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médis

Médis Health Insurance

General and Special Conditions of the Policy

Applicable to Médis Light, Médis Dental and Médis Light + Dental Insurance

Customer Service: +351 210 042 490 / +351 226 089 290
Cost of call to national landline
Personalised service available during business days,
from 8h30 to 19h00

www.ocidental.pt

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GENERAL CONDITIONS

CLAUSE 1 - DEFINITIONS

Definitions of terms and useful expressions to facilitate understanding the concepts and contents of the contractual conditions of the present insurance contract**:**

1. Relative to the entities involved in the health insurance contract

INSURER
Entity legally authorised to exercise insurance activity, and that underwrites the insurance contract together with the Policyholder.

MÉDIS
Exclusive and registered brand of the products managed by Médis - Companhia Portuguesa de Seguros de Saúde, SA, insurer, reinsurer and manager of the integrated healthcare system underlying the insurance of the Disease, Care and Accident branches, certified by Policies issued by Médis or other Insurers under its authorisation.

INSURANCE POLICYHOLDER
Entity that concludes the insurance contract with the Insurer, and is liable for the payment of the Premium.

INSURED PERSON
Natural person identified in the Particular Conditions and holder of the Individual Insurance Certificate, whose health or physical integrity is insured, and the beneficiary of the Policy's guarantees.

HOUSEHOLD
Group of persons identified in the Particular Conditions or Individual Certificate who live in common economy and include, in addition to the Insurance Policyholder, in the case of individual insurance, or the Subscriber, in the case of group insurance, his/her spouse or person living with him/her in non-marital partnership for more than two years, as well as his/her descendants or ascendants in a straight line or collateral up to the 2nd degree and that are economically dependent on the Insurance Policyholder or Subscriber.

2. Relative to the documents regulating and included in the contract

POLICY
Document that certifies the contract concluded between the Insurance Policyholder and the Insurer, of which the respective agreed General, Special and Particular Conditions and the Endorsement of the contract are an integral part.

GENERAL CONDITIONS
Set of clauses that define and regulate general and common obligations inherent to the insurance contract.

SPECIAL CONDITIONS
Clauses that, completing or specifying the General Conditions, are generally applicable to certain coverages, when they have been contracted.

PARTICULAR CONDITIONS
Document with the specific elements of each insurance contract, which are embodied in an Individual Certificate.

ENDORSEMENT
Document which certifies an amendment of the Policy.

3. Relative to the health insurance subscription:

MÉDIS LIGHT AND DENTAL INSURANCE
Health insurance contract established between the Insurer and the Policyholder, entitled by the issuance of a Policy, whereby the Insurer guarantees Insured Persons access to Médis' network of health care providers, pursuant to the terms and limits agreed with them, with the determination of the financing criteria expressly indicated, or the partial reimbursement of health expenses borne by non-agreed entities.

MÉDIS INSURANCE PROPOSAL
Insurer's form to be completed and signed by the Insurance Policyholder or by each Subscriber (Subscription Proposal), indicating the essential elements of information for acceptance of the insurance contract or individual subscription. This document is an integral part of the Policy when issued, and binds all the parties, i.e. the Insurance Policyholder, each Subscriber and the Insurer.

4. Relative to the values referred to in the health insurance contract

PREMIUM
Price paid by the Insurance Policyholder to the Insurer for coverage of the risk, by taking out the insurance. In group insurance under a contribution regime, the Premium can be totally or partially paid by the Insured Persons.

SUM INSURED
The Sum Insured represents the maximum value of the amount payable by the Insurer due to claim or insurance annuity, as established in the contract.

DEDUCTIBLE
Amount, percentage or number of days under the charge of the Policyholder and/or the Insured Person, whose amount, period or form of calculation is stipulated in the Policy.

CO-PAYMENT
Value payable by the Insured Person for each visit to the clinics belonging to the Médis Dental network, under the terms stipulated in the Particular Conditions or Individual Certificate.

CONTRIBUTION TO THE PAYMENT PER FUNDING
Value paid by the Insurer in the context of the agreed amounts paid directly to the healthcare provider, without prejudice to the payability of Co-payment or deductive items by the Insured Persons.

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.

5. Relative to the guarantees of the health insurance contract

SUBSCRIPTION CONDITIONS
Those established in the Particular Conditions or Individual Certificate relative to each Insured Person, Household or insured group.

AGREED BENEFITS
Guarantee of financing access, under the conditions established in the Policy, to an integrated network of doctors and health units, according to the list or indication of the Médis Line(1), of free choice and access subject to the use criteria established in the Médis Guide.

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

OCCURRENCE / CLAIM
All and every event that may trigger the functioning of the contract's guarantees.

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.

(1) Médis Line - 218 458 888 - 24/7 clinical triage and administrative issues from Monday to Friday from 8:00am to 8:00pm (cost of a call to the national fixed network)

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.

INDIVIDUAL INSURANCE
Insurance taken out in relation to natural persons that, while it can be included in the scope of coverage of a Household, does not consist of a Group Insurance.

GROUP INSURANCE
Insurance of a group of persons, linked to one another and to the Insurance Policyholder by a common bond or interest apart from the insurance.

GROUP INSURANCE UNDER CONTRIBUTION REGIME
Group insurance in which the Insured Persons/Subscribers pay, totally or partially, the amount corresponding to the premium owed by the Insurance Policyholder.

GROUP INSURANCE UNDER NON-CONTRIBUTION REGIME
Group insurance to which the Insurance Policyholder totally contributes to the payment of the Premium.

INSURABLE GROUP
Group of persons, linked to one another and to the Insurance Policyholder by a common bond or interest apart from the actual undertaking of the insurance.

6. Relative to the Médis Dental Healthcare System

MÉDIS DENTAL INTEGRATED HEALTHCARE SYSTEM
Organisation which coordinates the direct funding, under the agreed terms and limits, of the Insured Person to the providers in the agreed network.

ONLINE DOCTOR
Service performed remotely through the Médis app by a doctor legally registered at the Portuguese Medical Association, which includes health promotion, prevention and treatment of the disease, as well as rehabilitation of people who opt for an online consultation that may result in a referral for a face-to-face consultation, or for complementary procedures performed by other health professionals.

MÉDIS LINE[1]
Permanent telephone support, through which the Insured Person can be referred for more suitable care, with a view to the improved health of this person.

PHARMACIES NETWORK
Access to Network Pharmacies that provide various services with direct co-payment according to the coverage contracted. The network pharmacies are duly identified in the Médis Guide available on the website.

MÉDIS CARD
Personal and non-transferable card which identifies its holder, before the Insurer and before the Médis Light and Médis Dental Networks, in order to allow access to the health care system, recording, in the case of an own device, the appointments, medical acts and other means used.

MÉDIS LIGHT NETWORK
Set of agreed service providers within the scope of the Médis integrated health care system, covering natural health professionals and legal persons managing health units. These entities are duly identified in the Médis Guide available for consultation at medis.pt.

MÉDIS DENTAL NETWORK
Set of agreed service providers within the scope of the Médis integrated system of dental care. These entities are duly identified in the Médis Guide available for consultation at medis.pt.

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.

(1) Médis Line - 218 458 888 - 24/7 clinical triage and administrative issues from Monday to Friday from 8:00am to 8:00pm (cost of a call to the national fixed network)

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 - BASE OF THE CONTRACT

1.The insurance proposal, the individual subscription proposal and statements provided by the policyholder constitute the base of the insurance contract and are an integral part of the Policy.

2.The Insurance Policyholder should inform the Insured Persons about the contracted coverages and their exclusions, the obligations and rights in case of a claim, as well as contract amendments, in conformity with the sample drawn up by the Insurer, under penalty of civil liability under the general terms.

CLAUSE 4 - TERRITORIAL SCOPE

1. The territorial scope of the present contract is limited to national territory, unless agreed otherwise in the Special or Particular Conditions.

CLAUSE 5 - INSURED PERSONS

1.Benefit from the guarantees conferred by the present contract to the Insured Persons that accept the conditions of activation of the insured guarantees and use of the Médis Light Network and/or Médis Dental Network on the date of their inclusion in the Policy.

2. The insured persons are accepted by the Insurer in conformity with its acceptance criteria according to the risk assessment parameters in force.

3.The acceptance of the insurance relative to each Insured Person is confirmed by the Insurer, through the issue of the Policy or Individual Certificate, with subsequent submission of a Médis Card.

CLAUSE 6 – 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 7 – AGREED BENEFITS

1. Within the scope of the agreed benefits, the Insurer guarantees the Insured Person direct access to doctors, hospitals or health units, centres for complementary means of diagnosis and other health services that, at each moment, are part of the Médis Integrated Health Care System, whose conditions of use are established in the Policy and in the Médis Guide.

2. The financing conditions include limits on specific medical acts, as well as Copayments per visit paid by the Insured Person, whose scope is defined in the Special Conditions and Particular Conditions.

3. The coverage activation provided for in the Particular Conditions is the object of analysis of the clinical process and depends on the express authorisation of the Insurer's clinical services, which exclusively obeys criteria of a medical nature, in accordance with the principles of good clinical practice.

4. The Insurer makes available to the Insured Person on the Médis Website the Médis Guide with the list of providers that, at any given moment, are part of the Médis Light network and the Médis Dental network, being at the discretion of the Insured Person to choose the provider.

CLAUSE 8 – 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.

2. Unless expressly agreed to the contrary in the Particular Conditions, the Individual Certificate or the under a Special Condition, benefits arising from:
a) stomatology and dentistry, except surgery as a result of an accident covered by this contract and occurred during its term;
b) implants and all related procedures, namely diagnostic and surgical templates, guided bone regeneration, transepithelial abutments, articulator mounting, provisional crowns and definitive decisions on implants, among others, unless otherwise agreed in the Conditions private individuals;
c) medicines;
d) non-surgical prostheses and orthoses;
e) childbirth;
f) general health examinations (check-ups);

g) co-payments or deductibles resulting from medical acts or procedures guaranteed by another Médis policy in force for the same Insured Person, presented to the Insurer under the indemnity benefits, up to the limit of Copayment for the same act or procedure doctor guaranteed by the same Policy.

CLAUSE 9 – START AND DURATION OF THE CONTRACT

1. The start of the insurance, if accepted, depends on the date on which Médis receives the proposal:

a) If the insurer receives the offer before the 15th of the month, the insurance takes effect at midnight on the 15th of the same month.

b) If the insurer receives the proposal on or after the 15th of the month, the insurance takes effect from midnight on the 1st of the following month.

2. The guarantees are valid for the insured persons from the start date indicated in the Particular Conditions, without prejudice to what is defined regarding Grace Periods or other suspensive periods.

3. The duration of this contract shall be stipulated in the Particular Conditions of the Policy, which may be for a fixed and determined period or for one year to be continued for the following years.

4. When concluded for a fixed period of time, the contract ceases its effects at midnight on the last day of the fixed period.

5. When concluded for one year and continues for the following years, it is considered to be automatically and successively renewed for annual periods, except if any of the parties terminates it, by registered mail or other means by which it is recorded in writing, at least 30 days before the end of the annuity.

6. The benefits guaranteed by the Insurer relate exclusively to each period of validity of the contract, with no extension of the guarantees beyond the expiry date, without prejudice to the provisions regarding the non-renewal of the contract or enrolment.

CLAUSE 10 - TERMINATION OF THE CONTRACT

1. The guarantees conferred by the present contract are automatically no longer effective in relation to each Insured Person, unless explicitly agreed otherwise, in the following cases:

a) in the case of Household members when they are no longer dependent according to the definition in Clause 1;

b) at the end of the annuity, when they are no longer a Subscriber or member of the group through which the insurance contract was taken out;

c) failure to pay the Premium, under the applicable legal terms;

d) in the case of non-renewal of the contract or non-renewal of the subscription.

2.In the present contract, or when group insurance is involved, its subscription can be denounced by any of the parties, on its annual due date, by registered mail or other means of which there is a written record, sent to the other party at least 30 days in advance of the due date.

3. In the case of non-renewal of the contract or non-renewal of the subscription, the Insurer's responsibility ceases on the end date, without prejudice to the provisions in the following number.

4. In both cases foreseen in the previous number, the Insurer remains bound to the guaranteed payments, for the period of two years and in the last period of enforcement of the contract, relative to diseases manifest during the contract enforcement period or to accidents and other facts generating indemnity occurred in the same period, provided that they are covered by the contract and reported within 30 days after their termination, except in the case of a justifiable reason.

5. The Médis Card belongs to the Insurer, where its holder undertakes not to use it and return it immediately upon the end of the enforcement of the insurance contract under which it was issued, under penalty of incurring the civil and criminal liability corresponding to the fact. In the event of misplacement, abusive appropriation, theft or robbery of the card, the holder undertaken to report the event to Médis, within the maximum period of 72 hours, under penalty of incurring civil liability for improper use.

CLAUSE 11 - FREE CANCELLATION

1. An Insurance Policyholder that is a natural person has a time limit of 30 days, counted from when the policy is received, to cancel the contract, under the terms of the law, by written notification, in paper format or other durable means available and accessible to the Insurer.

2. The time limit referred to in number 1 begins from the conclusion of the contract, provided the Insurance Policyholder has, on that date, on paper or any other durable medium, all the relevant information about the insurance which must be featured in the policy.

3. The exercise of the right to free cancellation determines the termination of the contract, extinguishing all the obligations derived thereof, taking effect from its conclusion, with the Insurer being entitled to:

a) The value of the premium calculated pro rata temporis, as it has supported the risk up to the dissolution of the contract;

b) The amount of reasonable expenses incurred due to medical examinations whenever this value is contractually imputed to the Insurance Policyholder.

CLAUSE 12 - PAYMENT OF THE PREMIUM

1. The Premium corresponding to each duration period of the insurance contract is entirely payable, without prejudice to being able to be divided for effects of payment, by agreement between the Insurer and the Insurance Policyholder.

2. Unless it has been agreed that the Insured Person should directly pay the Premium to the Insurer, the obligation to pay the Premium impends on the Insurance Policyholder.

3. The Premium or initial instalment is due on the date of signing the contract. When group insurance is involved, the Premium or initial instalment corresponding to each subscription is

due on the date of the respective acceptance.

4. The following instalments of the initial Premium, the subsequent annuity Premiums and the successive instalments of it are payable on the dates established in the contract.

5. The variable amount of the Premium relative to value adjustment and, when applicable, any part of the Premium corresponding to contract amendments are payable on the dates indicated in the respective notices.

6. In the case of early termination of the insurance contract, for any reason, the Premium or instalment payable by the Insurance Policyholder is calculated in proportion to the period of time elapsed up to the moment of termination. The Insurance Policyholder is entitled to a refund corresponding to the period of time that has not elapsed if the Insurance Policyholder has already paid the entire Premium or instalment.

7. The Insurance Policyholder or Insured Person, when applicable, indicates in the subscription proposal, or in a separate document, the Bank Identification Number (BIN) relative to the bank account which should be debited by the value of the Premium and credited by the value of the Insurer's payments.

CLAUSE 13 – NOTICE OF PAYMENT OF THE PREMIUM

1. During the enforcement of the contract, the Insurer must notify the Policyholder or Insured Person in writing, in case it was agreed that the latter should pay the premium directly to the Insurer, the amount to be paid, as well as the form and place of payment, at least 30 days in advance of the date on which the Premium or its instalments fall due.

2. The notice must present, in a legible manner, the consequences of non-payment of the Premium or its instalment.

3. For insurance contracts where it is agreed that the premium should be paid in instalments every three months or less and whose contractual documentation indicates the due dates of the successive instalments of the Premium and the corresponding amounts payable, as well as the consequences of their non-payment, the Insurer can decide not to send the notice referred to in number 1. In this case, the Insurer is responsible for proving the issue, acceptance and sending to the Insurance Policyholder of the contractual documentation referred to in this number.

CLAUSE 14 - NON-PAYMENT OF THE PREMIUM

1. Non-payment of the initial Premium or its first instalment, on the due date, determines the automatic dissolution of the contract from the date of its conclusion.

2. Non-payment determines the automatic cancellation of the contract on the due date of:

a) an instalment of the Premium in the course of an annuity;

b) an additional Premium arising from an amendment to the contract based on a supervening increase of risk.

3. In contribution group insurance, when the Insured Person does not give the Insurance

Policyholder the amount intended for the payment of the Premium or, when it has been agreed that the Insured Person should pay the Premium directly to the Insurer, this payment does not take place, the Insured Person is excluded from the insurance coverage.

4. Non-payment of the Premium of subsequent annuities or the first instalment of the Premium, on the due date, precludes the extension of the contract or coverage of the Insured Person in question.

5. Non-payment, by the due date, of an additional Premium arising from a contractual amendment shall make the amendment void, with the contract or coverage remaining with the scope and under the conditions that were enforced before the intended amendment, unless the contract proves impossible to remain in effect, in which case it shall be cancelled on the due date of the unpaid Premium.

CLAUSE 15 - TEMPORARY IMPOSSIBILITY OF NEW SUBSCRIPTION

In the case of unsubstantiated termination of the present Contract by the Policyholder or by the Insured Person(s), the Insurer reserves the right to not accept the subscription of a new Médis Light or Médis Dental Insurance in the 365 days immediately after the date of the aforesaid termination, without prejudice to all the other legally and commercially applicable provisions in this context, namely the subscription rules in force at the time.

CLAUSE 16 - DUTIES OF THE POLICYHOLDER AND/OR INSURED PERSON

1. The Policyholder shall inform the Insurer of the inclusions of the Insured Persons that occur during the term of the Policy, coming into force on the first day of the month following the date of communication made by the Policyholder.

2. The Policyholder shall inform the Insurer of the exclusions of Insured Persons that occur during the term of the Policy, entering into force on the due date of the insurance annuity in which said change occurred.

3. When the Médis Light or Médis Dental Insurance is contracted, when it is verified, during the term of the contract, any illness or accident covered by the warranties of this contract, the Policyholder and/or Insured Person, are required to:
a) Select a provider of the Médis Light Network or Médis Dental Network.
b) Always present your Médis Card and a valid identification document with photograph to the Médis Light Network or Médis Dental Network to request the respective guaranteed services.
c) Pay the provider the amount under its responsibility, in accordance with the Special Conditions of the Policy.

CLAUSE 17 - SUBROGATION

1. Up to the value of the funding supported under the agreed payments, the Insurer is subrogated, in all the rights of the Insured Person before third parties civilly liable for them, where the Insurance Policyholder and the Insured Person undertake to provide the Insurer with all the relevant elements for the exercise of these rights, under penalty of being accountable for loss and damage.

CLAUSE 18 - AMENDMENTS TO THE TERMS OF THE CONTRACT

1. The Insurer can propose alteration of the coverages, sums insured, Deductive Items, Co-payments and Premiums, as well as the criteria on use of funding or reimbursement of health expenses, to be enforced during the next annuity of the contract, provided that these alterations are communicated by the Insurer to the Insurance Policyholder or Insured Person 30 days in advance of the date of renewal of the contract or coverage.

2. The alterations are deemed to be accepted if the Insurance Policyholder or Insured Person says nothing within the period of 14 days counted from the date when the proposal is received.

3. If the alterations proposed by the Insurer are not accepted, the contract is extinguished on the date of renewal of the contract or coverage.

4. The Insurer formalises the alterations to the contract in a written document.

CLAUSE 19 - ARBITRATION

1. If, regarding issues of exclusively clinical nature, the Insured Person's right to the Insurer's payments is controversial, arbitration may be used.

2. In the case described in the previous number, each party appoints a physician to represent him/her, with the appointed physicians being responsible for appointing one other physician who chairs.

3. The costs associated to the arbitration process are paid by each party in relation to the arbitrator he/she appointed and half in relation to the chairing arbitrator.

CLAUSE 20 - COMMUNICATIONS AND NOTIFICATIONS

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

2. In the event of change of address, the Insurance Policyholder or Insured Person should inform the Insurer within 30 days following the date on which the change occurs, otherwise future communications or notifications made by the Insurer to the last known address will be considered valid and effective.

3. All documentation containing clinical information can only be provided by physicians, safeguarding the due confidentiality and secrecy relative to personal and health data.

CLAUSE 21 - APPLICABLE LAW AND COMPETENT JURISDICTION

1. When the parties have not chosen, within the legal limits, another rule of law applicable to them, this contract will be ruled by Portuguese law.

2. The competent jurisdiction to settle disputes arising from this contract is that established in Civil Law.

SPECIAL CONDITIONS

SPECIAL CONDITION – DAILY HOSPITALISATION ALLOWANCE

1. For the purpose of this Special Condition, the following definitions shall apply:
Territorial Scope: Hospitalisations carried out in the Portuguese territory.
Daily Allowance: Daily and fixed amount, which is due for the duration of the Hospital stay, as established in the Particular Conditions.

2. Under the terms of this Special Condition, when the coverage is contracted, the Insurer undertakes to pay the Insured Person a Daily Allowance, as a result of Illness, under the terms and limits set out in the Particular Conditions, after the date of entry into force thereof.

3. Payment is dependent on sending the following documentation to the Insurer:
a) Original declaration of hospital discharge and the respective medical report.
b) Justification of the expenses incurred with a detailed description and/or indication of the services provided, in particular as to the number of days of hospitalization, description of the surgical intervention performed and other similar ones.
c) The insurer does not pay expenses for which it does not have the necessary evidence.

4. Exclusions:
a) The exclusions referred to in the General Conditions of the Health Insurance unless otherwise expressly stated in the terms established in the Particular Conditions.

SPECIAL CONDITION – OUTPATIENT CLINICAL CARE

1. Under the terms of this Special Condition, when the coverage is contracted, the Insurer undertakes to:
a) Pursuant to the scope of the Agreed Benefits, finance the access of the Insured Person to outpatient clinical service providers integrated in the Médis Light Network, under the terms and with the limits established in the Particular Conditions.
b) Within the scope of Indemnity Benefits, reimburse the Insured Person for expenses incurred with medical care on an outpatient basis, under the terms and within the limits established in the Particular Conditions.

2. They constitute financial expenses under the access scheme to integrated or reimbursable clinic services providers, those incurred in payment of medical, surgical or diagnostic acts that do not require specific means and services in a hospital environment for their performance.

3. The Contributions, Refunds, Capitals, Deductibles and Copayments are provided for in the Particular Conditions.

SPECIAL CONDITION – ONLINE DOCTOR COVERAGE

1. Under the terms of this Special Condition, should the policy be subscribed, the Insurer undertakes the following obligations:

a) In accordance with the Agreed Payments, to finance access to the Online Doctor service by the Insured Person, under the terms and according to the limits specified in the Particular Conditions;

2. Co-payments are specified in the Particular Conditions.

PECIAL CONDITION – HOME ASSISTANCE SERVICES

1. Under the terms of this Special Condition, when the coverage is contracted, the Insurer, through the Assistance Services, guarantees the coverage of the services mentioned in No. 2 and No. 3, within the limits established in the Particular Conditions, observing the conditions and exclusions established in the Policy.

2. As long as the Insured Person is ill, proven by a medical report, the Assistance Service guarantees the following services up to the limit of the capital:

i) Collection of Clinical Tests at Home
Following a medical prescription, the Assistance Service arranges for a technician to collect clinical tests at the Insured Person's home up to the limit set in the Particular Conditions.
The cost of the tests shall always be borne by the Insured Person.

ii) Physical therapy Services
The Assistance Service guarantees the transport of a physical therapy professional to perform the prescribed treatments that may be performed at the Insured Person's home.
The associated costs shall be borne by the Assistance Service up to the stipulated limit. Once the limit has been exceeded, the Insurer may provide all services, and all costs shall be borne by the Insured Person, the Assistance Service dealing only with its availability and organisation.

iii) Home nursing services:
In the event of a medical prescription, the Assistance Service shall arrange for a nursing professional to be sent out to perform the prescribed nursing acts up to the stipulated limits in the Particular Conditions.
The following nursing acts shall be provided for in this guarantee:
a. Treatment of wounds, pressure ulcers and/or scars.
b. Injections, considering all routes of administration.
c. Placement of urinary catheter.
d. Nasogastric intubations.
e. Saline administration and monitoring.
f. Removing stitches and staples.
g. Hygiene and comfort care services.
h. Vaccination.
i. Aerosols.
j. Oxygen therapy.
k. Nursing care for colostomies, ileostomies, tracheostomies and urostomies.

The Insured Person shall be responsible for the payment of consumables used in the acts to be provided. The Insurer shall bear the costs, up to the stipulated limits, related to the nursing fees, once the limit is exceeded, the Insurer can make the services available, and all costs shall be borne by the Insured Person, the Assistance Service dealing only with its availability and organisation.

The Assistance Service guarantees the following services up to the limit set in the Particular Conditions without the need for a medical report:

i) Home doctor
In case of sudden illness and after evaluation by its Medical Services, the Insurer sends a doctor to the Insured Person's home. The insured person shall be responsible for the cost of consumables used in the acts to be performed. This guarantee is provided every day, 24 hours a day.

ii) Food Services
The Assistance Service arranges and bears the respective costs of sending a specialised person to provide food/meals at the Insured Person's home up to the limits set in the Particular Conditions, the cost of food being the Insured Person's responsibility.

iii) Non-urgent Transport of Patients
The Assistance Service arranges the Transport of the Insured Person in an ambulance or taxi, for journeys to the Health Units for Supplementary Diagnostic Examinations, Appointments, Hospital Admissions and Hospital Discharges.
A journey shall be considered as the route between the Insured Person’s location and the health unit, and its return, for the purpose of calculating the limits of this guarantee.

3. This Support Services coverage is not subject to a Grace Period. To request the services, the Insured Person should contact the Médis Line.

4. The Assistance Services provided for in this Special Condition are exclusively provided by professionals belonging to the network of agreed providers by the Assistance Services and apply exclusively to the national territory.

5. The Contributions, Insured Capitals, Copayments and Grace Periods related to each of the coverages referred to in this Special Condition are provided for in the Particular Conditions.

6. In addition to the exclusions established in the General Conditions and those specifically mentioned for each of the coverages, the following benefits are also excluded:

a) Those which have not been requested to the Insurer or which have not been carried out with its prior agreement, except in cases of force majeure or proven material impossibility.

b) Those resulting from suicide or attempted suicide and voluntary mutilations, or attempt, as well as personal injury that Insured Persons practice or cause on themselves, even if these acts are performed in a state of inability to discern.

c) Those related to claims arising from the deliberate misconduct of any of the Insured Persons.

d) Those related to claims arising from the action or omission of the Insured Person when they have a blood alcohol level higher than the legally permitted or when they are under the influence of narcotics or other drugs or toxic products or in a state of mental disorder.

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.

(1) Médis Line - 218 458 888 - 24/7 clinical triage and administrative issues from Monday to Friday from 8:00am to 8:00pm (cost of a call to the national fixed network)

SPECIAL CONDITION - DENTAL COVERAGE

1. Under the Special Condition, the Insurer assures access to the Médis Dental Network and funding of the identified acts to the Insured Persons, under the terms and within the limits established in the Particular Conditions.

2. For purposes of the present Special Condition, the following definitions are applicable:

Funded acts in the Médis Dental Network:

- **Dental appointment -** Appointment with a dental practitioner and/or stomatologist registered with the Dental Practitioners Association and/or the Medical Association, respectively, at a dental practice, to assess oral health.
- **Application of dental sealants (by quadrant)** - Application of liquid resin on the masticatory surface of teeth to prevent tooth decay; funded up to 18 years old;
- **Topical application of fluorides** - Application of fluorides to prevent tooth decay;
- **Bimaxillary removal of calculus** - Dental cleaning;
- **Sodium bicarbonate jet cleaning** – jet spraying of high-pressure water combined with air and sodium bicarbonate onto the surface of teeth to remove tartar and plaque;
- **Orthopantomography** - X-ay enabling an overview of the jaws and teeth;
- **Restorations** - Treatment of damaged teeth, restoring their form and function;
- **Pulpal protection** – application of a medicinal product of cavity liner to preserve tooth vitality;
- **First Session of Endodontics** - Devitalisation or root canal treatment, which consists of full removal of the pulp and dental nerve;
- **Follow-up endodontics** – total removal of the dental pulp and root canal treatment;
- **Extraction of deciduous tooth** - Extraction of milk teeth;
- **Tooth extraction with odontosection and osteotomy** – surgical tooth extraction (minor surgery);
- **Extraction of multiradicular teeth** – extraction of teeth with more than one root;
- **Extraction of monoradicular teeth** - extraction of teeth with a single root;
- **Implantology study pack** – Study made before the customer places a dental implant. This study includes a dental medicine appointment, study of rehabilitation with implants and study models;
- **Orthodontics study pack** – Study made before the customer places the dental brace. This study includes a dental medicine appointment, orthodontic study models, cephalometric analysis, teleradiography and photographic study;
- **Control of fixed brace** - 6 controls of fixed brace are funded during 2 years (maximum of 3 controls per year). The funding begins when the 1st control of this brace is done in the Médis Dental network.

The present document is a translation of the Portuguese version. In case of discrepancy between the versions, the Portuguese version shall prevail. Does not exempt consultation of the legally required pre-contractual and contractual information.