Médis Health

General and Special Conditions

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General Conditions

Special Conditions

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 this insurance contract:

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

INSURANCE COMPANY
Entity that is legally authorised to conduct the insurance business and that takes out an insurance policy with the Policyholder.

MÉDIS
Exclusive trademark of the products developed by Médis – Companhia de Seguros de Saúde, S.A., insurer, reinsurer and manager of a healthcare insurance integrated system, covering: Health, Assistance and Accidents, through policies issued by itself or by other authorised Insurance Companies with its consent.

POLICYHOLDER
Entity that concludes the insurance contract with the Insurance Company and that is responsible for payment of the Premium.

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

HOUSEHOLD
Group of people identified in the Special Conditions or in the Individual Certificate, who live together in shared economy, 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 non-marital partnership for over two years, as well as his/her descendents or ascendants, whether directly related or up to a second degree, and who are economically dependant of the Insurance Holder or the Member.

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

POLICY
Document representing the contract between the Insurance Holder and the Insurance Company, which includes the agreed General, Special, and Specific Conditions, as well as the 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, whenever 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 representing an amendment to the Policy.

3. Regarding the subscription to the Insurance Policy:

MÉDIS HEALTH INSURANCE
Health insurance contract agreed between the Insurance Company and the Policyholder, represented by an issued Policy document, whereby the Insurance Company provides the Insured People with access to the Médis healthcare network, under the terms and limits agreed with the healthcare providers, where specific financial criteria, or 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 (Proposal form), in which the information elements that are 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 including a range of indicators regarding health information, in order to form a profile and medical history that allows for a correct assessment of the risk to be taken by 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 of partially, by the Insured People.

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

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

CO-PAYMENT
An amount that the Insured Person shall pay for each medical act or set of medical acts, as per the terms set out in the Specific Conditions or the Individual Certificate.

INDEXATION
Amendment, if contracted, to the guaranteed capital and the corresponding Premium, according to an index set out in the Specific Conditions or Individual Certificate.

COST-SHARING AMOUNTS
Amounts borne by the Insurance Company under the in-network care provision, which are paid directly to the healthcare provider, without prejudice to the right to a co-payment or deductible from the Insured People.

REFUND/REIMBURSABLE AMOUNTS
Amount returned to the Insured Person by the Insurance Company, after deducting the applicable Deductible and Co-payments, or paid to the healthcare provider whenever a '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 acts or procedures, 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
They are established in the Specific Conditions or Individual Insurance Certificate, for each Insured Person, Family Unit or Insured Group.

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

ACCIDENT
Fortuitous, abnormal and sudden event, attributed to external causes beyond the control of the Insured Person and which provokes bodily harm, clinically and objectively established, likely to activate the coverage provided by this Policy.

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
Pathological condition of which the Insured Person was aware, or should have been aware, prior to subscribe an insurance policy, as a result of having undergone a clinical assessment, previous treatment or another medical act, or due to the existence of specific signs or symptoms of the pathology at the date of subscription, regarding which a diagnosis, although not yet definitive, had already been made, and which is excluded from the insurance coverage due to all the above referred reasons.

CONGENITAL DISEASE
A disease that is present at birth, as a result of hereditary factors or conditions verified during pregnancy and up to the moment of birth. The congenital disease may be evident or recognized 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 recognized by the Portuguese Medical Association or Portuguese Dental Association, or by similar entities in the countries where they carry out their activity.

HEALTHCARE UNIT
Establishment which may or may not be integrated in the National Health Service, legally licensed to provide medical services and other healthcare. This covers establishments offering inpatients' treatment, recovery wards, general hospitalisation, in and outpatient services and specialist units for outpatient and complementary means of diagnostic and therapeutic, regardless of the name and legal form adopted, including Hospitals, Clinics and complementary means of diagnostic and therapeutic Centres.

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

CLINICALLY REQUIRED SERVICES
Services consistent with the clinical condition of the patient, in accordance with the protocols and standards recognised by the medical community within the scope of the Insurance Policy.

ELIGIBLE HEALTH INSURANCE EXPENSES
Expenses directly related to medical and/or surgical treatments, both diagnostic and/or therapeutic, performed by duly licensed healthcare professionals after a clinical diagnosis and always under medical supervision and guidance, and which shall 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 included in this definition are: all consumable articles whose usefulness is exhausted during their own use, but that have no therapeutic purpose or are not objectively justifiable by medical prescription. Unless otherwise is expressly stated, non-surgical prosthetic devices and orthosis are excluded. Likewise, the co-payment or deductible related to another Médis Policy in force for the same Insured Person is excluded up to the limit of the homologous co-payment fin the Policy claim invoked.

INDIVIDUAL INSURANCE POLICY
Individual Insurance Policy that may include coverage for a household, but is not a Group Insurance.

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

6. Regarding the Médis Healthcare Integrated System:

MÉDIS HEALTHCARE INTEGRATED SYSTEM
An organisation that, under the agreed terms and limits, channels the direct funding of the Insured Person to the healthcare providers of the agreed network, namely doctors, hospitals, clinics, complementary means of diagnostic and therapeutic centres.

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 assistant doctor's advice through the telephone.

MÉDIS CARD
Personal and non-transferable card, identifying the respective holder to the Insurance Company and the Médis network, in order to grant him/her access to the healthcare system, registering the respective appointments, medical treatments and other means used, whenever such healthcare system is equipped with the necessary device for that effect.

REFERRALS
Requirement necessary for making specialty appointments, for the execution of the Complementary Means of Diagnosis and Therapeutics within certain specialties, which consists in the Médis Assistant 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 of 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, which manage healthcare units.

DOCTOR ASSOCIATED TO THE MÉDIS NETWORK
A doctor specialised in any of the specialties recognised by the respective Medical Association, 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: General 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 ASSISTANT DOCTOR
A doctor specialized in General, Family, or Internal Medicine, accessible and available as a result of the 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 – OBJECT

By this contract, the Insurance Company guarantees the coverage to the Person Insured, in terms of healthcare, integrating – solely or jointly – of the agreed payments, fixed pecuniary benefits, and assistance services, identified in the Specific Conditions of the Policy, and whose scope is defined in the respective Special Conditions and in these 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, this Insurance Contract.

2. The Policyholder shall inform the Insured People about the contracted coverage and its exclusions, the obligations and rights in case of an accident, as well as the amendments to the contract, in accordance with the specimen provided by the Insurance Company, otherwise he/she may incur civil liability under the general terms.

CLAUSE 4 – DUTY OF INITIAL STATEMENT OF RISK

1. Before signing the contract, the Policyholder or the Insured Person is bound to inform all the circumstances that he/she knows and reasonably should know that are significant for the assessment of the risk by the Insurance Company.

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

3. The Insurance Company that has accepted the contract, except in the case of fraud of the Policyholder or Insured Person with the purpose of gaining advantage, may not invoke:

a) omission of answer to a question of the questionnaire;
b) the imprecise answer to a question expressed in terms which are too general;
c) evident inconsistency or contradiction in the answers to the questionnaire;
d) facts that its representative, at the date of conclusion of the contract, or knew was not correct or, having been omitted, was aware of;
e) circumstances that the Insurance Company was aware of, especially when such circumstances are public and well-known.

4. Before the conclusion of the contract, the Insurance Company must clearly explain to the Policyholder concerned or Insured Person the duty referred to in no. 1, as well as its non-compliance regime, otherwise the former shall be subject to civil liability under the general terms.

CLAUSE 5 – WILFUL NON-COMPLIANCE OF THE DUTY OF INITIAL STATEMENT OF RISK

1. In case of wilful non-compliance of the duty referred to in no. 1 of the previous article, the contract is voidable by means of a declaration sent by the Insurance Company to the Policyholder.

2. If no claim has occurred, the declaration referred to in the previous number must be sent within three months counted from the knowledge of such non-compliance.

3. The Insurance Company is not bound to cover any claim that occurs prior to knowledge of the wilful non-compliance referred to in no. 1 or during the period provided for in the previous number, in accordance with the general regime of annulment.

4. The Insurance Company is entitled to the premium payable until the end of the period referred to in no. 2, except in case of intentionality or gross negligence on the part of the Insurance Company or its representative.

5. In the case of intentionality of the Policyholder or of the Insured Person with the purpose of obtaining an advantage, the Premium is due until the term of the contract

CLAUSE 6 – NEGLIGENT NON-COMPLIANCE OF THE DUTY OF INITIAL STATEMENT OF RISK

1. In case of non-compliance involving negligence of the duty referred to in no. 1 of Clause 4, the Insurance Company may, by means of a declaration sent to the Policyholder, within three months counted from the knowledge of such non-compliance:

a) propose an amendment to the contract, setting a deadline of no less than 14 days for the acceptance to be sent or, if so admitted, a counter-proposal;
b) terminate the contract, indicating that under no circumstances does the latter conclude contracts for the coverage of risks related to facts that were omitted or inaccurately declared.

2. The contract ceases to have effect 30 days after the declaration of termination has been sent or 20 days after reception of the amendment proposal by the Policyholder, if the latter does not reply to or rejects the proposal.

3. In the case referred to in the previous number, the premium is returned *pro rata temporis* taking into account the coverage that existed.

4. If, before the termination of or amendment to the contract a Claim occurs, whose verification or consequences were influenced by a fact regarding which there were omissions or negligent inaccuracies:

a) the Insurance Company covers the accident in proportion to the difference between the premium paid and the premium that would be payable if, at the conclusion of the contract, the former had had knowledge of the omitted or inaccurately declared fact;

b) the Insurance Company, indicating that under no circumstances would it have concluded the contract, if it had knowledge of the omitted or inaccurately declared fact, does not cover the Claim and is only bound to return the Premium.

CLAUSE 7 – TERRITORIAL SCOPE

1. Unless otherwise specified in the Special or Specific Conditions, the territorial scope of this contract is limited to the national territory.

2. Healthcare expenses that have taken or shall take place abroad are only covered in case of accident or sudden illness, duly justified in a medical report, and which has taken place during an occasional stay abroad, not exceeding 45 days.

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

CLAUSE 8 – INSURED PEOPLE

1. The guarantees offered in this 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 accordance with its criteria of acceptance, as per the risk evaluation parameters in force;
c) Accept the rules of activation of the insured guarantees, as well as those related to the use of the Médis Healthcare Integrated System.

2. The Insurance Company shall confirm the acceptance of the Insurance, for each Insured Person, through the issuance of a Policy or Individual Certificate, with the subsequent delivery of a Médis Card.

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

CLAUSE 9 – COVERAGE AND MODALITIES

1. The coverage is defined in the Special Conditions, and the coverage referred to in the Specific Conditions shall be included in the Insurance Contract.

2. The coverage integrates the modalities of the agreed payments, refunds, and assistance services, under the terms of the following clauses and respective Special Conditions.

CLAUSE 10 – APPROVED PROVISION

1. Under the scope of the agreed provisions, the Insurance Company guarantees the Insured People the 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 Healthcare Integrated System, whose conditions of use are established in the Policy and in the Médis Guide.

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 well as Co-payments or deductibles 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 provided for in the Specific Conditions is subject to the analysis of the clinical records and depends upon 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 the Médis Client Guide, which includes the list of the service providers that, 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, with the exception of specialty appointments and the carrying out of complementary means of diagnosis and therapeutics that require referrals or Authorisation.

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 11 – REFUND PAYMENTS

1. The Insurance Company is bound to refund the Insured Person the expenses incurred with healthcare providers outside of the Médis Network, under the terms and limits provided for 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 shall benefit from the application of the agreed prices, without prejudice to be reimbursed by the Insurance Company only for the amount agreed in the Special Conditions.

CLAUSE 12 – ASSISTANCE

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

CLAUSE 13 – EXCLUSIONS

1. Benefit is always excluded from this contract, when derived from:

a) pre-existing condition or illnesses resulting from accidents occurred before the date on which the insurance or insurance membership starts;
b) car accidents, accidents at work or occupational diseases, as well as other accidents and diseases covered by other compulsory insurance;
c) Infectious and contagious diseases, whenever 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 Special Conditions. Any benefit resulting from psychological assistance, appointments or psychoanalytical treatment, hypnosis and sleep therapy, is excluded;
f) treatments related to physical, cognitive or language development problems, as well as learning or behavioural problems, namely dyslexia, attention deficit or hyperactivity;
g) problems resulting from alcohol intoxication, use of drugs or narcotics not prescribed by a doctor, or abusive use of medication;
h) illness or injury resulting from any malicious or seriously negligent acts carried out by the Insured Person, self-inflicted or resulting from an illegal act practiced by the Insured Person;
i) any method of birth control and family planning and voluntary pregnancy termination, as well as all medical acts related to it;
j) sexual dysfunctions, whichever the cause;
k) appointments, treatments and infertility tests, as well as artificial insemination methods and their consequences;
l) any treatment:
   i) or surgical intervention carried out with the intention of improving one's personal appearance or remove healthy body tissue, and their consequences;
   ii) or sclerosing therapy for chronic insufficiency of lower limbs;
   iii) or surgery of aesthetic or reconstructive nature and its consequences, except if included in the treatment of a malignant disease or resulting from an accident that takes place during the Policy lifetime;
   iv)obesity correction, slimming treatments, and other similar treatments, and their consequences;
m) treatments, surgery, and other acts intended for the correction of congenital diseases or malformations, unless otherwise expressed in the terms set out in the Specific Conditions regarding newborns covered by Médis Policy since their birth;
n) haemodialysis treatments;
o) organ transplants and respective implications, unless otherwise stated in the terms of the additional coverage, when specifically contracted;

p) treatments in sanatoriums, health spas, nursing homes, old people's 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 acts that are not recognized by the Portuguese Medical Association;

q) medication whose introduction into the market has not yet been authorised by the competent authority;

r) accidents occurred and diseases caught, as a result of:
i) the professional practice of sports and amateur participation in sporting events integrated in championships, and respective training;
ii) the participation in sporting competitions and respective training, in vehicles with or without motor (skate, all-terrain bike, rafting, hang-glider, paraglide and ultra-light included);
iii) 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;
iv) the use of motorized two-wheel or three-wheel vehicles, or quad bikes;
v) natural calamities, acts of war, declared or otherwise, acts of terrorism, sabotage, public order disturbances, and the use of chemical or bacteriological weapons;
vi) the consequences of exposure to radiation.

s) expenses incurred with doctors who are: spouses, parents, children or brothers of the Insured Person;

t) nursing treatments provided at home or in the hospital, which are not contemplated in the hospital services;

u) experimental procedures, as well as all diagnostic and therapeutic procedures, whose clinical safety and efficiency have not yet been scientifically proven, according to the medical practice;

v) long-term care, understood as clinical services that do not require hospitalisation, and which may and should be provided in a special unit;

w) expenses with services that are not clinically necessary, as well as with any hospital treatment and assistance for social reasons;

x) expenses involving the transport of the Insured Person, related to physiotherapy and dialysis;

y) consequences of unjustified delay or negligence attributable to the healthcare provider or the Insured Person whilst seeking medical assistance, or to the refusal or failure to comply with treatments that have been prescribed to him/her.

z) expenses incurred by the persons accompanying the Insured Person, excluding the case of hospitalisation of children under 14 years of age.

2. Within the scope of Hospital and Surgical Assistance, the following situations are always excluded from this 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) *in situ* laser-assisted keartomileusis;
iv) intraocular phakic contact lens insertion.

b) surgical treatment for roncopathy;

c) breast enlargement or reduction surgery and their respective consequences, whichever the surgical indications, or removal of breast implant material, except in cases of treatment of oncological diseases;

d) treatments and surgeries that are a direct consequence of procedures previously refused by the Insurance Company

3. Unless otherwise agreed to in the Specific Conditions, in the Individual Certificate, or under the Special Condition, the 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) implants and all related procedures, namely diagnostic and surgical ferrules, diagnostic and surgical ferrules, guided bone regeneration, transepithelial pillars, assembly in articulator, provisional and definitive crowns placed on implants among others, unless otherwise provided for in the Specific Conditions;

c) medication;

d) non-surgical prosthetic and orthosis devices;

e) childbirth;

f) general health check-ups;

g) co-payment or deductible resulting from medical acts or procedures guaranteed by another Médis Policy in force for the same Insured Person, presented to the Insurance Company under the regime of compensation payment, up to the co-payment limit for the same medical acts or procedures covered by the same policy.

CLAUSE 14 – GRACE PERIODS

1. The grace 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 the above referred in the previous number, a 6-month (180 days) grace period is still enforced for coverage regarding the following treatments and associated procedures:

a) Surgical or other invasive treatment of benign prostatic hypertrophy
b) Surgical or other invasive treatment of benign uterus condition;
c) Surgical treatment of cystocele and rectocele

3. Without prejudice to the referred in the previous number, a 12-month (365 days) grace period is still enforced for coverage regarding benefit or medical acts resulting from:
a) surgical treatment of varicose veins of lower limbs;
b) surgical treatment of herniated disk;
c) haemorrhoidectomy and other haemorrhoid treatments, as well as the treatment of the perianal fistula;
d) surgical treatment of osteoarticular pathology of the shoulder, hip and knee;
e) septoplasty;
f) tonsillectomy, adenoidectomy, myringtomy with or without ventilating tubes;
g) rhinoseptoplasty;
h) surgical excision of cutaneous or subcutaneous benign lesions;
i) laser treatments of benign skin lesions;
j) surgical treatment for sleep apnoea.

CLAUSE 15 – BEGINNING AND DURATION OF THE CONTRACT

1. The Policy or Membership, once accepted, shall be valid from 00h of day 1 or day 15 of the month following receipt of the proposal by the Insurance Company, provided this occurs respectively up to the 15th day or after day 15 of any given month, and the benefit for the Insured People shall be effective from the starting date stated in the Special Conditions, without prejudice to grace periods or other standstill periods.

2. The duration of the contract is established in the Policy's Special Conditions and may be for a determined fixed period, or for one year and following.

3. When the contract is signed for a fixed period, its effect ceases at the 24:00 of the last day of the established period.

4. When the contract is signed for one year and following, it shall be considered as being automatically and successively renewed for another year, except if either party terminates 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 each period of duration 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 16 – TERMINATION OF THE CONTRACT

1. The guarantees granted by this contract, automatically cease to produce effects in relation to each Insured Person, unless otherwise expressly stated, in the following cases:
a) expiry of the annuity in which the Insured Person reaches the age limit set out in the Specific Conditions;
b) if the Household members are no longer dependant in terms of the definition stated in Clause 1;
c) on the expiry date 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.

d) in case of lack of payment of the premium as legally required;
e) in case of non-renewal of the Contract or Membership.

2. This Contract or in case of a group contract: the Membership may be terminated by either party, on its annual expiry date, through registered mail or another means that produces a written record, sent to the other party at least 30 days prior to the expiry date.

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

4. In the cases above referred, the Insurance Company shall 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 is 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 Insurance Company is the owner of the Médis Card and its holder is forbidden to use it and shall 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, object of embezzlement, robbed, or stolen, the Holder is obligated to communicate it to Médis, within a maximum of 72 hours counted from the event, otherwise (s)he may be held responsible for its improper use.

CLAUSE 17 – PREMIUM PAYMENT CONDITIONS

1. The risk coverage depends upon 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 effects of payment, if agreed to by the Insurance Company and the Policyholder.

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

4. The Premium, or its first instalment, is due on the date of conclusion of the contract. 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 applicable, the part of the Premium that corresponds to the amendments made to the contract, is due on the dates indicated in the respective notices.

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

8. The Policyholder or the Insured Person, where applicable, shall indicate in the membership proposal that they submit, or in a separate document, the Bank Account Number where they want the amount of their Premium to be withdrawn from, and credited with the amount of the Insurance Company's benefits.

CLAUSE 18 – NOTICE OF PAYMENT OF THE PREMIUM

1. During the term of the contract, the Insurer must notify the Policyholder or the Insured Person in writing, in case it was agreed that the latter shall pay the premium directly to the Insurer, of the amount to be paid, as well as of 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 notice must contain, in a legible form, the consequences of the non-payment of the Premium or its instalment.

3. In the Insurance Contracts under which the Premium has been agreed to be paid in instalments, in periods equal or inferior to 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 notice mentioned in Nr. 1, in which case it shall be responsible for proving that the contractual documentation mentioned in this number, be issued, accepted and sent to the Policyholder.

CLAUSE 19 – LACK OF PAYMENT OF THE PREMIUM

1. The lack of payment of the initial Premium or of its first instalment, until its expiry date, results in the automatic termination of the contract as from the date of its conclusion.

2. The lack of payment shall cause 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 an amendment 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 allocated to the payment of the Premium, or when it has been agreed that the Insured Person shall pay the Premium directly to the Insurance Company, and such payment does not happen, the Insured Person is excluded from the Insurance coverage.

4. The lack of payment of the Premium of subsequent annuities, or the first instalment thereof, on its expiry date, prevents the extension of the contract or its respective coverage of the Insured Person in question.

5. The lack of payment until its expiry date of an additional Premium resulting from a contractual amendment shall render the amendment ineffective, maintaining the contract or its respective coverage in the conditions that were in force before the requested amendment (unless that is not possible) in which case its respective termination shall take place on the date of expiry date of the unpaid Premium.

CLAUSE 20 – ACCESS, PROCEDURES AND BENEFIT PAYMENTS

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

2. In the case of in-network healthcare, the Insured Person may:
a) choose an Assistant Doctor from the Médis network;
b) consult a doctor from the Médis Healthcare Integrated System or contact the Médis Line who shall indicate a doctor or health service appropriate to each case. If necessary, either of these contacts shall indicate a specialist doctor or a healthcare unit of the Médis Network;
c) contact the Médis Line where a nurse shall 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 means that are most suitable to the situation, and also alerting for signs and symptoms that may require another action, which shall not constitute in any circumstance a medical act or a clinical diagnosis.

3. In any of the cases referred in the previous number and in order to allow the use of the maximum amount of the respective coverage, the Insured Person must take the following procedures into consideration:
a) to 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) to supply the necessary information for a correct evaluation of his/her health status;
c) to obtain a referral - when required - under the health plan, to consult a Médis in-network specialist or to be submitted to any supplementary diagnostic and therapeutic treatment in a Médis in-network healthcare unit.

d) to make sure that the Assistant Doctor obtains clearance from the Insurance Company where funding is required, to ensure that the benefit is available for procedures and medical acts.
e) to submit him/herself to an examination by a doctor appointed by the Insurance Company, if the latter deems it necessary

4. The use of out-of-network doctors or doctors which are not agreed healthcare providers of the Médis network is considered as a benefit outside the Médis Healthcare Integrated System, and is reimbursed as fixed pecuniary benefits, under the terms and within the limits of the coverage set out in the applicable Specific Conditions.

5. In the case of fixed pecuniary benefits, the Insured Person shall:
a) ask the Insurance Company – through the Assistant Doctor – for the necessary authorisation for purposes of coverage of the corresponding procedures and medical acts;
b) inform the Insurance Company about the clinical situation and medical acts performed, 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 deems it necessary.

6. The expenses incurred under the terms of this contract shall be reimbursed after submitting the supporting documents, valid according to the legal rules in force, and the following procedures shall be taken into account:
a) in the case of an accident, to mention the date, time, place, intervenients, causes and consequences of the event, witnesses, the authority that recorded the event, as well as the identification of the person who was allegedly responsible for the accident;
b) to provide, within a maximum of 120 days of the date of the expense, subject to losing the right to be reimbursed, all the original documents corresponding to the expenses incurred. These shall 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.
c) to submit him/herself to a medical examination performed by a doctor appointed by the Insurance Company, if the latter deems it necessary.

7. In any of the above referred cases, 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 assistance rendered, with the strict obligation to observe confidentiality and to comply with the legislation in force.

8. Without prejudice to the provisions set out in the Policy's Special and Specific Conditions, the reimbursement amount related to the medical expenses is based on the actual amount supported by the Insured Person and which has not been reimbursed by any other entity, provided the following procedures are taken into consideration:
a) when the original supporting documents of any expense are provided, the reimbursement percentage shall be based on the total value of the documents;
b) when the documents from another unit the Insured Person has previously sought are provided, supporting the expenses and the respective co-payment, the reimbursement percentage shall be based 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 21 – SUBROGATION

Up to the amount of the claims paid by reimbursement or up to the value of the benefit borne within the scope of the in-network care provision, the Insured Person's rights before third parties responsible for accidents or illness occurring under this policy, are subrogated to the Insurance Company. The Policyholder or the Insured Person shall provide the Insurance Company with all the information to enable it to exercise these rights, otherwise, all damages and losses incurred shall be at their expenses.

CLAUSE 22 – AMENDMENTS TO THE TERMS OF THE CONTRACT

1. The Insurance Company may propose the amendment to the coverage, the capitals insured, the Deductible, Co-Payments, and the Premiums, as well as the criteria to use the financing or reimbursement of the healthcare expenses, to be included in the contract's following annuity, provided that these amendments are communicated to the Policyholder or the Insured Person's Insurance Company within 30 days prior to the date of the contract or coverage renewal.

2. The amendments are considered as having been accepted if the Policyholder or the Insured Person says nothing within 14 days after having received the proposal.

3. In case the amendments proposed by the Insurance Company are not accepted, the contract shall terminate on the date of the renewal of the contract or coverage.

4. The insured capitals, Premiums and Deductible, may be subject to an annual indexation, which shall 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 groups, the Premiums corresponding to the Insured Person's changes of group, shall be required on the date of the contract's next renewal.

6. The Insurance Company shall put the amendments to the contract in writing.

CLAUSE 23 – CO-ORDINATION OF PAYMENTS

1. The Insured Person shall inform the Insurance Company about other policies of identical nature to this one, as soon as it is aware of them, as well as, when communicating an accident, in order to allow, if that is the case, the coordination of the in-network payments or reimbursement payments, under the different contracts.

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

3. For the purposes of this clause, any systems of reimbursement or co-payment of expenses similar to those granted by this contract, of which the Insured Person benefits, are equivalent to insurance policies.

CLAUSE 24 – 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 have recourse to arbitration.

2. In the case referred in the previous number, each party shall appoint a doctor to represent them. These two doctors shall appoint a third one, who shall be the Chairman.

3. The arbitration costs shall be borne in equal parts by the parties in what concerns each arbitrator they appoint, and each party shall also pay half of the expenses and fees of the third arbitrator.

CLAUSE 25 – COMMUNICATIONS AND NOTICES

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

2. If the Policyholder or Insured Person change the head office or home address, they should notify the Insurance Company within 30 days counted from the date of such change, otherwise, the Insurance Company's communications or notices shall continue to be delivered to the last known address and shall 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 the personal and health data.

CLAUSE 26 – PERSONAL DATA

1. The personal data are treated by the Insurance Company and its sub-contracted personnel with the express consent of the holder. This data treatment is necessary for the execution of the insurance contract and for purposes of managing the supply of healthcare or medical treatment or 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 those data.

CLAUSE 27 – APPLICABLE LAW AND JURISDICTION

1. If, within the legal limits, the parties do not choose a different law applicable to the contract, it shall be governed by Portuguese law.

2. The competent jurisdiction to solve any disputes arising from this contract is the one provided for in the Civil Law.

SPECIAL CONDITIONS

SPECIAL CONDITION – IN-PATIENT MEDICAL CARE

1. Under the terms of this Special Condition, whenever the coverage has been contracted, the Insurance Company shall be bound to:

a) fund the Insured Person's access to the Médis network's healthcare service providers in terms of hospitalisation, under the terms and within the limits stipulated in the Special Conditions;
b) in terms of fixed pecuniary benefits, reimburse the Insured Person for the expenses incurred with the clinical assistance that requires specific means and services in a hospital environment, under the terms and within the limits stipulated in the Specific Conditions.

2. This coverage includes the benefit for healthcare in a hospital unit, including outpatient hospital assistance, as long as the need for a hospital environment is clinically proven.

3. Eligible expenses under in-patient coverage through the Médis network, are those related to the payment of medical treatments, surgeries or laboratory analysis, which require specific resources and services that can only be provided and carried out in a hospital environment, namely:

a) fees related to treatments carried out in the hospital, such as the fees of doctors/surgeons, anaesthetists, assistants and instrumentalist;
b) complementary means of diagnosis and therapeutic associated to acts carried out in hospital environment;
c) medication, when administered during the period of hospitalisation and associated to the treatment carried out;
d) materials, equipments and products, when associated with the treatment carried out in the hospital environment;
e) resources used in in-patient treatment (operating theatres, recovery ward and room);
f) ambulance or other means of transportation to and from the hospital, provided the Insured Person's health requires it;
g) surgically implanted prosthetic devices;
h) 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 grace period.

5. The Contributions, Reimbursements, Capitals, Deductibles and Co-payments stipulated in the Specific Conditions.

6. Private expenses or expenses associated with non-clinical issues are not reimbursable.

SPECIAL CONDITION – OUTPATIENT MEDICAL CARE

1. Under the terms of this Special Condition, whenever the coverage has been contracted, the Insurance Company is bound to:

a) fund, under the agreed benefits, the Insured Person's access to the Médis network healthcare service providers, as an out-patient, under the terms and within the limits stipulated in the Specific Conditions.
b) in terms of fixed pecuniary benefits: to reimburse the Insured Person for the expenses incurred with outpatient medical care, under the terms and within the limits stipulated in the Special Conditions.

2. Eligible expenditure under the in-network healthcare service provider coverage that is related to the payment of medical treatment, surgery or laboratory analysis that do 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, carried out outside of the hospital;
d) materials and equipments associated to specific acts and used during these same acts;
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.

3. The coverage for Outpatient Medical Care is subject to a 60-day grace period.

4. The Contributions, Reimbursements, Capitals, Deductibles and Co-payments are provided for in the Specific Conditions.

SPECIAL CONDITION – STOMATOLOGY AND DENTAL MEDICINE

1. Under the terms of this Special Condition, whenever the coverage has been contracted, the Insurance Company is bound to:
a) in terms of the agreed benefits, fund the Insured Person's access to stomatology and dental clinics within the Médis network, under the terms and within the limits stipulated in the Special Conditions;
b) in terms of the fixed pecuniary benefits, to reimburse the Insured Person for the expenses incurred with stomatology and dental care, under the terms and within the limits stipulated in the Specific Conditions.

2. The expenses that shall be financed under the access to the Médis Network, or the expenses that shall be reimbursed, are those relate to:
a) appointments;
b) dentistry (restoration and filling of cavities);
c) periodontology (removal of tartar);
d) minor oral surgery;
e) prosthetic devices;
f) orthosis (corrective apparatus);
g) complementary means of diagnosis and therapeutic;

3. For the purposes of the above referred in the previous number, the following shall 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;

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

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

5. The guarantees covered in this Special Condition are subject to the establishment of Deductible, as well as minimum and maximum reimbursable amounts, duly stipulated in the Specific Conditions.

SPECIAL CONDITION - MEDICATION

1. Under the terms of this Special Condition, when coverage has been contracted, the Insurance Company is bound to reimburse the Insured Person, within the terms and limits stipulated in the Specific Conditions, for the expenses incurred with the acquisition of medication, 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. The payment of the following items is not considered as a refundable expense:
a) non-prescription medication;
b) vaccines;
c) baby food;
d) dietary products, natural products, 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. The payment of reimbursable expenses shall depend upon the verification of the following assumptions:
a) Medication shall be prescribed by a doctor and be intended for treatment of injuries 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 or barcode, or the prescribed medication registration number and corresponding receipt, shall be sent to the Insurance Company. The claim shall clearly and legibly indicated the medication supplied, and their values, after deduction of the reimbursement amount, where applicable, paid by the Insured Person, under the terms stipulated for the coordination of benefits.

The Insurance Company shall not reimburse expenses, whose supporting documents have not been provided.

5. The coverage for Medication is subject to a 60-day Grace Period.

6. The Contributions, Reimbursements, Capitals, Deductibles and Co-payments are provided for in the Specific Conditions.

SPECIAL CONDITION - CHILDBIRTH

1. Under the terms of this Special Condition, whenever the coverage has been contracted, the Insurance Company is bond to finance the Insured Person's access to healthcare providers for childbirth or involuntary interruption of pregnancy on medical recommendation, except for illegal abortion, and if, during the normal gestation period, the birth occurs after the end of the Grace Period, under the terms of the following numbers and within the limits stipulated in the Specific Conditions:
a) under the agreed benefits, ensure the Insured Person the access to integrated clinical service providers;
b) under the fixed pecuniary benefits, to reimburse the Insured Person for the incurred expenses.

2. Reimbursable expenses or the expenses eligible for financing under the regime of access to in-network healthcare service providers, relate 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 carried out during the hospitalisation period;
e) medication administered during hospitalisation;
f) materials, products and equipment, when associated with treatments during the hospitalisation;
g) facilities suitable for the performance of treatments (operating theatres, recovery ward, delivery room, 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 health condition so requires.

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

4. The Contributions, Reimbursements, Capitals, Deductibles and Co-payments are provided for in the Specific Conditions.

SPECIAL CONDITION – PROSTHETIC DEVICES AND ORTHOSIS

1. Under the terms of this Special Condition, whenever the coverage has been contracted, the Insurance Company is bound to reimburse the Insured Person, under the terms and according to the limits set out in the Specific Conditions, for the expenses incurred with the acquisition or rental of prosthetic and orthotic devices, as per the medical prescription.

2. Constitute reimbursable expenses within the scope of indemnity benefits or expenses eligible for funding under the regime of access to integrated clinical service providers, expenses incurred with the payment of:

Ocular orthotic devices

Constitute reimbursable expenses within the scope of indemnity benefits, expenses incurred with the payment of:
Non-ocular prosthetic and orthotic devices

3. For the purposes of this 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;

ORTHOSIS: all instruments clinically conceived or recommended, whose purpose is to – totally or partially – help the member or organ to function.

3. Under this Special Condition, a partial reimbursement is attributed for the expenses related to the acquisition of:
a) a pair of graduated contact (or other) lenses, for each insurance contract annuity, or even two pairs, in case the Insured Person is under 16 years of age on the date of the expense; disposable contact lens are also eligible for partial reimbursement, regardless of its number, until the annual limit of the capital stipulated in the Policy's Special Conditions;
b) one frame for every two Insurance Contract years, or one frame for every annuity, in case the Insured Person is under the age of 16 on the date of the expense;

c) hearing and ocular prosthetic devices and correction of orthopaedic footwear;
d) the rental or acquisition of a wheelchair and crutches, provided the rental value does not exceed the acquisition value.

4. Under this Special Condition, a partial reimbursement is attributed to cover the expenses incurred with the acquisition of ocular prosthetic devices, namely to substitute enucleated eyes.

5. For attributing a partial reimbursement for the expenses incurred with the acquisition of prosthetic or orthotic devices, it is necessary to present the following documents:
a) photocopy of the ophthalmic prescription, issued no more than 90 days prior to the date of acquisition of the prosthetic or orthotic devices;
b) photocopy of the doctor's prescription, in the case of hearing aids, ocular prosthetic devices, correction of orthopaedic footwear, wheelchair and crutches;
c) receipt issue by the prosthesis or orthosis supplier, expressly indicating the quality, quantity and price of the acquired materials.

6. In addition to the exclusions provided for in the General Conditions of the Policy, this coverage does not cover:
a) stomatology prostheses;
b) medical belts, elastic socks, orthopaedic mattresses, orthopaedic pillows or orthopaedic footwear;
c) other equipment classified as technical assistance;
d) sunglasses, including, separately or jointly, frames and graduated (or not) lens.

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

9. The Contributions, Reimbursements, Capitals, Deductibles and Co-payments are provided for in the Specific Conditions.

SPECIAL CONDITION – MEDICAL ASSISTANCE WHILST ABROAD

1. Under the terms of this Special Condition, whenever the coverage has been contracted, the Insurance Company is bound to provide an assistance service to the Insured People who need healthcare abroad, regarding the clinical situation covered by this Policy, until the limit stipulated in the Specific Conditions.

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

3. Refundable expenses are the following:

3.1. Admission
In the event of illness or accident affecting the Insured Person, that requires the hospitalisation or treatment in a medical facility, the Insurance Company shall handle the required procedures for the Insured Person's admission into the selected hospital unit.

3.2. Transport
a) Should the Insured Person require transportation to the hospital where (s)he shall be hospitalised, or treated, and is physically incapable of using normal transportation, the Insurance Company is bound to provide for transportation by ambulance, light sanitary vehicle, or any other means, depending upon the seriousness of the illness, to the unit where the patient shall be admitted for in-patient care or treatment, as indicated by the Insured Person. At the request of the Insured Person, the Insurance Company shall arrange for identical services for an accompanying person – doctor, family member, or other.

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

3.2.1. The Insurance Company is only bound to transport the Insured Person in need of hospitalisation to a healthcare facility outside the national territory, when he/she is already abroad on the date of the event, in a sudden manner, or provided there is no medical facility in Portugal that can carry out the necessary treatment. The service is also guaranteed whenever 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 transportation depends upon the airline's authorization. In case the authorization is denied, the Insured Person may choose, if he/she so wishes, another means of transportation, if previously 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 shall be responsible for the expenses related to the necessary legal formalities at the place of death, as well as for the expenses incurred with 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 purposes 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 he/she chooses, and the costs shall be borne by the Insured Person.

3.5. Departure from the Healthcare Unit
After having been released from hospital, the Insurance Company shall, 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 shall guarantee its search and delivery.

4. The coverage of Medical Assistance Whilst Abroad is subject to a 180-day Grace period.

5. The Contributions, Reimbursements, Capitals, Deductibles and Co-payments are provided for in the Specific Conditions.

SPECIAL CONDITION – SERIOUS ILLNESS

For the purposes of this Special Condition, the following definitions are taken into account:

Territorial Scope: healthcare services provided outside of Portugal.

Personal Medical Assistant: Doctor of the provider responsible for the management of the service, which will assist the insured person in completing the second medical opinion request for the selection of the best international centre and medical examinations to be annexed.

Selection of international centres: The team of the provider appointed by Médis for the management of the coverage shall select, based on its international network of specialists, the centres outside of Portugal that offer the best treatment alternatives for the insured person. The patient and family shall receive a report with a proposal of the centres selected as the best alternatives at an international level for your treatment.

Under the terms of this Special Condition, whenever the coverage has been contracted, the insurance contract guarantees, according to the limits stipulated in the Specific Conditions, the expenses incurred by the Insured Person with diagnosis, treatments, clinical services, provisions or prescribed medication, within national territory and deemed to be clinically necessary, whenever they result or are a consequence of any serious illness or clinical situation described in no. 4 and whose first symptoms occurred during the period in which the guarantee was in force and after the Grace Period had elapsed.

1. The application of the guarantees set out in this Special Condition is subject to the selection of the international centres by the provider appointed by the insurance company, in order to confirm the diagnosis and the suitable treatment, and the Insured Person shall - in any circumstance - authorise the doctors and hospitals that he/she has sought, to disclose to the Insurance Company and to the Provider appointed by the insurance company the clinical reports and any other elements deemed necessary by the latter for documenting the file.

2. The agreed benefits provided for in this Special Condition are only valid in the hospitals recommended by the Provider responsible for the management of the coverage, located outside the national territory.

3. For the purposes of this Special Condition, the following are considered as being 'serious illness' or 'guaranteed clinical situation':
a) treatment of malignant diseases except in the case of situ cancer;
b) neurosurgery: any surgical intervention to the brain or the intracranial structure;
c) by-pass surgery of the coronary arteries (coronary artery by-pass graft), surgical treatment involved in open-heart surgery and the use of by-pass to correct stenosis of at least two coronary arteries;
d) surgery of the heart valves;

e) organ transplants, more specifically, the surgical transplant of the heart, lung, liver, kidney, pancreas or bone marrow resulting from the irreversible loss of their function.

4. Regarding the serious illnesses or 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) Expenses associated with hospitalisation in a room, ward or intensive care unit;
   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 for an accompanying person, if the hospital offers that service.
b) Expenses incurred in outpatient surgical centres, provided the treatment, surgery or prescription is covered by this Special Condition;
c) Doctor's fees related to doctor's visits or treatments;
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 respective application, whenever it has been given by an anaesthesiologist;
   ii)Clinical pathology, pathological anatomy, imaging and electromedical examinations, as well as radiotherapy and chemotherapy treatments, required for the diagnosis and treatment of a covered illness, whenever they have been prescribed and supervised by a doctor;
   iii) Transfusions of blood products;
   iv) Administration of medical gases and injectable therapies
f) Expenses incurred with pharmaceutical products or medication used under 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 procedures;
g) Expenses relating to travelling and ambulance transport by land and air, when its use is indicated and prescribed by a doctor and has the prior approval of the Insurance Company;
h) Expenses related to an economy class return journey for the Insured Person and an accompanying person;
i) Accommodation expenses for the Insured Person and an accompanying person;
j) In case of the Insured Person's death during the treatment, the Insurance Company shall support the expenses related to the necessary legal formalities at the place of death, as well as the expenses incurred with the transport or the body to the funeral location in Portugal.

6. Without prejudice to the exclusions provided for in the Policy's General Conditions, this Special Condition does not guarantee the payment of the expenses incurred with, or generated by, any diagnosis, treatment, service, provision, or medical prescription, in any way related to, or resulting from:

a) Any serious illness or other clinical situation, which is not provided for in no. 4 of this Special Condition;
b) The Seropositivity for – HIV and the Acquired Immunodeficiency Syndrome (AIDS), any illness that is secondary or provoked by these conditions, as well as all those that are a consequence of its treatment, including the illness known as Kaposi Sarcoma;
c) The Expenses related to custody services, healthcare at home or services provided at a convalescence centre or institution, asylum or old people's 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 approved by the Insurance Company;
e) Any type of prosthetic or orthotic devices, even when their use is considered to be necessary during chemotherapy treatment, with the exception of breast implants following a mastectomy;
f) Any type of pharmaceutical products and medication that have not been provided by a licensed pharmacist, or for whose purchase no medical prescription is required;
g) Expenses related to the use of alternative medicine, even when a doctor has specifically prescribed it;
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 accompanying person, with the exception of those expressly guaranteed under this Special Condition;
j) The following treatments are not guaranteed:
   i) any tumour or lesion which has been histologically described as being pre-malignant;
   ii) in situ tumour (in situ cancer);
   iii) tumours related to the acquired human immunodeficiency virus (HIV);
   iv) skin cancers, with the exception of the malignant melanoma;
   v) bladder papillary cancer;
k) Intracranial surgery when the pathology is a consequence of a trauma injury;

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.
o) Any expenses incurred prior to the approval by the insurance company of the selection of the centres of treatment;
p) Any expenses incurred in a non-authorised hospital or hospital not included in the selection of centres of treatment approved by the insurance company;
q) Any expenses incurred at a non-authorised hospital or hospital that is not included in the Prior Medical Certification;
r) Any expenses incurred that are directly related to the diagnosis, treatment, service or medical prescription of any nature carried out in the Portuguese territory;
s) Any expenses incurred that do not comply with the procedures defined in the number below;
t) Any diagnosed disease or clinical situation or whose first symptoms manifest themselves during the first 180 days counted from the date of subscription of the Insured Person's Policy;
u) Any expenses incurred that are directly related to the diagnosis, treatment, service or medical prescription of any nature anywhere in the world, when the Insured Person has lived outside of Portugal for more than 91 consecutive days in a 12-month period;
v) All types of pre-existing conditions or congenital diseases.

7. If the Insured Person has been diagnosed with a Serious Disease, Guaranteed Clinical Situation or has been prescribed a medical procedure, the Insured Person or any person acting on his/her behalf, before being submitted to any treatment, service or medical prescription that he/she intends to claim within the scope of this Special Condition, shall comply with the following procedure:

i) Notice of the claim
The Insured Person, or any person acting on his/her behalf, shall contact the Médis Line [(1)] as quickly as possible, to notify the Insurance Company of the accident and to request the service of selection of international centres. The Insured Person is informed by the provider responsible for the service of the steps deemed necessary for the review of the clinical case, which includes an authorisation from the Insured Person that allows the provider to request medical information and relevant diagnostic exams to confirm the serious disease or clinical situation under this Special Condition.

ii) Evaluation of the claim
After the selection of international centres service has been concluded, the Insured Person receives a report from the specialist whereby Linha Médis confirms whether it is a Serious Disease or Guaranteed Medical Situation under this Special Condition. If this is the case and the Insured Person chooses to be treated outside of Portugal, the latter must inform the provider responsible for the service of this decision.

iii) Selection of the International Hospital
The provider appointed by the insurance company provides the Insured Person with a list of recommended Hospitals outside of Portugal.

iv) Prior Medical Certification
As soon as the Insured Person has confirmed in writing to the appointed provider the hospital that he/she has selected from the list of recommended Hospitals, the provider makes all the preparations for the correct admission of the Insured Person to the selected Hospital, allowing the Insured Person to access, at the Hospital, the treatment, hospital services and medication prescribed within the scope of the guarantees and limits of this Special Condition set out in detail in the Medical Certification.

v) Treatment and Payment
Following the validation and confirmation of the acceptance of the claim by the provider responsible for the management of the service, after the Insured Person has obtained the Prior Medical Certification from the provider and the latter has coordinated the treatment, hospital services and prescribed medication in the Hospital, confirmed to the provider, and to which the Prior Medical Certification was issued, the Insurance Company, under the guarantees of this Special Condition, directly assumes the medical expenses incurred by the Insured Person, subject to the conditions, limits and exclusions provided for in the present Special Condition.

The Insured Person, his/her relatives or legal representatives, must allow the visit of doctors of the provider responsible for the management of the service or of the Insurance Company, as well as any and all inquiries considered necessary by the provider or the Insurance Company. For this purpose, the doctors shall be exempt from the obligation to observe professional secrecy.
Failure to meet these obligations shall be considered as an express waiver to the right to the guarantees covered by this Special Condition.

In more complex clinical situations, to be assessed by the insurance company and the provider responsible for the management of the coverage, a doctor shall be appointed to accompany the insured person in his/her treatment outside of Portugal.

8. The Contributions, Reimbursements, Capitals and Co-payments are provided for in the Special Conditions.

SPECIAL CONDITION – VINTAGE HOME ASSISTANCE

1. Under the terms of this Special Condition, whenever the coverage has been contracted, the Insurer, through the Assistance Services, guarantees in the case of a claim covered by the policy, the coverage of the risks referred to in the following number, within the limits stipulated in the Specific Conditions, observing the precepts and exclusions established in the policy, upon prior request through the Médis Line.

2. Following a claim leading to in-patient treatment duly authorised by the Clinical services of Médis, provided that the Insured Person is in a situation of dependency of a third party, duly confirmed by medical report, the Assistance Service guarantees the following services up to the limit of the capital:

a) Special Transport for Children: the Insurer guarantees the transport of children under 13 years of age, who are in charge of the Insured Person, in specialized transport up to the limit established in the Specific Conditions;
b) Babysitter: the Insurer shall organize and pay the babysitting cost, up to the limit established in the Specific Conditions;
c) Cleaning and Personal Hygiene Services of the Insured Person: the Insurer shall ensure the provision of the necessary cleaning and personal hygiene services of the Insured Person, paying the costs up to the limits established in the Specific Conditions;
d) Food Services: the Insurer shall organize and pay the respective costs related to the sending of a specialised person to provide meals at the domicile of the Insured Person up to the limits established in the Special Conditions, and the cost of the meals shall be charged to the Insured Person;
e) Physiotherapy and Nursing Services: the Insurer shall organise and pay the costs of the physiotherapy sessions and nursing care at the domicile of the Insured Person, under medical prescription, up to the limits established in the Specific Conditions, with the payment of the deductible indicated for each treatment and cost of the materials being charged to the Insured Person.

3. The Domicile Service established in this Special Condition shall be provided exclusively by healthcare professionals belonging to the provider network agreed with the Assistance Services and applies exclusively to national territory.

4. The Contributions, Reimbursements, Capitals, Insurance, Deductibles, Co-payments and Grace Periods are provided for in the Specific Conditions.

5. The benefits and compensations established in the present contract shall be paid in excess and as a complement to other insurance contracts, which cover the same risks, or other compensations to which the Insured Person is entitled.

6. In addition to the exclusions established in the General Conditions and those specifically referred to each coverage, the following benefits are also excluded:

a) The benefits, which have not been requested from the Insurer and have not been carried out with the prior agreement of the Insurer, except in cases of force majeure or demonstrated material impossibility, or authorised in-patient treatment which do not lead to a clinically confirmed situation of dependency;
b) The benefits arising from bets, participation in sports competitions or training with a view to these competitions;
c) The benefits arising from strikes, riots and disturbances of public order.

SPECIAL CONDITION OF HOME ASSISTANCE

1. Definitions

Assistance Service
Permanent attendance structure, through a Protocol signed with the Insurer and the service provider, thereby assuming the obligations of the service provider arising from the present Special Condition. The identification and contacts of the provider can be consulted at www.medis.pt.

2. Scope of Guarantee

By the present contract, the Insurer, through the Assistance Service, guarantees the coverage of the risks referred to in number 3 of the present Special Condition, within the limits stipulated in the Specific Conditions, observing the precepts and exclusions established in those numbers and in the General Conditions.

3. Main Guarantees

1. Nursing Service at Home

When prescribed by doctors, the Assistance Service shall arrange a visit of a professional nurse to perform the nursing acts described below.

The nursing acts provided for in this guarantee include:

- Treatment of wounds, pressure ulcers and/or sores;
- Injections;
- Catheterisation;
- Naso-gastric intubations;
- Placement of serum and monitoring;
- Removal of stitches and staples;
- Hygiene care and comfort;
- Pre- and post-natal education; newborn care;
- Vaccination;
- Aerosols;
- Oxygen therapy;
- Nursing care for: colostomies, ileostomies, tracheostomies and urostomies.

For each nurse home visit request, the cost of the consumables used in the acts to be provided will be the paid by the Insured Person, under the terms and limits set out in the Particular Conditions.

2. Transport of the Insured Person to Medical Services

The Assistance Service shall organise the transport of the Insured Person by ambulance or taxi, to Health Units, for Complementary Diagnosis Exams, Appointments, Hospital Admissions and Discharges.

3. Delivery of Medication to the Domicile

Following a medical prescription and by request of the Insured Person, the Assistance Service shall deliver at your domicile the indispensable medication, between 12:00 pm and 09:00 am during business days and 24/24 hours at weekends and public holidays, with the Insured Person being responsible for the cost of the medication and of the transport used.

The terms and limits of this guarantee are described in the Specific Conditions.

4. Territorial Scope

The Guarantees provided for in the present Special Condition are valid in Mainland Portugal and the Autonomous Regions.

SPECIAL CONDITION OF ASSISTANCE FOR EXPATRIATES

1. Definitions

Scope of Guarantees
The Guarantees of the present Special Condition are valid for Expatriates all over the world, except in the national territory, and only in cases of medical emergency, clinically proven, or accident.

Assistance Service
Permanent attendance structure, through a Protocol signed with the Insurer and the service provider, thereby assuming the obligations of the service provider arising from the present Special Condition. The identification and contacts of the provider can be consulted at www.medis.pt.

Emergency
Acute illness (including after-effects of an accident) or exacerbation of chronic illness covered by the specific conditions, which leads to:
a) immediate hospital internment following medical observation (non-elective internment)
b) immediate performance of therapeutic procedure at a hospital Emergency Service (excluding episodes with only medical evaluation and possible referral for an external consultation)

Expatriate
All employees of the Insurance Policyholder with tax residence in national territory and their Family, provided they are covered by the policy, who are absent from the country only and exclusively on company business, continuously or at different intervals.

2. Guarantee of Personal Assistance

1.Repatriation or medical transport of injured or ill and medical surveillance

If the Insured Person suffers bodily injury due to accident or falls ill, provided that the medical situation warrants it, the Insurer, through its Assistance Service, up to the limit stipulated in Specific Conditions, shall take charge:
a) Of the organisation and the cost of transport by ambulance to the nearest clinic or hospital;
b) Of the surveillance by its medical team of the ASSISTANCE Service, in collaboration with the doctor attending the injured or ill Insured Person, to determine the suitable measures for the best treatment to be followed and the most appropriate means for his/her possible transfer to another more suitable Hospital Centre or even to the country of origin;
c) Of the cost of this transfer by the most appropriate means of transport, provided it is not possible to use the means of transport or return on the date initially planned.
The means of transport to be used shall be decided by the medical team of the Insurer and the insured through the Assistance Service;
d) When the indications given by the medical team of the Insurer, through the Assistance Service, are not accepted, the envisaged guarantees cease to be valid.

2.Transport or repatriation after the death of the Insured Person

In the case of death of the Insured Person, the Insurer, through the Assistance Service, shall pay the expenses related to all the legal formalities to be complied with at the place of death, as well as those relative to his/her transport or repatriation to the place of burial in Portugal, up to the limits foreseen in Special Conditions.
If the Insured Person dies during the period of hospital internment, and provided the guarantee foreseen in number 6 is activated, the Insurer, through the Assistance Service, also pays the expenses related to the return of the family member or the person that has been appointed, to his/her domicile in Portugal.

3.Transmission of urgent messages

Following an incident covered by this policy, the Insurer will be responsible for the transmission of urgent messages it receives from the Insured Person, through the Assistance Service.

4.Medical, Surgical, Pharmaceutical and Hospitalisation Expenses Abroad

If in situations of medical emergency resulting from accident or illness, the Insured Person requires medical, surgical, pharmaceutical or hospital assistance, the Insurer through the Assistance Service, and after the conditions specified in number 4 - Table of Guarantees are applied, shall pay, up to the established limit, or shall reimburse in accordance with a prior agreement and supporting documents:

a) Medical and surgical expenses and fees;
b) Pharmacy expenses relative to medication prescribed by a doctor;
c) Hospitalisation expenses.

Any surgical intervention shall only be the Insurer's responsibility, through its Assistance Service, if urgent, indispensable and unable to be postponed until the Insured Person returns to Portugal.

5. Escort of the Hospitalised Insured Person

If the Insured person is admitted to hospital and his/her condition discourages immediate repatriation or return, the Insurer, through the Assistance Service, shall pay the hotel expenses of a family member or person appointed by him/her to stay with the Insured Person, up to the limits foreseen in Special Conditions.

6. Return Transport for a Family Member and Respective Sojourn

If the hospitalisation period of the insured person exceeds 5 days and it is not possible to activate the guarantee foreseen in number 1, the Insurer, through the Assistance Service, shall pay the return 1st class train ticket or tourist-class plane ticket expenses, with departure from Portugal, of a family member to stay with the Insured Person, as well as the sojourn expenses, up to the limits foreseen in Special Conditions.

7. Extension of Stay at Hotel

If in medical emergency situations, resulting from accident or illness, the condition of the Insured Person does not justify hospitalisation or medical transport, and if he/she is unable to return on the date initially scheduled, the Insurer, through the Assistance Service, shall pay the hotel expenses, if any, of the Insured Person and the accompanying person, up to the limits foreseen in Special Conditions.

8. Travel Ticket for the Early Return of the Insured Person in the case of death of a family member

If, during the period of expatriation, the spouse or partner, ancestors or descendants up to the 2nd degree, adopted persons, brothers and sisters, parents-in-law or brothers and sisters-in-law of the Insured Person pass away in Lisbon, and if the means used for his/her journey or acquired ticket does not allow him/her to anticipate his/her return, the Insurer, through the Assistance Service, shall pay the 1st class train ticket or tourist-class plane ticket expenses, from the current location to his/her place of residence or to the place of burial in Portugal.

This guarantee also applies in the case of the spouse or partner of the Insured Person, ascendant or descendant up to the 2nd degree, being the victim of an accident or unpredictable illness in Portugal whose severity, to be confirmed by the medical team of the Assistance Service after contacting the attending doctor, requires his/her urgent and imperative presence.

9. Location and Urgent Dispatch of Medication Abroad

The Insurer, through the Assistance Service, shall pay the cost of sending, to the location abroad where the Insured Person is found, the medication of habitual use indispensable to the Insured Person, provided they do not exist in the visited country and have no local substitutes.

3. EXCLUSIONS

1. General exclusions

This service excludes the payments that have not been requested from the Insurer through the Assistance Service, as well as the expenses which were not made with the Insurer's agreement, except in case of force majeure or demonstrated material impossibility.

2. Exclusions of Guarantees relative to Insured Persons within the scope of the coverage of Assistance to Expatriates:

2.1. The following are excluded from the scope of coverage of Assistance to Expatriates:

a) The exclusions established in the General Conditions of the Health Insurance, as well as the particular exclusions relative to the Insured Person;
b) Expenses related to prosthesis, contact lenses, as well as dental expenses;
c) Childbirth and complications due to the condition of pregnancy;
d) Accidents derived from the Insured Person's use of aircraft or sea-going vessels not belonging to commercial lines or carriers;
e) expenses related to rehabilitation and physiotherapy carried out without the agreement of the Insurer's medical team, through the Assistance Service;
f) Illnesses arising from not performing, by the Insured Person, prevention treatment suited to the existing diseases in the destination country (recommended vaccination; medication; among others).

SPECIAL CONDITION OF ONCOLOGY IN NAVARRA

1. For the purpose of the present Special Condition, the following definitions are applicable:
Territorial Scope: Exclusive coverage at the University Clinic of Navarra, Spain.

Surgical internment: Internment as a result of surgery.
Medical internment: Internment that does not involve surgical intervention, arising or not from a surgical internment.

2. Under this Special Condition, when the coverage is contracted, according to the limits established in the Specific Conditions, the Insurer undertakes to guarantee the expenses incurred by the Insured Person with diagnosis and treatment of oncological diseases, within the territorial scope considered and after the end of the Grace Period mentioned in number 5.

3. Regarding the clinical situations covered by this Special Condition, the Insurer guarantees the payment of the expenses mentioned below, according to the limits established in the Specific Conditions:
a) Surgical internment.
b) Medical internment.
c) Outpatient – hospital environment.
d) Confirmation appointments for medical and surgical treatment, as well as for treatments covered in the day hospital.
e) Pre-operation tests and analyses, once surgery has been indicated.
f) The first post-operative outpatient reassessment.
g) Oncological staging, after the end of each chemotherapy or radiotherapy cycle.
h) Stay during the outpatient chemotherapy and radiotherapy treatments for the patient and an accompanying person, in a bed and breakfast regime.
i) Expenses and organisation of the return journeys on a tourist-class plane for the patient.
j) Surgical prostheses.

4. Without prejudice to the exclusions foreseen in the General Conditions of the Policy, there is no guarantee, under the present Special Condition, of the payment of expenses incurred of resulting from:

a) Any assistance that is not provided at the University Clinic of Navarra.
b) Illnesses, pathologies or injuries that already existed at the start date of the coverage, known by the Insured Person or that already presented some type of symptom.
c) Medication of any class and para-pharmacy products which, even if provided by the University Clinic of Navarra, are administered outside the Hospitalisation of Day Hospital regime.
d) Robotic surgery.
e) Travel of the accompanying person.

5. The coverage of Oncology in Navarra is subject to a 90-day Grace Period.
The Contributions, Reimbursements, Capitals and Co-payments are provided for in the Particular Conditions.

SPECIAL CONDITION – 2nd OPINION

1. Under the terms of this Special Condition, and according to the limits stipulated in the Specific Condition, the Insurance Company is bound to grant the access of the Insured Person to the medical 2nd opinion services, provided by specialized entities appointed by Médis and upon previous request through the Médis Line (1).

2. The approved provisions provided for in this Special Condition are only valid for the specialized provider appointed by Médis.

3. What is granted:

3.1. Within the scope of this Special Condition, the insurance contract guarantees the Insured Person, according to the limits stipulated in the Specific Conditions and for the illnesses listed in 3.2, the access to the 2nd medical opinion, which is the remote analysis of the clinical situation, the respective diagnosis and indication of the most appropriate medical care.

3.2. For the purposes of this Special Condition, are considered diseases or medical conditions that have been diagnosed by a medical physician, with the exclusion of diagnosis made by General and Family Medicine and Pediatrics specialties.

4. The financing of any additional medical acts is excluded, even if resulting from recommendation obtained within the scope of this Specific Condition.

5. Benefit is always excluded from this coverage, when derived from: acute episodes of short term diseases, psiquiatric conditions, odontology and second opinions about hospitalized patients and hospital admissions.

6. Under the terms of this Special Condition, it is guaranteed a single service to the same pathology, however, in case of a new diagnosis proven to aggravate the disease or to change the treatment a new review will be granted. This situation must be properly justified with a medical report.

7. This coverage is subject to a 60-day Grace Period.

8. The Contributions, Reimbursements, Capitals, Deductibles and Co-payments are provided for in the Specific Conditions.

(1) Médis Line – 218 458 888 / 222 078 888 / 919 358 888 / 935 228 888 / 965 998 888 - Available all weekdays, 24 hours