60-day waiting period.

6 - The partial reimbursements, refunds, co-payments and waiting periods are set out in the Specific Conditions.

SPECIAL CONDITION - CHILDBIRTH

1 - Under the terms of this Special Condition, the Insurance Company is obligated to finance the Insured Person's access to healthcare providers for childbirth or the involuntary interruption of pregnancy, except for illegal abortion, and if in the case of, during the normal gestation period, the birth occurs after the end of the Waiting Period, under the terms of the following numbers, and with the limits set out in the Specific Conditions;

- a) Under the agreed benefits, ensure the Insured Person access to integrated clinical service providers;
- b) Under the refund benefits, to reimburse the Insured Person for incurred expenses.

2 - Reimbursable expenses or those eligible for financing under the regime of access to in-network healthcare service providers, relates to:

- a) Medical fees for obstetrics;
- b) Fees related to anaesthetist, assistant and instrument technician, where justified;
- c) Medical fees for Paediatrics during hospitalisation of the mother giving birth, covered by this Special Condition;
- d) Complementary means of diagnosis during the hospitalisation period;

- e) Medication administered during in-patient treatment;
- f) Materials, products and equipment, when associated with the in-patient treatment;
- g) Resources used in performing in-patient treatment (operating theatres, recovery ward, delivery room, private room);
- h) Daily charges related to the newborn child, while the mother remains hospitalised, under the terms of this Special Condition;
- i) Ambulance or other means of transportation to and from the hospital, if the mother and/newborn's health condition so requires.

3 - Coverage for Delivery is subject to a 365-day Waiting Period.

4 - The Partial Reimbursements, Refunds, Deductive Items, Co-payments and Waiting Periods are set in the Specific Conditions.

SPECIAL CONDITION - PRÓSTHETIC DEVICES AND ORTHOSES

1 - Under the terms of this Special Condition, the Insurance Company is obligated to reimburse the Insured Person - under the terms and according to the limits set out in the Specific Conditions - for the expenses related to the acquisition, or rental, of prosthetic devices and orthoses, as per the medical prescription.

2 - For the effects of the current Special Condition, the following must be taken into account:

Prosthetic Devices - all instruments clinically conceived or recommended, whose purpose is to - total or partially - replace a member or organ;
Orthoses - all instruments clinically conceived or recommended, whose purpose is to - totally or partially - help the member or organ to function.

3 - The expenses resulting from the acquisition of prosthetic devices and ophthalmic orthoses, are eligible for partial reimbursement, as long as they are prescribed by an ophthalmic doctor, under the terms and limits set out in the Policy's Specific Conditions, but always excluding expenses related to sunglasses, including - solely or jointly - frames and lens (corrective or not).

4 - Under the current Special Condition, a partial reimbursement will be attributed for the expenses related to the acquisition of ocular prostheses, namely, to substitute enucleated eyes.

5 - Under the current Special Condition, a partial reimbursement will be attributed for the expenses related to the acquisition of ophthalmic

orthoses, as long as prescribed by an ophthalmic doctor, under the following conditions:

- a) A pair of contact (or other) lens, for each contract annuity, or up to two pairs in case the Insured Person is under 16 years of age at the time that the expense takes place; Disposable contact lens are also eligible for partial reimbursement, independently of its number, until the annual limit of the capital set out in the Policy's Specific Conditions;
- b) One set of frames for every two Insurance Contract years, or one frame for every annuity in case the Insured Person is under the age of 16 at the time that the expense takes place.

6 - For attributing a partial reimbursement for the expenses related to the acquisition of ocular prostheses or ophthalmologic orthoses, it is necessary to present the following documents:

- a) Photocopy of the ophthalmic doctor's prescription, issued no more than 90 days before the date of acquisition of the prostheses/orthoses;
- b) Receipt of the prosthesis/orthoses supplier, expressly indicating the quality, quantity and price of the acquired materials.

7 - Besides the exclusions stated in the General Conditions, the current Special Condition does not cover:

- a) Stomatology prostheses;
- b) Medical belts, elastic socks, and orthopaedic mattresses;
- c) Orthopaedic shoes.

8 - The coverage for Prosthesis and Orthosis is subject to a 60-day Waiting Period.

9 - The Partial Reimbursements, Refunds, Deductive Items, Co-payments and Waiting Periods, are set out in the Specific Conditions.

SPECIAL CONDITION - MEDICAL ASSISTANCE WHILST ABROAD

1 - Under the terms of this Special Condition, the Insurance Company is obligated to provide an assistance service to the Insured People who need healthcare abroad, regarding the clinical situation covered by this Policy, until the limit set out in the Specific Conditions.

2 - The application of this coverage and of the guarantees set out in this Special Condition depend on the authorisation of the Insurance Company's clinical services, which must sought directly or through the Médis Line, who must be notified within 48 hours in case of emergency.

3 - Refundable expenses are:

3.1 - Admission:

In the event of illness or accident affecting the Insured Person, that has been proved to require hospitalisation or treatment in a medical facility, the Insurance Company will handle the required procedures for the Insured Person's admission into the selected hospital.

3.2 - Transport

a) Should the Insured Person require transport to the hospital where s(he) will be hospitalised, or treated, and is physically incapable of using normal transportation, the Insurance Company is obligated to arrange for transportation by ambulance, light sanitary vehicle, or other such means, depending on the seriousness of the illness, to the unit where the patient will be admitted for in-patient care or treatment, as indicated by the Insured Person. At the request of the latter, the Insurance Company will arrange for identical services for a companion - doctor, family member, or other.

b) After being released from hospital, the Insurance Company will arrange for transportation for the Insured Person and companion's return, in an appropriate means of transportation, as per the Conditions defined in this Policy.

3.2.1 - The Insurance Company is only obligated to transport the Insured Person in need of hospitalisation, into a healthcare facility outside of the national territory, when s(he) is already abroad on the date that the event took place, in a sudden manner, or as long as there is no medical facility in the country that can carry out the necessary treatment. The service is also guaranteed when there is no possibility of being hospitalised in due time, in a national healthcare facility, due to the Insured Person's life being at risk.

3.2.2 - If the Insured Person has a contagious disease, the use of common air transport is dependent on the airline's authorisation. In case authorisation is denied, the Insured Person may opt for another means of transportation, if agreed with his/her doctor and the clinical services of the Insurance Company.

3.3 - Funeral and Repatriation Expenses

If, during the hospitalisation period, the Insured Person dies, the Insurance Company will be responsible for the expenses related to the necessary legal formalities at the place of death, as well as those incurred in the transport or the body and coffin, from the place of the event, to the location of the funeral in Portugal, up to the limits set out in the Specific Conditions.

3.4 - Release from healthcare unit, under medical supervision

If, for the purpose of a medical appointment, or after having been released from hospital, the

Insured Person needs to be accommodated outside of his/her usual residence for medical supervision, the Insurance Company guarantees the reservation at the accommodation that s(he) chooses.

3.5 - Departure from the Healthcare Unit

After having been released from hospital, the Insurance Company will, along with the hospital, take care of all the administrative procedures necessary for the departure of the Insured Person, guaranteeing that same service in case of the Insured Person's death during the hospitalisation.

3.6 - Delivery of Medication

In case the doctor has prescribed medication to the Insured Person, and such is not available at the location where s(he) is, the Insurance Company will guarantee its search and delivery.

4. The partial reimbursement, refunds, capitals, Deductive item, co-payments and waiting periods are set out in the Specific Conditions.

SPECIAL CONDITION - SERIOUS ILLNESS

1 - Under the terms of this Special Condition, the insurance contract guarantees - according to the limits set out in the Specific Conditions - the payment of expenses supported by the Insured Person for diagnosis, treatments, services, provisions or prescribed medication that is considered to be clinically necessary, whenever these are a result or consequence of any serious illness or clinical situation - as described further on - and whose symptoms and first diagnosis occurred during the period in which the guarantee was in force.

2 - The application of the guarantees set out in this Special Condition depends on the authorisation of the Insurance Company's clinical services, which must be sought with a minimum of 14 working days before, and the Insured Person must - in any circumstance - authorise the doctors and hospitals that s(he) has sought, to disclose to the Insurance Company, the clinical reports and any other elements necessary for documenting the process.

3 - The agreed benefits set out in this Special Condition are valid only for the *Best Doctors*¹ network providers, outside of the national territory.

4 - For the effects of this Special Condition, the following are considered as being 'serious illness' or 'guaranteed clinical situation':

¹ *Best Doctors* is a Trademark, registered by *Best Doctors, Inc.*, with its headquarters in One Boston Place, 32nd Floor, Boston, United States of America.

- a) Treatment of cancer, which implies the treatment of a malignant tumour characterized as not being encapsulated, and by the growth an uncontrolled dispersion of malignant cells and by the invasion of the tissues;
- b) Any surgical intervention to the brain or any other intercranial structure;
- c) Surgical treatment involved in open-heart surgery and the use of by-pass to correct stenosis of at least two coronary arteries;
- d) Surgical procedures for the substitution of heart valves, more specifically, the total substitution of one or more heart valves;
- e) Organ transplants, more specifically, the surgical transplant of the heart, lung, liver, kidney, pancreas, bone marrow resulting from the total and irreversible loss of its organic function, resulting in the need for substitution of the organ or bone marrow for another of the same kind, and be from another human-being identified as being a donor.

5 - Regarding the serious illnesses and clinical situations covered by this Special Condition, the Insurance Company guarantees the payment of the expenses listed below, as per the limits set out in the Specific Conditions:

- a) Hospitalisation expenses, namely:
 - i) Nursing expenses during the hospitalisation period, in a private room, ward, intensive care unit, or observation room;
 - ii) Other hospital services, including services rendered in the outpatient department of a hospital;
 - iii) Daily fees of the Insured Person;
 - iv) Expenses corresponding to the cost of an additional bed or that for a companion, if the hospital offers that service.
- b) Expenses incurred in outpatient or independent surgical centres, as long as the treatment, surgery or prescription is covered by the current Special Condition;
- c) Doctor's fees related to the doctor's visits, treatments, medical care or surgeries;
- d) Fees related to the Insured Person's doctor's visits, as an in-patient in a hospital;
- e) Fees resulting from the following services, treatments or medical and surgical prescriptions:
 - i) Anaesthesia and its application, whenever it has been given by a professional anaesthetist;
 - ii) Laboratory and pathological examinations, radiography for diagnostic purposes, radiotherapy, radioactive isotopes, chemotherapy, electrocardiograms, echocardiograms, myelograms, electroencephalograms,

angiograms, computed tomography and other similar examinations and treatments, required for the diagnosis and treatment of a covered illness, whenever it has been provided by a doctor, or with the supervision of a doctor;

- iii) Blood transfusions, the application of plasma and drips;
- iv) Oxygen consumption and the use of intravenous solutions and injections.
- f) Expenses incurred with pharmaceutical products or medication applied through medical prescription while the Insured Person is hospitalised, or after s(he) has been released for a maximum period of 30 days, as long as those products are prescribed within the scope of post-op processes.
- g) Expenses related to travelling and ambulance transport by land or air, when its use is indicated and prescribed by a doctor.
- h) Expenses related to an economy class return journey for the Insured Person and a companion.
- i) Accommodation expenses for the Insured Person and a companion.
- j) In case of the Insured Person's death during treatment, the Insurance Company will support the expenses related to all the legal formalities that must take place at the location of decease, as well as those incurred in the transport of the body and the coffin, to the funeral location in Portugal.

6 - Without prejudice to the exclusions set out in the Policy's General Conditions, this current Special Condition, does not guarantee the payment of expenses resulting from, or motivated by, any diagnosis, treatment, service, provision, or medical prescription, in any way related to, or resulting from, the following:

- a) Any serious illness or clinical situation not set out in Nr 4 of the current Special Condition.
- b) The Acquired Immunodeficiency Syndrome (AIDS), any illness that is secondary or provoked by AIDS, as well as all those that are a consequence of its treatment, including the illness known as the Kaposi's sarcoma.
- c) Expenses related to the custody, healthcare at home, or services provided at a convalescence centre or institution, asylum or old age home, even when such services are required or needed as a result of an illness covered by the Policy.
- d) Any expenses incurred outside the scope of the international medical providers recommended by the Insurance Company.
- e) Any type of prostheses, orthopaedic devices, medical belts, bandages, crutches, artificial organs or members, wigs (even when their use is considered to be necessary during the

chemotherapy treatment), orthopaedic shoes, hernia supports and other similar equipment or articles, with the exception of artificial breasts.

- f) Any type of pharmaceutical products and medication that have not been provided by a licensed pharmacist, or for whose purchase a medical prescription is not required.
- g) Expenses related to the use of alternative medicine, even when a doctor has specifically prescribed these.
- h) Expenses related to the purchase or hire of wheelchairs, special beds, air conditioning apparatus, air purifiers, and any other similar equipment or articles.
- i) Expenses that are not of a medical nature, incurred by the Insured Person or his/her companions, with the exception of those expressly guaranteed under the current Special Condition.
- j) The following treatments are not guaranteed:
 - i) Any tumour which has been histologically described as being pre-malignant or which only shows the first malignant alterations;
 - ii) Non-invasive or *in-situ* cancers: which means that the malignant tumour is restricted to the epithelium from which it originated and did not invade the stroma or the surrounding tissue;
 - iii) Tumours related to the Acquired Human Immunodeficiency Virus (HIV);
 - iv) Skin cancers, with the exception of the malignant melanoma;
 - v) Kidney papillary cancer.
- k) Craniotomy when the pathology is a consequence of trauma;
- l) Surgery derived from trauma or congenital alterations of the aortic coronaries;
- m) Any corrective surgery procedure of congenital alterations of the cardiac valves;
- n) Any organ or tissue transplant in the cases where:
 - i) The Insured Person is him/herself the donor to a third party;
 - ii) The need for transplant results from a congenital pathology;
 - iii) The need for transplant results from cirrhosis of the liver, of alcoholic aetiology;
 - iv) The transplant is a surgical act of auto transplantation, with the exception of transplant of the bone marrow.

7. The coverage for serious illness is subject to a 180-day Waiting Period.

8 - The Partial Reimbursement, Refund, Capitals, Deductive Item, Co-Payments, and Waiting Periods are set out in the Specific Conditions.

SPECIAL CONDITION - HOME ASSISTANCE

1 - Under the terms of this Special Condition, the Insurance Company is obligated to guarantee the Insured Person with a medical appointment service, the delivery of medication and nursing services to his/her home, under the terms of, and with the limits, set out in the Specific Conditions.

2 - The Insured Person must request the services mentioned in the previous number, through the Médis Line ⁽¹⁾.

3 - Expenses that are refundable under the Home Assistance, are:

- a) In case of emergency, the Insurance Company guarantees the Insured Person with medical appointments at home, between 20:00 hours and 08:00 hours, on working days, and at any time during holidays and weekends. The respective expenses related to the doctor's travel and fees, are of the Insured Person's responsibility, according to the limits set out in the Specific Conditions;
- b) The Insurance Company guarantees the delivery of medication whenever the Insured Person has a medical prescription and is unable to acquire them through his/her own means, although the cost of the medication is of the Insured Person's responsibility;
- c) When, as a consequence of serious illness or hospitalisation, proved by a medical report, the Insured Person requires nursing services at home, the Insurance Company will provide nursing professionals during the period of time necessary for his/her recovery. The mentioned nursing services may go beyond the capital limit of this coverage, in which case the Insured Person, who will always be previously informed of their value by the Assistance Services, will directly support the respective costs.

4 - The Home Assistance set out in this Special Condition will be exclusively provided by healthcare professionals belonging to the network of agreed providers by the Assistance Services and is only valid for the national territory.

5 - The Partial Reimbursement, Refund, Capitals, Deductive Item, Co-Payments, and Waiting Periods are set out in the Specific Conditions.

SPECIAL CONDITION - SECOND OPINION NETWORK

1 - Under the terms of this Special Condition, and according to the limits set out in the Specific

Conditions, the Insurance Company is obligated to grant access of the Insured Person, to the medical second opinion services, provided by the Network *Best Doctors*, of *Best Doctors, Inc.* ⁽²⁾, having previously requested it through the *Médis Line* ⁽¹⁾.

2 - The provisions agreed to in this Special Condition are only valid for the *Best Doctors* Network of Agreed Providers outside of the national territory.

3 - Benefits provided

3.1 - Within the scope of the current Special Condition, the Insurance contract guarantees the Insured Person - according to the limits set out in the Specific Conditions and for the illnesses listed below - access to the medical second opinion services provided by professionals belonging to the *Best Doctors* Network, who will verify the analysis of his/her clinical situation against the respective diagnosis and indication of the most appropriate medical care.

3.2 - For the effects of that set out above, the following are 'Illness' or 'Clinical Situations' considered under this Special Condition:

- a) AIDS;
- b) Aphasia;
- c) *Alzheimer's* disease;
- d) Multiple Sclerosis;
- e) Blindness;
- f) Organ transplant;
- g) Benign cerebral tumour;
- h) Cancer;
- i) Motor Neurone Disease;
- j) Cardiovascular disease;
- k) *Parkinson's* Disease;
- l) Coma;
- m) Paralysis;
- n) Deafness;
- o) Serious burns;
- p) Kidney failure.

4 - Benefit for any additional medical acts is excluded, even if resulting from recommendation obtained within the scope of this Special Condition.

Ocidental - Companhia Portuguesa de Seguros, S.A .
Anonymous society with its head-office in Avenida José Malhoa, nr 27, in Lisbon, legal entity nr 501 836 918 and registered with this number in the Lisbon Trade Registry, with a capital stock of € 12.500.000,00.
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