OneCare

HEALTH INSURANCE

INSURANCE PRODUCT INFORMATION DOCUMENT

Aegon Santander Portugal Não Vida, Companhia de Seguros, S.A., with head office in Portugal, an insurance company registered with the Portuguese Insurance and Pension Funds Supervisory Authority under no. 1192

Full pre-contractual and contractual information on this insurance product is provided in other documents.

What type of insurance is this?

This is a health insurance product and covers risks related to healthcare provision.

What risks are insured?

Coverage you can take out

- ✓ Inpatient care
- ✓ Childbirth and involuntary termination of pregnancy
- ✓ Outpatient care
- ✓ Dentistry
- ✓ Prosthetic and orthotic devices
- ✓ Medicines
- ✓ Daily allowance for private hospital inpatient care
- ✓ Daily allowance for private hospital inpatient care - critical illness
- ✓ Second international medical opinion
- ✓ International critical illness coverage
- ✓ Online Medical Assistance
- ✓ Mental health
- ✓ OneCare assistance
- ✓ Access to the medical network
- ✓ Access to the stomatology network
- ✓ Access to the health and well-being network
- ✓ Preventive medicine
- ✓ Extension abroad
- ✓ Travel medical assistance

Sum insured

The sum insured varies according to the selected and contracted coverage; it is indicated in the legally required pre-contractual and contractual information. It is renewed annually and can apply to each insured person or their family.

Which risks are not insured?

- ✗ Pre-existing disease, injuries or deformities at the time this policy was taken out
- ✗ Mental health disorders
- ✗ Infertility treatments
- ✗ Voluntary termination of pregnancy
- ✗ Obesity treatments
- ✗ Diseases and accidents subject to compulsory insurance
- ✗ Aesthetic treatments or surgeries
- ✗ Medically unnecessary treatments
- ✗ **These and <u>other</u> of the 40 general exclusions, as well as the exclusions specific to each cover, are detailed in the insurance conditions.**

Are there any coverage restrictions?

- ! Malicious or negligent omission of relevant information may result in the refusal of claims or even cancellation of the policy
- ! Deductibles, co-payments, limit of sum insured associated with each cover
- ! Waiting period associated with each cover or specific treatments
- ! Limit to the value of the "K" coefficient, according to the Code of Nomenclature and Relative Value of Medical Acts, in reimbursements outside the agreed network
- ! Expenses incurred outside the agreed network or not authorized by the insurer
- ! Expenses incurred outside the territorial scope of the policy or specific cover

Where am I covered?

- ✓ In Portugal and, for some optional coverages, also abroad.

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Santander Entidade Distribuidora

aegon Santander Seguros

What are my obligations?

Before the contract is signed

- Provide the insurer with all information that is relevant, on a reasonable basis, to the risks insured under this policy, including where it has not been expressly requested;

During the term of the agreement

- Bear the costs associated with deductibles and co-payments under the terms defined in the policy;
- Pay the insurance premium on time;

In the event of a claim

- Cooperate with the insurer in obtaining clarification on the particulars of the claim or the documents requested for the purpose;
- Use all reasonable means at their disposal to prevent or limit the worsening of any illness and/or injury before medical intervention, as well as report the claim no later than eight days after its occurrence;
- Carry out the exams requested by the insurer after a doctor has determined that this is the most appropriate way to reach a diagnosis;
- Send the original receipts for expenses incurred under the reimbursement system within 365 days of their issue.

When and how should I pay?

- The premium is payable by the policyholder and shall be due from the moment the policyholder and the insurer have mutually accepted the contract, resulting in the issuing of the policy and the first receipt. The following premiums are due by the due date of each receipt.
- Premiums are collected by direct debit pursuant to the SEPA Debit Authorization signed by the policyholder for this purpose.
- The premium refers to an annuity and can be divided into half-yearly, quarterly or monthly instalments.

When does the coverage start and end?

- Coverage begins with the issue of the policy by the insurer and it is set forth in the policy schedule as from the start date established therein upon payment of the insurance premium;
- This policy is an annual contract, automatically renewable each year.

How can I cancel the contract?

- The policyholder may exercise the right of **withdrawal**, without the need to invoke any grounds, within 30 days from the date of receipt of the specific policy conditions. To exercise this right, the policyholder shall notify the insurer by means of an explicit communication delivered on a durable and accessible medium. Termination of the contract under these terms entitles the insurer to retain the portion of the premium corresponding to the period during which it bore the risk, as well as to recover any reasonable expenses incurred in connection with medical examinations, insofar as such costs are contractually attributable to the policyholder.
  The right of withdrawal may likewise be exercised in respect of insurance policies remotely sold, within 14 days from the date of receipt of the specific policy conditions. In such cases, where risk coverage has commenced before the expiry of the withdrawal period, the insurer shall be entitled to retain the portion of the premium corresponding to the period during which it bore the risk and to recover any reasonable expenses incurred in connection with medical examinations, insofar as such costs are contractually attributable to the policyholder.
- By **revocation** at any time by agreement between the parties.
- By prior **notice**, the insurer and the policyholder can terminate the insurance unilaterally. This prior notice must be sent in writing at least 30 days before the policy renewal date.
- By **termination** at any time, upon reasoned notice sent by registered mail. The contract is deemed terminated within a maximum of eight working days from receipt of the notice.
- **Failure to pay the initial insurance premium** or first instalment thereof on its due date shall automatically cause the termination of the contract from the date on which it was executed. Failure to pay any other fraction of the premium during an annuity or an additional premium will result in the automatic termination of the contract from the due date.
- By **expiration** the policy ceases for each insured person who reaches the age limit for remaining insured, as set out in the policy schedule.

The communications supporting these forms of termination must be made in writing or on a durable medium.

What can you do to find out about your policy and use the services in the event of a claim?

You can download the OneCare app or contact us by phone.

Download the OneCare app

To access the OneCare app, simply *download* it from the App Store or Google Play Store. Log in by entering your tax number and the cell phone number associated with the insurance.

Contact your OneCare Health Assistant on +351 210 546 822

Between 9 a.m. and 7 p.m. on working days, charged as a call to the national fixed network. For a home doctor, available 24 hours a day, 365 days a year.

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TERMS AND CONDITIONS

Preliminary clause

Between the insurer Aegon Santander Portugal Não Vida, Companhia de Seguros S.A. and the policyholder mentioned in the policy schedule, the insurance contract is established, which is governed by the terms of this policy, contracted in accordance with the declarations contained in the Insurance Proposal on which it is based and the clinical information necessary for the acceptance of the risks by the insurer, which form an integral part thereof.

The individualization of this contract is made in the policy schedule, which include, inter alia, the identification of the parties and their domicile, the data of the insured person(s), the collection elements and the determination of the premium.

Chapter 1. Scope, definitions, exclusions and territorial scope

01 Contract scope

Health insurance

The contract guarantees the insured person, in the event of sickness or accident occurring during its term, certain health care covers which may include, jointly or separately, benefits within the agreed network, reimbursement benefits, access to the agreed network and assistance services, as defined in the policy documents.

02. Definitions

Insurance policy

The policy is the set of documents that constitute the insurance contract with the insurer and consists of the following elements:

1. **Insurance Terms and Conditions**
   Document that sets forth the characteristics of the insurance, namely coverage and respective capital, general exclusions, as well as the parties' rights and duties.
2. **Policy schedule and riders**
   Document containing the details of the parties involved, as well as the specific insurance elements contracted. It can be updated through subsequent addenda, at the parties' initiative.
3. **Medical information**
   Collection of medical information regarding the insured persons. This can be done via a medical questionnaire or health declaration filled out on a specific website or via a telephone interview. This information can be consulted by the insured person at any time.
4. **Other written communications**
   Any type of correspondence between the parties involved, in particular regarding acceptance of the risk and/or risk aggravation.

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5. **Insurance proposal**
   A document in which the policyholder expresses their wish to take out an insurance contract and informs the insurer of the risk they wish to insure. Its correct completion and the signing of the declarations that form part of it are essential for the insurance to be accepted by the insurer.

The documents that make up the policy can be provided by the insurer digitally or on paper.

Participants

6. **Insurance Agent**
   The entity that promotes the sale of insurance, acting as an intermediary between the insurer and the policyholder, and also providing assistance throughout the term of the contract.
7. **Household**
   Group of insured persons identified in the policy, which may include the policyholder's ascendants, descendants, spouse or siblings.
8. **Insured person**
   Person whose health or physical integrity is insured, as identified in this contract.
9. **Insurer**
   The insurance company covering the contracted risks is Aegon Santander Portugal Não Vida, Companhia de Seguros, S.A., hereinafter referred to as the insurer.
10. **Policyholder**
    A person entering into the insurance contract with the insurer and is liable for paying the relevant premium.

Clinical or medical

11. **Inpatient care (with or without surgery)**
    Stay of the insured person in a hospital unit for more than 24 hours to receive health care (medical and surgical) that cannot be administered in outpatient care.
12. **Out-patient surgery**
    A scheduled surgery, performed under general, locoregional or local anesthesia, in a hospital environment, safely and in accordance with good medical practice, with same-day admission and discharge.
13. **"K" Coefficient**
    Weighting coefficient for the valuation of medical acts used in the Nomenclature Code and Relative Value of Medical Acts [*Código de Nomenclatura e Valor Relativo de Atos Médicos*], as published by the Portuguese Medical Association.
14. **Critical illness**
    A disease that increases the risk to life or the possibility of permanent disability, therefore requiring continuous treatment.
15. **Pre-existing disease or injury**
    Illness or injury of which the insured person should have been aware or could not have been unaware, by evidence of the signs and symptoms or by having received medical advice or treatment in relation therewith, prior to the date of commencement of cover under the policy.
16. **Congenital disease or malformation**
    A disease and/or malformation diagnosed or identified during pregnancy or until 30 days after birth.
17. **Illness**
    An involuntary change to the health condition (which has not been caused by an accident) and may be medically and objectively established. The illness is considered sudden when it occurs

unexpectedly and acutely, implying a risk of death or loss of function for the insured person, requiring urgent medical assistance in a hospital environment.

18. **Pre-existing pregnancy**
    A pregnancy that has occurred or has given rise to medical care in the year immediately preceding the effective date of the guarantees for each insured person.
19. **Implant**
    Material (device, prosthesis or orthosis, apparatus, including intrasurgical) and/or substance with therapeutic or corrective, or morphological and/or functional alteration purposes, to be placed in the body of an individual.
20. **Injury**
    An involuntary morphological or functional change to the health condition, which has been caused by an accident and may be medically and objectively established.
21. **Medical doctor/dentist**
    A person holding a university degree issued by a School of Medicine or Dentistry, who is legally authorised to practice and whose speciality and registration are recognised by the Portuguese Medical Association or Dentist Association in Portugal, or any similar entities of a country where their professional activity is performed with respect to any healthcare services provided outside national territory.
22. **Minor surgery**
    Any and all surgical procedure meeting all of the following criteria:
    a) does not require an operating room to be performed;
    b) does not require the surgeon to completely change clothes;
    c) is performed under local anaesthesia;
    d) does not require any special recovery care;
    e) have a limit of 50K for associated medical acts.
23. **Non-conventional therapists**
    Healthcare providers using non-conventional therapies, whose occupation is subject to the applicable legal framework.
24. **Prosthetic and orthotic devices**
    Devices replacing, in part or in full, one member or organ (prosthesis) or fully or partially assisting with the respective function (orthosis).
25. **Permanent customer service**
    Service available at any time during the day or night, limited to a minimum diagnostic capability, namely general practice consultations and basic complementary diagnostic tests.
26. **Medically necessary services**
    Services that justify, according to the protocols and standards recognized by the medical community, the performance of medical acts within the scope of the insurance, provided that they are cumulatively:
    a) necessary for the treatment of the insured person's illness or injury;
    b) appropriate to the diagnosed situation;
    c) of recognized clinical validity;
    d) prescribed and carried out by a doctor or another health professional;
    e) provided at the most appropriate location for the diagnosed situation (insured person's home, doctor's surgery, outpatient clinic, hospital);
    f) provided in the most cost-effective way without being detrimental to any of the above points.

27. **Transplant**
    Placing an organ, tissue or cells from oneself or from another person into the body of an individual for therapeutic purposes or to correct a morphological alteration.
28. **Healthcare unit**
    A legally authorised facility, whose purpose is the provision of medical or other healthcare services, including general or specialised inpatient facilities, providing medical appointments, examinations and treatments, regardless of its name. It includes hospitals, clinics and centres providing complementary means of diagnosis and therapy.
29. **Hospital Unit**
    A healthcare unit providing permanent medical, surgical and nursing care assistance. It includes inpatient facilities, having operating rooms and recovery rooms.

Use of insurance in healthcare providers and/or care

30. **Hospital Setting**
    A set of infrastructural means, technical, technological and human resources that allow each act to be carried out with quality and safety, including the ability to respond effectively to sudden events that put at risk the life of the insured person, which exist in structures conventionally known as "hospitals" or other synonyms.
31. **Authorisations**
    Approval of payment for healthcare services requested from the insurer's services, inside or outside the agreed network. This authorization can be requested by the insured person and/or healthcare provider
    Without prejudice to the terms set forth in each cover, the following medical acts shall always require prior authorization from the insurer's clinical services:
    - inpatient care;
    - outpatient minor surgery;
    - childbirth, caesarean section and involuntary termination of pregnancy;
    - treatments of:
        - physical medicine and rehabilitation;
        - radiotherapy;
        - chemotherapy;
        - speech therapy.
    - outpatient care:
        - complementary diagnostic tests and medical genetics and/or nuclear medicine therapeutics;
    - the following complementary diagnostic tests:
        - invasive means of diagnosis and therapy in cardiology;
        - invasive means of vascular diagnosis and therapy;
        - polysomnography (if hospitalization is required);
        - nuclear magnetic resonance.
32. **Sum insured**
    Maximum limit of cost-shared health expenses per insured person, defined for each of the coverages contracted under the policy. Each cover may include sub-limits of sum insured for specific expenses under that cover. The sum insured is renewed each policy year.
33. **Health card**
    A personal and non-transferable card in physical and/or digital format belonging to each insured person for using the insurance and with which each healthcare use within the agreed

network is validated. The healthcare provider may require that the insured person's identity document be simultaneously presented

34. Cost-sharing

Amount payable by the insurer for each healthcare expense guaranteed by the policy, as defined in the policy schedule.

35. Co-payment

Amount payable by the insured person for each medical act within the agreed network, as identified in the policy schedule

36. Deductible

Amount of the claim that is not borne by the insurer. It can be a percentage of the claim/sum insured or a fixed amount in euros or days, and can be applicable either per medical act or per annuity. These factors can also be combined: for example, a 10% deductible on each claim, with a minimum of €200 and a maximum of €500. The deductible associated with each cover is set out in the Insurance Proposal and in the Policy Schedule.

37. Waiting period

The period that elapses between the date the insured person adheres to the insurance and the date on which certain covers can be activated or medical acts can be carried out regarding the insured person, in accordance with the terms set out in the policy.

In addition to the terms set out in table of coverage in the Policy Schedule, the following medical acts are subject to an extended 12-month waiting period:

- all expenses related to pregnancy, childbirth, caesarean section or involuntary termination of pregnancy, whether on an outpatient or inpatient basis;
- psychiatric hospitalization;
- prostatectomy for benign pathology and other genitourinary system surgeries for benign pathologies;
- treatment of urogenital prolapse;
- surgical treatment of varicose veins of the lower limbs;
- surgical treatment of herniated discs;
- hemorrhoidectomy, surgical interventions and treatments for benign coloproctological pathology;
- arthroscopies, arthrotomies, meniscectomies and ligamentoplasties;
- treatment of carpal tunnel syndrome, de Quervain's syndrome and *hallux valgus*;
- septoplasty;
- tonsillectomy, adenoidectomy, myringotomies with or without the use of ventilation tubes;
- surgical treatment of duodenal ulcers;
- surgical removal or treatment of benign lesions of the skin and soft tissues, such as nevi, moles, cysts, lipomas, warts and pilonidal disease;
- laser treatments for benign skin lesions;
- all benign otorhinolaryngological pathologies;
- renal and bladder lithotripsy;
- cholecystectomy;
- cataract surgery, vitrectomy and refractive surgery;
- arrhythmology.

38. Claim/Event

The event or series of events which may trigger the policy guarantees.

03. General exclusions - what is not covered

Some facts, situations, actions or events may cause or constitute an illness, injury or possible treatment, but are not covered by the insurance.
The exclusions are divided into:

1. **general - apply to all policy coverage;**
2. **specific - specific to each cover as listed in the "covers you can take out" section;**
3. **individual - result from the medical underwriting process and are set out in the policy schedule and/or a specific document addressed to each insured person.**

Unless otherwise expressly agreed in the Policy Schedule or in any individual document, insurance coverage shall exclude any expenses resulting from:

1. **Accidents resulting from**
   a. **acts of God, acts of war, whether declared or not, terrorism, sabotage or public order disturbances;**
   b. **participation in sports competitions and any practice and training sessions related thereto, both as a professional or amateur;**
   c. **engaging in land-based motorsports; Mountain biking; martial arts, wrestling and boxing; skydiving, including freefall, paragliding and hang-gliding, jumping or inverted jumping with a body suspension mechanism (bungee jumping); bullfighting and bull or cattle stampede; hunting of wild animals or other animals deemed as dangerous; horseback riding; motor boating and water skiing; nautical sports practised on a board; torrent or current rafting resulting from watercourse slopes; diving; spearfishing and underwater hunting; snow and ice sports; mountaineering and climbing; slide and rappelling; speleology;**
2. **accidents and illnesses covered by compulsory insurance, such as accidents at work, accidents on duty and occupational illnesses;**
3. **accidents or illnesses arising from a suicide attempt or self-inflicted injuries, involvement in betting or challenges, participation in confrontations and fights, or commitment of wrongful intentional, serious or unlawful misconduct by the insured person;**
4. **alcoholism and diseases resulting from the consumption of alcoholic beverages, narcotics or toxic products, as well as accidents occurring when the blood alcohol level is higher than the legal limit for driving light-duty vehicles;**
5. **acts carried out by doctors and other health professionals who are spouses or have a first or second degree relationship with the insured person (e.g. siblings, parents, children, brothers-in-law), including any type of prescription by doctors for themselves;**
6. **unjustified delay or negligence attributable to the healthcare provider or the insured person in seeking medical assistance, or the refusal or failure to comply with treatment that has been prescribed;**

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7. consultations and treatments in areas not recognized by the Portuguese Medical Association; save for non-conventional therapies, when contracted, under the terms indicated in the "outpatient care" cover;
8. medical appointments or examinations that are required for issuing any certifications, statements, attestations or information regarding any type of document other than for assistance or therapeutic purposes;
9. consultations, auxiliary diagnostic elements, prescriptions and treatments to assess infertility and all medical acts carried out within the scope of medically assisted reproduction, including, but not limited to, consultations, tests, infertility treatments, artificial fertilization methods, in vitro fertilization or embryo transfer procedures, as well as the consequences of their application, except in the case of life-threatening conditions;
10. consultations, treatments or surgeries of an aesthetic, plastic or reconstructive nature, such as breast augmentations, abdominoplasties or rhinoplasties, unless they result from an accident covered by the insurance or result from a malignant disease manifested during the term of the contract that justifies them, and even in these cases only up to 24 months after the diagnosis of the disease or the date of the accident;
11. correction of congenital diseases or malformations, except for newborns who adhere to the insurance under the terms indicated in this policy;
12. long-term care, understood as clinical services that do not require hospitalization, and can and should be provided in an inpatient unit of their own; as well as hospital care for purely social reasons;
13. travel and/or accommodation, except for the cases provided for in the international critical illness coverage and travel medical assistance;
14. expenses incurred by the person accompanying the insured person, except in the case of inpatient care of minors up to the age of 14 or citizens with congenital or acquired disabilities;
15. infectious diseases, when an epidemic has been declared by the competent authorities, or a pandemic declared by the World Health Organization;
16. diseases or sequelae resulting from radioactivity, including the consequences of the use of bacteriological weapons and/or chemical agents, as well as diseases resulting from the use of solariums, solar chambers or similar and their consequences, unless they result from therapies covered by this policy;
17. pre-existing diseases, injuries or deformities as at the time this policy was taken out - this exclusion only applies when confirmed in the policy schedule;
18. pre-existing diseases, injuries or deformities as at the time this policy was taken out and omitted from the medical underwriting questionnaire;
19. varicose vein sclerotherapy (varicosity drying);
20. examinations, consultations and treatments and/or surgery for weight regularization, whatever the diagnosis giving rise to the indication for these therapeutic interventions, even if it stems from a pathology associated with obesity and related metabolic alterations;

21. gymnastics, swimming, massages and other similar activities, even if prescribed by a medical doctor, except for those resulting from illness or accident falling within the scope of the guarantees provided under the contract;
22. pregnancy or childbirth existing before the start of the policy;
23. voluntary termination of pregnancy, including any medical conditions resulting therefrom;
24. surgical interventions to correct snoring, except in the case of severe apnea and failure of other non-surgical treatments;
25. medicines purchased at a pharmacy or administered outside the scope of inpatient cover, as well as any problem associated with the abuse of prescribed or non-prescribed medicines;
26. contraceptive and family planning methods - including associated examinations and consultations - as well as expenses incurred to reverse the effects of a voluntarily performed sterilization surgery;
27. pathologies or treatments related, directly or indirectly, to human immunodeficiency virus (HIV) infection;
28. any expenses claimed by the National Health Service or by any other health insurance or subsystem of which the insured person is a beneficiary, except for moderating fees or the excess not reimbursed, and may never exceed the value of the total expense;
29. any sexual dysfunctions, including treatment of impotence and erectile dysfunction, except as result of an illness guaranteed by the policy that has objectively caused the same;
30. services that are not medically necessary, given the clinical condition of the insured person and in accordance with the protocols and standards recognized by the medical community;
31. sessions of psychology, psychoanalysis, psychotherapy, hypnosis and sleep therapy, as well as hospitalizations associated with mental health disorders, whether or not they are the result of another illness, except when they fall within the scope of mental health coverage;
32. organ transplants, as a donor or recipient; except for cases covered by international critical illness coverage;
33. private and/or home nursing treatments, as well as any examinations or treatments (including physiotherapy) carried out at home, except those carried out as part of home hospitalisation previously authorized by the company;
34. chronic hemodialysis treatments;
35. treatments and/or surgery for gender reassignment or relating to any treatment for gender disorders, as well as complications and consequences thereof;
36. treatments performed in facilities that are not authorised to provide healthcare services;
37. treatments related to drug addiction;
38. thermal treatments and stays in thermal facilities, sanatoriums, nursing homes, assisted-living residences, rest and recovery homes, long-term care facilities,

drug addiction and/or alcoholism treatment facilities, as well as other similar facilities;

39. treatments, procedures and medicines of an experimental nature or that require medical proof;
40. use of narcotics and narcotic drugs that have not been prescribed by a medical doctor.

04. Territorial scope

Unless otherwise agreed in the special conditions or in the policy schedule, the insurance is only valid for health care provided in Portugal, except for international critical illness coverage, extension abroad and travel clinical assistance covers, when contracted, in which case the provision is always carried out outside Portuguese territory.

Chapter 2. Initial risk declaration, start and term of the policy

05. Initial risk declaration

Before executing the contract and at any time during its term, the policyholder and the insured person must inform the insurer of any relevant factors with regard to the risk being insured on a reasonable basis, even where no specific questionnaire has been made.

06. Wilful breach

Where this duty to inform is breached intentionally, the insurer is entitled to cancel the policy according to the law.

07. Negligence

If the breach occurs as an exclusive result of negligence, the insurer is entitled to elect to terminate or amend the policy, according to the law.

08. Start of the policy

The policy starts at 00:00 on the day specified in the policy schedule and takes effect when the following conditions are met:

- **the insured persons have been accepted by the insurer, following the respective underwriting process. The insurer has 14 days to decide on the acceptance of each insured person from the date of receipt of the insurance proposal. In the meantime, you can accept or reject the risk and request additional information. In the absence of a reply within this period, the risk is deemed to have been accepted;**
- **the premium or fraction thereof has been paid to the insurer by the due date.**

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09. Policy renewal

This policy is an annual insurance contract and is automatically renewed every year, up to the limit of permanence applicable to the insured persons established in the policy schedule.

10. Start of coverage

Coverage under this policy shall take effect after the lapse of the respective waiting period, set forth in the Policy Schedule, provided that the waiting period shall not apply in the event of an accident or sudden illness.

11. Coverage time-limits

The insurer only covers the payment of the agreed benefits or expenses incurred in each year of the contract, without prejudice to non-renewal or insured person coverage provisions.

12. Changes to the policy

12.1. By the insurer

Changes to coverage in any of its components by the insurer must be made on the policy annual expiry date and notice given to the policyholder at least 30 days in advance, provided that the policyholder shall be entitled a 30-day period to accept or refuse the change. In case of lack of reply and payment of the respective premium (or fraction thereof) for the following annuity, the changes are deemed as accepted. In case of refusal, the policy must be cancelled on the annual expiration date. Note: Rate changes associated with the age of the insured person are not deemed a change to the policy.

12.2. By the policyholder

The inclusion of insured persons must be preceded by the underwriting process with the insurer, and they are only considered covered by the policy upon acceptance of the risk. The waiting periods associated with the respective covers apply to insured persons included in the policy as from the date of their inclusion.

The inclusion of newborns can be requested from the insurer no later than 30 days after birth, effective as from that date, and no waiting period or exclusion of congenital malformations applies to the newborn.

The exclusion of persons must be requested at least 30 days before the policy expiry date, taking effect thereafter. The insurer shall return the premium *pro rata temporis* over the unexpired period.

12.3. Non-transferable

The policy is not transferable to third parties and the title shall remain until it ceases pursuant to the established conditions.

13. Termination of the policy

The policy terminates at the end of the insurance contract, according to the following events defined by law:

13.1. Withdrawal

The policyholder may exercise the right of withdrawal, without the need to invoke any grounds, within 30 days from the date of receipt of the specific policy conditions. To exercise this right, the policyholder shall notify the insurer by means of an explicit communication delivered on a durable and accessible medium, sent to the address Rua da Mesquita, No. 6 – 1070-238 Lisboa, or to the email address gestaorisco-aegonsantander@aegonsantander.pt. Termination of the contract under these terms entitles the insurer to retain the portion of the premium corresponding to the period during which it bore the risk, as well as to recover any reasonable expenses incurred in connection with medical examinations, insofar as such costs are contractually attributable to the policyholder.

The right of withdrawal may likewise be exercised in respect of insurance policies remotely sold, within 14 days from the date of receipt of the specific policy conditions. In such cases, where risk coverage has commenced before the expiry of the withdrawal period, the insurer shall be entitled to retain the portion of the premium corresponding to the period during which it bore the risk and to recover any reasonable expenses incurred in connection with medical examinations, insofar as such costs are contractually attributable to the policyholder.

13.2. Waiver

The policyholder may also cancel the insurance contract without cause within 30 days as from receiving the policy schedule, by written notice on paper or on another durable medium available and accessible to the insurer, who shall remain entitled to receive the premium referring to the period during which the risk was covered before the cancellation.

13.3. Termination for cause

The contract may be terminated for cause by the parties at any time, under the general terms, upon reasoned notice of termination by registered mail. The contract is deemed terminated within a maximum of eight working days from receipt of the notice.

No return premium shall be due to the policyholder where the law states that the insurer may keep the premium paid.

13.4. Agreement

The contract can be cancelled at any time by agreement between the parties.

13.5. Failure to pay the premium

Failure to pay the initial insurance premium or first instalment thereof on its due date shall automatically cause the termination of the contract from the date on

which it was executed. Lack of payment shall automatically cause the termination of the contract as from the due date of:

- **the instalment of the premium over the course of an annuity;**
- **an additional premium resulting from a modification of the contract based on the supervening aggravation of the risk.**

In this case, the insurer shall notify the policyholder of the cancellation of the insurance contract with at least 8-day's prior notice. The policyholder is entitled to reinstate the insurance contract in force under the original conditions and without the need for risk reexamination within 10 days from cancellation. The reinstatement request must be accompanied by payment of the relevant premium.

13.6. Expiry

The policy expires for each insured person who reaches the age limit set out in the policy schedule.

14. Liability of the insurer for non-renewal of the policy

Where the insurer elects not to renew the policy or not to include an insured person, and the risk is not covered by another policy, it must ensure for a period of no less than two years the benefits resulting from a manifest illness or other event occurring during the term of the policy, provided that they are covered by the insurance provided that the sum insured of the annuity prior to non-renewal is not exhausted.

The insurer must be informed of the illness or event referred to in the previous clause within 30 days of non-renewal, unless there is a justifiable impediment. Without prejudice to the maintenance of coverage during this period, any authorizations issued by the insurer before the policy expires are immediately void.

Chapter 3. Coverage and obligations of the parties

15. How covers are used

How the insurer provides services

The guarantees of this policy can be used in the form of benefits in the agreed network, reimbursement or mixed, or through access to the network. These different modalities are related to the contracted coverage.

Access to the agreed network

Provision of services guaranteed by the insurance contract, carried out by a specific national network of healthcare providers, which may change over time, to which the insured person has access under favourable price conditions compared to healthcare providers outside the agreed network. In this modality no co-sharing is due by the insurer and no co-payments, waiting periods or deductibles apply.

Benefits in the agreed network

Services guaranteed under the insurance contract, which are rendered by providers within the agreed network, regarding which the cost-sharing is guaranteed directly by the insurer and the insured person bears the payment of deductibles and/or co-payments, whose access is subject to the usage criteria as defined by the Insurer, including authorization for acts and procedures under the terms of the policy. In the event of access to the network without identification via access card or without authorization from the insurer, the insurer will be reimbursed, as specified in the following paragraph.

Reimbursement benefits, outside the agreed network

Health care expenses outside the agreed network guaranteed under the policy, subject to prior approval by the insurer that are paid by the insured person and subsequently reimbursed by the insurer, under the terms and in the percentage stated in the policy. The amounts to be reimbursed are subject to the "K" coefficient, i.e. the parameters for valuing medical-surgical acts according to the table of relative values established by the Portuguese Medical Association in the Code of Nomenclature of Relative Values of Medical Acts, and may never exceed the sum insured of the respective cover, as indicated in the Policy Schedule.

16. Obligations of the insurer

The insurer shall fully comply with the obligations regarding the benefits covered by the policy, in particular:

16.1. Access to the agreed network

By timely providing the access card allowing for immediate access to the agreed network, without prejudice to the waiting periods associated with each cover. This access is personal and non-transferable.

16.2. Authorization processing

The insurer shall not take more than five working days to process a request for authorization required for any medical act, as from the date it has received all of the elements required for analysis.

16.3. Reimbursement of expenses incurred

The insurer shall not take more than 30 working days to reimburse eligible expenses, upon determining its responsibility and the reimbursable amounts under the policy. Where the insurer has obtained all requested information to make the reimbursement and has exceeded this deadline, it shall incur default interest at the legal rate in force.

17 Obligations of the policyholder/insured person

Regarding a claim covered by this policy, the insured person shall:

17.1. Avoid the aggravation of the claim

The insured person must take all reasonable measures within their power to limit and/or control the worsening of the illness and/or injury prior to the relevant medical intervention, and report the claim to the insurer within eight days of its occurrence. The insurer may not be held liable for any consequences of any delay or negligence in

seeking assistance for which the insured person is liable, or if the latter refuses to adhere to the prescribed treatment.

17.2. Carry out the medical exams requested by the insurer

If the doctor(s) indicated by the insurer order(s) certain medical examinations, the insured person must make themselves available to carry them out in the exact terms requested, and the insurer's liability will cease if they fail to do so.

17.3. Provide information requested by the insurer

Following a claim for the provision or reimbursement of health care under the insurance contract, the insured person must authorize the medical doctors and other healthcare professionals or facilities which they have used to provide the medical doctor appointed by the insurer with the information requested by the latter regarding their medical condition and the clinical services provided.

17.4. Provide the insurer with proof of expenses regarding reimbursements

The insured person or policyholder must submit the original receipts for the expenses incurred under the reimbursement method within 365 days from the date they were incurred. If expenses are submitted on the website, in the respective certified customer area, the presentation of the originals is waived in the terms set out therein and if they have been expressly accepted by the insured person.

In cases where the originals have previously been delivered to another entity for reimbursement purposes, the insurer will accept photocopies thereof, provided that they are accompanied by documentary evidence from that entity stating the total expense and the amount that has been reimbursed. Where the insured person must submit the expense to another entity after being reimbursed under this policy, they must provide copies of the originals, accompanied by the same declaration to be issued by the insurer at their request.

Under no circumstances may the total reimbursement exceed the total amount of the expense.

17.5. Lost card or access number:

Any loss or misplacement of the health card must be immediately reported to the insurer and/or provider so that it can be annulled and a duplicate issued.

The policyholder and/or the insured person shall be liable under the law for damages in cases of fraud, misrepresentation and false statements to justify health expenses or any other use of fraudulent means aimed at misusing the policy to obtain an illegitimate benefit.
The insured person bears the burden of proving the veracity of the declarations, and the insurer may demand the appropriate means of proof that are available to it.

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18. Coverage features

18.1. Available covers:

The covers you can take out are listed in the relevant section of this document, which details their meaning and specific exclusions. The covers that are effectively contracted are set forth in the Policy Schedule.

18.2. Other features of the covers:

In addition to the specific exclusions, each cover may include amounts relating to:

- **deductible;**
- **co-payment;**
- **waiting period;**
- **sum insured;**
- **capital sub-limits;**
- **cost-sharing percentage outside the agreed network.**

These concepts are set out in the "Definitions" section and may have different values for each cover and are specified in the policy schedule.

Chapter 5. Premium

19. Premium

This is the amount payable by the policyholder to the insurer for the provision of the insurance service. Each year, the insurance premium is calculated according to the tariff in force. An issuance fee will be added to the premium indicated in the simulation, charged only once with the first receipt. The premium is paid by direct debit.

20. Update

If there is no risk change, any update of the premium applicable to the contract may be made on the next annual due date.

Upon contract renewal, the premium shall be updated by the insurer according to the technical and actuarial criteria on the basis of the tariff.

21. Maturity

The premium matures annually and is due on the date the contract is signed and paid in advance.

The premium may be paid in: monthly, quarterly, biannual or annual instalments. Payment modalities other than monthly instalments may be subject to discounts.

The premium is due on the start date of each relevant period as indicated in the receipt, regardless of any split up.

The part of the premium corresponding to any contract change is due on the date of the respective change. If the premium is not duly paid, the policy shall remain in force without taking into account the change to which the additional premium relates, unless the nature of the change renders impossible keeping the policy in force, which shall cause the termination thereof.

22. Payment notice

During the term of the contract, the insurer shall give notice in writing to the policyholder or the insured person if it has been agreed that they pay the premium

directly to the insurer of the amount to be paid, and the method and place of payment, no less than 30 days before the date the premium or fractions thereof are due.

The notice shall expressly state the consequences of non-payment of the premium or fraction thereof.

Where the premium of an insurance contracts is paid in quarterly instalments or shorter and the contractual documentation states the due dates of the successive instalments of the premium and the respective amounts to be paid, including consequences for lack of payment, the insurer may choose not to give the said notice, in which case it must prove that the contractual referred documentation has been issued, accepted and sent to the policyholder.

23. Failure to pay the premium

If the premium is not paid by the due date, the insurer is entitled to cancel the policy and refuse to pay expenses incurred after that date.

Chapter 6. Miscellaneous

24. Role of the insurance agent

No insurance agent shall be deemed authorized to conclude or terminate insurance contracts, to contract or amend the obligations arising therefrom or to validate additional declarations, on behalf of the insurer, except as provided in the following paragraphs.

An insurance agent to whom the insurer has given the necessary powers in writing may conclude insurance contracts, contract or amend the obligations arising therefrom or validate additional declarations on behalf of the insurer.

Notwithstanding the lack of the insurance agent's specific powers, the insurance is deemed effective if there was reasonable justification, taking into account the circumstances of the case, for the policyholder to trust in good faith in the legitimacy of the insurance agent, provided that the insurer has also contributed to establishing the policyholder's trust. In order to carry out this activity, the insurance agent must be registered with the Insurance and Pension Funds Supervisory Authority.

25. Communications and notices between the parties

The communications or notifications from the policyholder and the insured person provided for in this policy are deemed valid and effective if made in writing to the insurer's address - Avenida José Malhoa, 22 - 1070-159 Lisboa - or by email to aegonsantander@aegonsantander.pt.

The insurer must send the communications provided for in this contract if the recipient is duly identified, which shall be considered valid if sent to the address provided to the insurer.

Any change of address and contact details of the policyholder and the parties to the contract must be communicated to the insurer no later than thirty (30) days after the date on which it occurred, failing which any communications or notifications made by the insurer shall be deemed valid and effective.
The written communications that the insurer addresses to the parties under this contract or in compliance with any legal or regulatory provision will be provided in digital format, by sending a

message to the cell phone, or to the e-mail address indicated by the policyholder in the insurance contract, or through the reserved access area on the insurer's website (www.aegon-santander.pt).

In the event of multiple insured persons, the insurer's communications will be made in the name of the first holder, taking into account the contact details provided by the latter.

Without prejudice to the forms of communication provided for specific situations in these general conditions, the insurer may also use other means of communication, such as telephone, e-mail, express mail or similar service providers.

The preceding paragraphs shall not prevent the insurer from sending communications by post to the tax address or any other address provided by the policyholder or the insured person.

The insurer shall not be liable for delays, shortcomings, misdirection of correspondence, interruptions or other anomalies resulting from the use of mail or other means of communication, nor for the delivery of information or items addressed by it to the policyholder, the insured person or third parties at a place or to a person other than the addressee, unless such anomalies demonstrably result from its fault.

Without prejudice to the previous paragraphs, the policyholder may always request that any communication or information be sent by post or made available on paper.

26. Complaints

Complaints from the policyholder, the insured person or injured third parties must be submitted to the regulator or directly to the insurer, in writing or by any means of communication, by email to qualidade-aegonsantander@aegonsantander.pt or by post addressed to the Customer Care and Compliance Department of Aegon Santander Portugal Não Vida, S.A. at Avenida José Malhoa, 22 - 1070-159 Lisboa. Complaints must contain information relevant to their management, including at least the elements specified at **https://www.aegon-santander.pt/gestao-de-reclamacoes/.**

The Customer Care and Compliance Department of Aegon Santander Portugal Non-Life undertakes to analyse and reply to complaints within a maximum of 20 working days after receiving them. The process of replying to any complaint does not preclude or prejudice resorting to the courts, the intervention of the regulatory body (the Insurance and Pension Funds Supervisory Authority), or the intervention of the Customer Ombudsman.

The intervention of the Customer Ombudsman is justified when there are complaints previously submitted to the Insurance Company which have not been answered within a maximum of 20 days (the period to be considered is 30 days in particularly complex cases) or when, having been answered, the complainant disagrees with the response. The Customer Ombudsman's contact details are available at **https://www.aegon-santander.pt/gestao-de-reclamacoes/.**

Aegon Santander Portugal Non-Life has a Treatment Policy which can be consulted at **www.aegon-santander.pt**and is available in hard copy on request.

The complainant may also lodge a complaint with the Insurance and Pension Funds Supervisory Authority, provided that the complaint has previously been submitted to the insurer and has not been resolved within a maximum of 20 working days from the date of receipt or when, having been given an answer, the complainant disagrees with its meaning. You can find more information at **https://www.aegon-santander.pt/gestao-de-reclamacoes/.**

27. Legal or mandatory clauses

The following mandatory clauses apply to this policy:

27.1. Agreement regarding the place of performance of the obligation

The parties expressly agree that the obligations under this contract shall be performed in Portugal, specifically at the insurer's head office.

27.2. Governing Law

This contract shall be governed by the Laws of Portugal.

27.3. Jurisdiction

The competent jurisdiction for resolving disputes arising from this contract shall be that established under civil law.

27.4. Alternative dispute resolution

Considering that the policyholder is a consumer within the meaning of Law 144/2015, of September 8, in case of a dispute regarding this policy, they may resort to alternative dispute resolution for consumer disputes with recognized bodies. General information on Portuguese arbitration bodies is available at **https://www.aegon-santander.pt/informacoes-relevantes-para-o-cliente/**.

The insurer's adherence to arbitration is bound by the existing legal provisions with regard to compulsory adherence, and is on a case-by-case basis in other cases.

27.5. Tax regime

This contract is subject to the tax regime laid down by law at any given time, and the insurer will not be subject to any burdens, charges or liabilities as a result of legislative changes.

27.6. Report on solvency and financial status

This report is available for consultation by the policyholder on the Aegon Santander Portugal website: **https://www.aegon-santander.pt/relatorios/.**

27.7. Subrogation

Once the benefit has been paid, the insurer is subrogated, up to the amount of the benefit, to all the rights of the insured person against the third party liable for the damage. The insured person shall act to the extent necessary to guarantee this right, and shall be liable for any loss or damage resulting from voluntary acts or omissions that may prevent or prejudice the exercise of this right.

27.8. Third-Party Effectiveness

Any exceptions, ineffectiveness and other provisions which, in accordance with the contract or the Law, may be relied on against the policyholder or the insured persons may also be relied on against any third parties benefiting therefrom.

27.9. Claim set-off

When paying any amount under this contract, the insurer may, where permitted by law, deduct any amount it is owed by the policyholder or the insured person.

28. Additional information specific to distance contracting

This section is intended to comply with the obligation to provide additional and specific pre-contractual information for distance contracting, in strict compliance with article 11 et seq. of Decree-Law no. 95/2006, of May 29. We therefore inform you that:

- the amount of the premium to be paid by the consumer, including any taxes or other costs, is as stated in the policy schedule;
- the consumer incurs no additional cost for using remote means of communication;
- the information provided is valid for one month;

- payment will be made by bank domiciliation, through the bank account listed in the policy schedule;
- the consumer has the right to withdraw under the terms mentioned in the "Termination of the policy" section;
- until expiry of the 14-day period for exercising the right of withdrawal, the consumer has no obligation to pay the premium corresponding to the period during which the insurer bore the risk;
- failure to exercise the right of withdrawal within the aforementioned 14-day period implies that it can no longer be exercised and, consequently, the rights that would derive from its exercise can no longer operate;
- the insurer establishes relations with the consumer under Portuguese law, which is therefore the law applicable to the distance contract;
- the courts of competent jurisdiction to settle any disputes arising from this distance contract shall be as provided for in civil law;
- the minimum duration of the distance contract is one year;
- the rights of the parties with regard to early or unilateral termination of the distance contract and any resulting penalties are set out in the "Termination of the policy" section;
- out-of-court dispute settlement access and means are set out in points 13 and 14 of these insurance conditions.

29. Personal data

29.1. The personal data of the policyholder, the insured person and the beneficiaries are processed by the insurer Aegon Santander Portugal Non-Life, which, as the entity responsible for this data processing, may collect, store, interconnect and, in general, process, by computer or otherwise, the personal data (including health data) provided, as well as others that the insurer lawfully obtains, for the purposes identified in the Insurance Proposal.

29.2. Personal data may be processed by the insurer, depending on the type of contract and/or holders, for the following purposes:

i. contractualisation and management of the contract, even in the context of pre-contractual relations or subsequently, including premium collection operations, renewal management, communications regarding services inherent to the insurance contracted and claims management. The lawfulness of these purposes is based on the performance of the contract and pre-contractual procedures, as well as the consent of the data subjects when health data is being processed;

ii. claims management, the lawfulness of which is based on the performance of the contract, as well as the consent of the data subjects where the processing of health data is concerned;

iii. quality control (through satisfaction surveys) and marketing operations in relation to services, promotional offers and products marketed by Aegon Santander Portugal (this being a legitimate interest of the insurer, in order to gauge the level of quality of the services and present the holders with new products and proposals that may benefit them);

iv. compliance with legal obligations.

29.3. The insurer may carry out automated processing for the purposes of risk assessment, inherent to the establishment and maintenance of commercial relations between the policyholder and/or the insured person(s) and the insurer or any other companies with which it may enter into reinsurance contracts. Individual decisions based exclusively on automated processing comply with the provisions of Article 22, paragraphs, 2 and 3 of the General Data Protection Regulation. For the purposes of contract management and quality control, and with the prior consent of the

holders, the insurer may record telephone calls, under the terms and within the limits set out in the applicable law and regulations.

29.4. The personal data processed may be communicated to other companies with which the insurer has subcontracted services, to entities with which it may enter into reinsurance contracts or to other companies that are directly or indirectly in a control or group relationship with the insurer, solely for purposes strictly related to this contract. Personal data may also be communicated to third parties (namely administrative, judicial and supervisory bodies) in order to comply with legal obligations. In cases of communication to third countries, the insurer will guarantee an adequate level of protection for your data, through a contractual instrument in accordance with clauses adopted by the European Commission.

29.5. Under the applicable law, the data subject of the processed data has the right to, from time to time, request and obtain, directly or through a legally constituted representative, access to all the information recorded, as well as to request its updating, restriction, elimination or opposition to the purpose of marketing or quality control, and for this purpose must send a written communication by e-mail to aegonsantander@aegonsantander.pt. You can also withdraw any consents given to the insurer in the same way (to the extent that this does not affect the performance of the contract) and exercise the right to portability of your data (for you or an expressly identified entity), with regard to the automated data provided by you and which concerns you, and insofar as this does not affect the rights and freedoms of third parties. The exercise of the right to delete or limit data for the purposes of contractualisation and management of the contract and claims management, during the term of the insurance contract, which prevents its regular management, will result in its termination.

29.6. The personal data collected will be kept after the end of each insurance contract, until the end of the respective legal limitation period or until the end of the claim or claim management process if longer than the former, with the exception of data that must be kept for a longer period under the law.

29.7. Aegon Santander Portugal Não Vida, as data controller, can be contacted via e-mail at aegonsantander@aegonsantander.pt and/or via its Data Protection Officer at dpo@aegonsantander.pt. You can also lodge complaints with the legally established Supervisory Authority.

29.8. The data provided must be complete and accurate, and its absence or inaccuracy will prevent the insurance contract from being concluded and maintained.

29.9. For more information on the processing of personal data, see the Privacy Policy available at **https//www.aegon-santander.pt/politicas**.

SPECIAL CONDITIONS

Covers that you can take out

The insurance allows you to take out a set of covers in the same policy, from among several options. Each of these covers has its own characteristics regarding its use, as well as specific exclusions solely applicable to that cover. **In addition, they may include a capital limit, deductibles, cost-sharing percentage, waiting periods, co-payments, among other features indicated in the policy schedule.**

The covers effectively contracted are set out in the policy schedule of this policy.
The covers are subscribed to in the insurance proposal, and can also be added to the policy at a later date. In both cases, **coverage is subject to acceptance by the insurer** and can only be used once it has been included in the policy schedule and/or addenda, provided that the respective waiting period has elapsed.

01. Inpatient care

Cost-sharing scheme: in-network and out-of-network

What is covered

The following expenses are covered if they require the specific means and services of an inpatient environment:

- accommodation and use of the infrastructures required to perform any medical acts (daily rates, operating room, recovery room, intensive care unit and equipment), including outpatient surgery, under the terms set out in the "Definitions" section;
- doctors' and nursing care fees related to the assistance provided;
- medicines, materials and all products associated with the care provided;
- complementary diagnostic tests associated with the medical acts performed;
- osteosynthesis material and intra-operative prostheses (implantable medical devices);
- stomatological, dental and maxillofacial surgery resulting from an accident and/or illness covered by the contract;
- cytostatic chemotherapy and radiotherapy treatments, even if carried out on an outpatient basis, are considered to be isolated claims or occurrences.

Regardless of whether the hospitalization takes place inside or outside the network, medical fees are limited to the amount per "K".

What is not covered

In addition to the general exclusions, this cover does not cover expenses arising from

a) **stomatological or maxillofacial surgery, except if it is the result of an illness manifested during the term of the contract or of an accident requiring emergency treatment in hospital, either on an inpatient or outpatient basis, covered by this contract and occurring during its term;**
b) **perfusionist costs, except during cardiothoracic surgery;**
c) **normal childbirth, caesarean section and involuntary termination of pregnancy;**
d) **prostheses and stomatological implants;**

e) **breast augmentation or reduction and consequences thereof, regardless of the surgical indications or removal of breast prosthesis material, except in the case of justification for underlying secondary pathology;**
f) **non pre-authorized complementary tests carried out on the newborn (e.g. otoemissions);**
g) **resulting from minor surgery, regardless of the length of stay in the hospital;**
h) **persons accompanying the insured person, except in the case of insured persons under the age of 14 or those with congenital or acquired disabilities in inpatient care;**
i) **accommodation, per diem or any personal expenses.**

02. Childbirth and involuntary termination of pregnancy

Cost-sharing scheme: in-network **and** out-of-network

What is covered

This sub-cover is part of the inpatient cover and the costs are deducted from the respective sum insured. It guarantees, under the terms and limits set out in the policy schedule, the payment of expenses incurred with diagnostic or therapeutic acts, inherent to childbirth and involuntary termination of pregnancy that require the specific hospital-setting means and services.
This sub-coverage covers expenses incurred with:

- accommodation and use of the infrastructures required to perform any medical acts (daily rates, operating room, recovery room, intensive care unit and equipment), including outpatient surgery, under the terms set out in the "Definitions" section;
- doctors' and nursing care fees related to the assistance provided;
- medicines, materials and all products associated with the care provided;
- auxiliary examinations associated with the medical acts performed.

After the mother's discharge, medical expenses for the newborn are only guaranteed if the policyholder asks the insurer to join within 30 days of the birth. Once the newborn has been included as an insured person, the corresponding premium will be due from the date of birth.

What is not covered

In addition to the general exclusions, this sub-cover does not cover expenses:

a) **associated with voluntary termination of pregnancy;**
b) **personal expenses;**
c) **related to persons accompanying the insured person.**

03. Outpatient care

Cost-sharing scheme: in-network **and** out-of-network

What is covered

This cover guarantees, under the terms and limits set out in the Policy Schedule, the payment of expenses incurred with diagnostic or therapeutic acts which do not require the specific hospital-setting means and services, even if so performed.
This cover covers expenses incurred with:

- medical fees related to appointments;
- medical and nursing fees for other medical acts carried out on an outpatient basis, including minor surgery, regardless of the length of stay in the hospital;
- material and equipment associated to medical acts carried out an outpatient basis;

- complementary diagnostic tests;
- physical medicine and rehabilitation treatments, including speech therapy, which have been prescribed by a doctor and whose need arises directly from an illness or accident covered by this policy and provided that they have been contracted under this insurance. These expenses have a sub-limit as set out in the policy schedule;
- expenses incurred with fees within the scope of legally approved non-conventional therapies (under the terms of Law 71/2013, of September 2, or any other equivalent that may precede it), such as:
    a) acupuncture;
    b) homeopathy;
    c) osteopathy;
    d) traditional Chinese medicine;
    e) naturopathy;
    f) phytotherapy;
    g) chiropractic.

These expenses have a sub-limit as set out in the policy schedule.

What is not covered

In addition to the general exclusions, this cover does not cover expenses relating to

a) surgery carried out in a hospital setting, as defined in the inpatient cover;
b) any dental appointments, treatments, surgeries, prostheses, and orthoses;
c) prosthetic and orthotic devices;
d) medicines or any products for therapeutic purposes;
e) physiotherapy as a result of chronic illnesses;
f) speech therapy not prescribed by a doctor or whose need does not arise exclusively from accidents or diseases covered by this policy.

04. Dentistry, prosthetic and orthotic devices

Cost-sharing scheme: in-network **and** out-of-network

What is covered

This cover guarantees, under the terms and limits set out in the policy schedule, the payment of expenses incurred with diagnostic or therapeutic acts in the field of stomatology and with prostheses or orthotics duly prescribed by a specialist doctor, namely and respectively, by a stomatologist and optometrist or orthoptic technician.

Included are the following expenses, excluding any other:

- medical fees;
- complementary diagnostic tests;
- dental (except implant-supported prostheses), hearing and orthopaedic protheses;
- frames with lenses;
- prescription lenses (whether contact lenses or otherwise);
- wheelchairs, articulated beds, canes and other auxiliary equipment;
- material and all products associated to performed medical acts.

For this cover, the first specialist consultation carried out in the Medical Network includes a record of the clinical situation for each insured person, resulting in an observation form being drawn up for the insurer's records.

Procedures

With regard to ophthalmic orthotics, the cover provided by this policy is accepted by the insurer by applying the following procedures:

- the first lenses expense submission will only be reimbursed when accompanied by the respective prescription from a doctor, optometrist or orthoptic technician. in the following submissions, cost-sharing of expenses will only be made when the correction is changed in relation to the previous prescription;
- frames may only be reimbursed when purchased together with the eye lenses, provided that the latter are also reimbursable;
- the shelf life of frames and lenses is considered as three years, after which they become reimbursable, including if the correction from the previous prescription is not changed. This shelf life does not apply to disposable contact lenses;
- for children under 16, frames and lenses may reimbursed without such change occurring, and before the three-year period have elapsed, provided that the medical prescription expressly requires the need to change glasses as a result of their growth;
- cases of theft, robbery, loss or breakage of glasses or lenses shall never be considered, except when resulting from an accident guaranteed by the insurance, provided that the respective claim is accompanied by a document proving the physical injuries caused to the insured person, prepared by the Doctor or hospital unit who provided assistance.

Eye orthoses are subject to an annual sub-limit, which is set out in the policy schedule.

What is not covered

In addition to the general exclusions, this cover does not cover expenses relating to:

a) inpatient care;
b) orthodontic appliances and related molds and studies (including specific imaging) and control consultations, unless orthodontics is included in the policy schedule;
c) treatments made using precious metals;
d) rehabilitation of missing teeth or those already subject to prosthetic rehabilitation at the execution date of the agreement;
e) stomatological implants, including all the necessary clinical and laboratory procedures, namely the pre-prosthetic bone regeneration phase, the surgical phase (placement of dental implant and dental implant per se) and the prosthetic phase (crown on implant), including the connection system (magnetic, cemented or screwed);
f) treatments of a purely aesthetic nature, such as bleaching;
g) theft, robbery, loss or breakage of glasses or lenses, except when resulting from an accident guaranteed by the insurance, provided that the respective claim is accompanied by a document proving the physical injuries caused to the insured person, prepared by the Doctor or hospital unit who provided assistance;
h) orthopaedic footwear (only material intended for correction or insoles is covered);
i) medical and orthopaedic girdles, elastic stockings and rest socks, orthopaedic and anti-bedsore mattresses and pillows;
j) brachial suspensions and cervical collars (except for post-surgical situations or as a result of an accident);
k) humidifiers and similar equipment, as well as air conditioning equipment or air purifiers;
l) any prosthesis or orthotic whose purpose is only aesthetic and not functional;
m) myogenic or bioelectric prostheses or electronic implants;
n) wigs, even if their use is considered necessary during chemotherapy treatment;

o) other equipment classified as technical aid;
p) frames without lenses;
q) sunglasses, including frames and lenses, whether graduated or not.

05. Dentistry

Cost-sharing scheme: in-network **and** out-of-network

What is covered

This cover guarantees, under the terms and limits set out in the policy schedule, the payment of expenses incurred with diagnostic or therapeutic acts in the stomatological field.
Included are the following expenses, excluding any other:

- medical fees;
- complementary diagnostic tests;
- dental cleanings;
- dental prostheses (except implants);
- X-ray;
- material and all products associated to performed medical acts.

What is not covered

In addition to the general exclusions, this cover does not cover expenses relating to:

a) inpatient care costs;
b) orthodontic appliances and related molds and studies (including specific imaging) and control consultations;
c) Stomatological implants, including all the necessary clinical and laboratory procedures, namely the pre-prosthetic bone regeneration phase, the surgical phase (placement of dental implant and dental implant per se) and the prosthetic phase (crown on implant), including the connection system (magnetic, cemented or screwed);
d) treatments made using precious metals;
e) rehabilitation of missing teeth or those already subject to prosthetic rehabilitation at the execution date of the agreement;
f) treatments of a purely aesthetic nature, such as bleaching.

06. Prosthetic and orthotic devices

Cost-sharing scheme: in-network **and** out-of-network

What is covered

This cover guarantees, under the terms and limits set out in the policy schedule, the payment of expenses incurred with prostheses or orthotics duly prescribed by a specialist doctor, namely and respectively by a stomatologist and optometrist or orthoptic technician.
Included are the following expenses, excluding any other:

- medical fees;
- complementary diagnostic tests;
- hearing aids and orthopaedic prostheses;
- frames with lenses;
- prescription lenses (whether contact lenses or otherwise);
- wheelchairs, articulated beds, canes and other auxiliary equipment;
- material and all products associated to performed medical acts.

For this cover, the first specialist consultation carried out in the Medical Network includes a record of the clinical situation for each insured person, resulting in an observation form being drawn up for the insurer's records.

Procedures

With regard to ophthalmic orthotics, the cover provided by this policy is accepted by the insurer by applying the following procedures:

- the first lenses expense submission will only be reimbursed when accompanied by the respective prescription from a doctor, optometrist or orthoptic technician. in the following submissions, cost-sharing of expenses will only be made when the correction is changed in relation to the previous prescription;
- frames may only be reimbursed when purchased together with the eye lenses, provided that the latter are also reimbursable;
- the shelf life of frames and lenses is considered as three years, after which they become reimbursable, including if the correction from the previous prescription is not changed. This shelf life does not apply to disposable contact lenses;
- for children under 16, frames and lenses may reimbursed without such change occurring, and before the three-year period have elapsed, provided that the medical prescription expressly requires the need to change glasses as a result of their growth.

Eye orthoses are subject to an annual sub-limit, which is set out in the policy schedule.

What is not covered

In addition to the general exclusions, this cover does not cover expenses relating to:

a) inpatient care costs;
b) theft, robbery, loss or breakage of glasses or lenses, except when resulting from an accident guaranteed by the insurance, provided that the respective claim is accompanied by a document proving the physical injuries caused to the insured person, prepared by the Doctor or hospital unit who provided assistance;
c) orthopaedic footwear (only material intended for correction or insoles is covered);
d) medical and orthopaedic girdles, elastic stockings and rest socks, orthopaedic and anti-bedsore mattresses and pillows;
e) Orthodontic and stomatological prosthesis costs;
f) brachial suspensions and cervical collars (except for post-surgical situations or as a result of an accident);
g) humidifiers and similar equipment, as well as air conditioning equipment or air purifiers;
h) any prosthesis or orthotic whose purpose is only aesthetic and not functional;
i) myogenic or bioelectric prostheses or electronic implants;
j) wigs, even if their use is considered necessary during chemotherapy treatment;
k) other equipment classified as technical aid;
l) frames without lenses;
m) sunglasses, including frames and lenses, whether graduated or not.

07 Medicines

Cost-sharing scheme: out-of-network

What is covered

This cover guarantees, under the terms and within the limits set out in the Policy Schedule, the reimbursement of expenses incurred by the insured in the purchase of the following medicinal products::

a) medicinal products prescribed by a physician;
b) medicinal products registered with INFARMED, irrespective of their tax status;
c) vaccines not excluded, below;
d) compounded medicinal products prepared in accordance with legally established good practices.

What is not covered

In addition to the General Exclusions, this cover shall not provide reimbursement for expenses relating to

a) medicinal products for the treatment of obesity (including morbid obesity and its consequences);
b) medicinal products for the treatment of infertility;
c) vaccines included in the National Vaccination Programme or otherwise reimbursed by the State, beyond the amount so reimbursed;
d) all vaccines administered in the context of a Travel Health Consultation;
e) over-the-counter medicinal products not prescribed by a physician;
f) hygiene products and dermocosmetic products;
g) contraceptives of any nature.

08 Daily allowance for private hospital inpatient care

Cost-sharing scheme: in-network and out-of-network

What is covered

This cover guarantees, under the terms and limits set out in the Policy Schedule, the payment of a capital sum in the event that the insured person is admitted to a private hospital in Portugal as a result of an illness or accident occurring during the term of the contract. For this purpose, a daily compensation amount is determined, which may be different for cases of hospitalization in an intensive care unit.

To access this benefit, the policyholder or the insured person must, within 30 days of the start of inpatient care, provide the insurer with:

- a document issued by the hospital stating the causes and the start and end dates of the insured person's inpatient care in such facility;
- participation in the accident, describing the circumstances in which it occurred;
- a certificate signed by the doctor responsible for the inpatient care, stating the cause and nature of the illness and detailing the following information:
  - illness that caused the inpatient care;
  - date in which the symptoms appeared;
  - date of diagnosis;
  - date in which inpatient care was recommended and the expected duration;

- other elements requested by the insurer that are of interest for the assessment of the claim/occurrence.

If the 30-day deadline is not complied with, the date of receipt of these documents will be considered as the start date of the inpatient care.
This cover has a usage limit of 180 days per year and per insured person.

What is not covered

a) **hospitalizations as a result of treatments not officially recognized by conventional medicine;**
b) **general exclusions no. 26 and 27 are waived in the case of subscription to this cover;**
c) **hospitalizations under the National Health Service.**

09. Daily allowance for private hospital inpatient care – critical illness

Cost-sharing scheme: in-network **and** out-of-network

What is covered

This cover guarantees, under the terms and limits set out in the policy schedule, the payment of a capital sum in the event that the insured person is admitted to a private hospital in Portugal as a result of an illness that has been the subject of previous assistance under the international critical illness coverage. For this purpose, a daily compensation amount is determined, which may be different for cases of hospitalization in an intensive care unit.
To access this benefit, the policyholder or the insured person must, within 30 days of the start of inpatient care, provide the insurer with:

- a document issued by the hospital stating the causes and the start and end dates of the insured person's inpatient care in such facility;
- participation in the accident, describing the circumstances in which it occurred;
- a certificate signed by the doctor responsible for the inpatient care, stating the cause and nature of the illness and detailing the following information
  - illness that caused the inpatient care;
  - date in which the symptoms appeared;
  - date of diagnosis;
  - date in which inpatient care was recommended and the expected duration;
  - other elements requested by the insurer that are of interest for the assessment of the claim/occurrence.

If the 30-day deadline is not complied with, the date of receipt of these documents will be considered as the start date of the inpatient care.
This cover has a usage limit of 180 days per year and per insured person.

What is not covered

Any hospitalization that is not the result of previous assistance under the international critical illness coverage is excluded.

10. Second international medical opinion

Cost-sharing scheme: in-network

What is covered

This cover consists of preparing, and providing the insured person with, a report containing a second medical opinion regarding their illness or medical condition. This report is drawn up by one or more specialist doctors within the International Medical Network whose knowledge is specifically indicated to analyse the case in question. The analysis carried out will be subject to previous clinical elements that must be provided by the insured person, including reports of medical consultations in Portugal and/or all the tests already carried out, without prejudice to further tests being requested that are considered crucial to the preparation of the report. The second international medical opinion is eligible for any illness.

What is not covered

This cover has no specific exclusions, only the general exclusions apply.

11. International critical illness coverage

Cost-sharing scheme: in-network **and** out-of-network

What is covered

This cover is intended to cover the cost of treatment for certain critical illnesses, always provided outside Portuguese territory by the International Medical Network. It applies to a range of specific illnesses and conditions, as detailed below.
This cover encompasses, up to the limit of the sum insured, all eligible expenses that are authorized, including travel and subsistence expenses for the insured person and the person accompanying the insured person, provided that the following are subject to the capital sub-limit set out in the policy schedule:

a) expenses arising from the death of the insured person (or donor);
b) medicines after the insured person returns to Portugal;
c) daily allowance for inpatient care abroad.

The following treatments or medical conditions are covered on an exclusive basis:

- coronary artery bypass surgery, an open-heart surgical procedure using bypass grafts, to correct stenosis of a minimum of two coronary arteries. the underlying disease must be proven by angiographic examination;
- heart valve surgery, a procedure involving the replacement of one or more heart valves as a treatment for a disease. the underlying disease must be proven by angiographic examination;
- neurosurgery, i.e. any surgical intervention on the brain and/or intracranial structures;
- cancer treatment, in the case of non-encapsulated malignant tumours with uncontrolled development and spread of malignant cells and invasion of tissues, or tumours described histologically as pre-malignant or showing the first malignant changes, including non-invasive or in situ cancers whose treatment is also covered;
- living donor organ/tissue transplant, whereby the insured person receives a kidney, part of the liver, a lung lobe, part of the pancreas or bone marrow (autologous or allogeneic transplant) from a compatible living donor.

Expenses incurred

In order for treatment expenses to be covered by the insurer, they must be explicitly certified as medically necessary procedures, thus meaning that they are essential and appropriate for the diagnosis and/or treatment of an injury or illness, which shall be prescribed by a doctor, shall not exceed the scope, duration, intensity and medical standard accepted in Portugal or in the country where such procedures are being carried out, and shall be carried out in a hospital. Only the following types of expenses are covered, provided that they are duly authorized:

- surgeries, including all services and medical fees associated with such surgeries, and the respective recovery, whether on an outpatient or inpatient care;
- inpatient care, including general ward service expenses during hospitalization[1]or other hospital services, including outpatient consultation costs and the cost of an additional bed for a person accompanying the insured person, where the hospital provides this service;
- outpatient care, including treatments, medical care or consultations, even on an outpatient care when the insured person is hospitalized;
- tests and therapies, whether in the form of laboratory tests[2], various specialties imaging tests[3], or other diagnostic aids[4] including clinically necessary therapies[5] for the treatment of a covered illness or medical condition, provided that they have been prescribed and supervised by a doctor;
- medicines, expenses with pharmaceutical or prescription medicines while the insured person is hospitalized, or after hospital discharge for a maximum of 30 days, provided that the products concerned are prescribed as part of post-operative procedures, and only when they are purchased prior to returning to Portugal;
- transfers and ground transportation or air ambulances, when their use is indicated and prescribed by a doctor and pre-approved;
- in transplantation procedures for services rendered (to a living donor) during the organ or tissue harvesting procedure for transplantation into the insured person as a result of:
  - research procedure to locate potential donors;
  - hospital services provided to the donor, including inpatient care in a hospital room or ward, meals, general nursing services, regular services provided by hospital staff, analyses and use of equipment and other hospital facilities (excluding items for personal use that are not needed during the organ or tissue harvesting procedure for transplantation).
- round air trip in economy class for the insured person and the person accompanying the insured person;
- with accommodation for the insured person and the person accompanying the insured person;
- with repatriation in the event of death: where the insured person (and/or living donor, in the case of a transplant) dies outside Portugal while undergoing treatment under this policy, the insurer shall pay for the repatriation of the remains. This cover shall be limited to the services needed to prepare the body and its transport to Portugal, including the services provided by the funeral home carrying out the international repatriation, namely embalming and all administrative formalities, the minimum compulsory coffin, and the transportation of the remains from the airport to the chosen funeral location in Portugal;
- daily allowance for inpatient care abroad, valid outside Portuguese territory, provided that the hospitalization is the result of a covered illness and/or treatment;

[1] Whether you're in a room, hall, hall or intensive care unit
[2] Including chemical and pathological analyses or biopsies
[3] Including echocardiograms, ultrasounds, CT and MRI scans, among others
[4] For example, electrocardiograms, myelograms, ECG, angiographies
[5] For example, radiotherapy, chemotherapy, hormonal or biological therapies, blood transfusions or the application of plasma or serum or other injectable products, as well as the application of oxygen

- with medicines after returning to Portugal, the costs of medicines purchased in Portugal following the treatment of an illness covered abroad being considered as such. These costs shall be covered exclusively for medicines:
  - that have been recommended by a doctor from the International Medical Network who has accompanied the insured person, and in cases where they are necessary to continue treatment;
  - that are approved by the respective medical/pharmaceutical authority in Portugal, including regulation in their prescription and administration;
  - that require a medical prescription in Portugal and are purchased and paid for by the insured person (on their behalf) only in Portugal;
  - whose dosage does not exceed two months in duration, unless otherwise specifically requested in the prescription.

How to access the service

The cost-sharing scheme for this cover may be applied within or outside the international network (in the case of this cover, it corresponds to the agreed network), with the percentages indicated in the policy schedule.
The agreed network International Medical Expert was created specifically for this cover, and ensures payment and logistical support for treatment and/or clinical care for covered illnesses. Through this service, the health units within the network (and always outside Portugal) with the best indication for the treatment of the disease are determined, as well as the booking of travel and accommodation up to the established limits.
Through International Medical Expert, the insurer, on behalf of the insured person, shall make appointments with medical or health service providers, organise the details of medical treatment, including hospital admission and inpatient care, medical consultations, hotel accommodation, transport and customer care services. **The provider shall also handle the** processing and payment of medical expenses on behalf of the insurer, including the verification of invoicing to ensure its correctness (e.g., duplication, errors or excess amounts) and that applicable discounts obtained through contractual agreements with medical and health service providers are reflected in the invoices. The International Medical Expert service is not available for treatments or procedures within Portugal.
Access to this cover requires the following rules to be met:

- diagnosis confirmation, which is the immediate need as soon as contact is made between the insured person or their representative and the provider, who shall indicate all procedures to guarantee timely access to all examinations, reports and other diagnostic elements that are necessary to confirm the diagnosis, in order to initiate an international second medical opinion process so as to confirm the diagnosis and determine whether the illness is covered;
- preliminary certificate, issued by the International Medical Expert service after confirmation that the illness is covered, through which it assumes the expenses associated with the respective treatments, provided that they are within the limits, rules and exclusions established, and already within the scope of the International Medical Expert service.

In the event of a diagnosis of a covered illness, the following requirements must be met:

- before receiving any treatment, service or medical prescription for a covered illness, the insured person shall report the situation to the provider as soon as possible, via the telephone line **210546822**, and request a second international medical opinion;
- the insured person shall be informed of the procedures deemed necessary for the insurer to review all data and clinical tests, and obtain confirmation of the diagnosis;

- once the results of the review have been obtained, and where the clinical condition assessed by the second international medical opinion is confirmed as a covered disease, a preliminary certificate confirming the coverage of the medical expenses that the insured person will bear shall be issued, subject to the conditions, limitations and exclusions of the policy. Then, it will be possible to access the International Medical Expert service;
- the preliminary certificate shall indicate the international medical centres authorized by the insurer for the respective treatment, service or medical prescription, as well as the confirmation of the diagnosis and the coverage of the policy;
- the insured person and their family members shall allow doctors to visit them and carry out any inquiries deemed necessary by the insurer, and the doctors accompanying the insured person shall provide the doctors indicated by the insurer with all the data necessary to verify their cover under this policy;
- failure to comply with the provisions of this clause or to use the international medical services recommended by the insurer shall result in the assumption of 50% of the expenses relating to the cover;
- if the policy is cancelled and, at the same time, a claims procedure is underway, the insurer shall fulfil its obligations with regard to treatment and expenses abroad.

Any expenses incurred by the insured person outside the scope of the International Medical Expert service shall always be subject to their eligibility pursuant to this policy, i.e., considering exclusions, illnesses and type of expenses covered, and shall be reimbursed by the insurer at a maximum of 50% and up to the limit of the sum insured, except in cases where these expenses have occurred outside the defined territorial scope or within the waiting period of this cover, in which cases there shall be no reimbursement.

What is not covered

This cover is intended to cover costs, up to the limit of the sum insured, associated with specific treatments, under specific conditions and for specific illnesses. In general, all expenses, treatments and illnesses that are not foreseen are not eligible for this cover. In these circumstances, in addition to the general exclusions, this cover does not cover the payment of expenses:

a) arising from illnesses or traumatic injuries caused by accidents, such as traumatic injuries to the aorta or heart valves, as well as craniotomy caused by trauma or injury following an accident;

b) associated with:

- **brain syndrome, including all medical care and/or hospitalization expenses arising from cases of senility or brain deterioration;**
- **acquired immunodeficiency syndrome (HIV/AIDS), as well as all secondary diseases resulting from it or that are a consequence of its treatment, including the disease known as Kaposi's sarcoma;**
- **illness caused by organ transplantation, unless it is eligible as a covered illness as specified in the section "How covers are used";**
- **occupational diseases, regardless of the insured person's profession;**
- **medical care or injuries arising from war, acts of terrorism, seismic movements, riots, floods, volcanic eruptions, as well as direct or indirect consequences of nuclear reaction, and any other extraordinary or catastrophic phenomena, as well as officially declared epidemics;**

- necessary health care as a result of an accident suffered in the course of the insured person's professional activity, as well as accidents and occupational illnesses related to the use of motor vehicles covered by compulsory motor vehicle liability insurance;
- accidents occurred or illnesses contracted as a result of the professional practice of any sport, as well as the practice of aerial or underwater activities, combat sports, martial arts, climbing, rugby, caving, bullfighting activities, participation in sports competitions and respective training with vehicles or any other high-risk sport;
- necessary health care as a result of alcoholism, intoxication due to alcohol abuse, drug addiction, use of psychotic, narcotic or hallucinogenic drugs, as well as necessary health care as a result of illnesses resulting from attempted suicide and self-injury or illnesses or accidents suffered by the insured person when committing a crime;
- all illnesses or medical conditions diagnosed during the waiting period;
- any critical illness or medical condition caused intentionally or as a result of acts of reckless imprudence or gross negligence on the part of the insured person;
- expenses incurred due to treatment, service, provision or medical prescription for a disease that basically requires an organ transplant.

c) regarding the following procedures:
- angioplasties, as well as any non-surgical coronary treatment and all angioplasty techniques for unblocking blood vessels using a catheter + balloon, as well as any coronary treatment not involving surgery;
- experimental treatments and/or alternative medicines, even where they are specifically prescribed by a doctor. In this context, alternative medicines shall consist of systems, practices, medicines or treatments not currently considered to be part of the conventional practice of medicine, including all diagnostic and/or therapeutic procedures whose safety and clinical efficacy has not been scientifically proven, thus considered to be experimental treatments. This definition shall include all treatments (including medicines) not universally accepted as safe for the treatment at hand by the various scientific organizations recognized by the international medical community, or still in the study, research, testing period or any stage of clinical experimentation. Examples of alternative medicine include, but are not limited to, aromatherapy, acupuncture and chiropractic, homeopathic, naturopathic or osteopathic medicines;
- in the case of organ/tissue transplants from a living donor, all transplants shall be excluded where the inherent need for the transplant is due to
  - alcoholic hepatitis;
  - congenital condition of the insured person;
  - autotransplantation, except bone marrow transplants;
  - the insured person is a donor to a third party;
  - dead donor organ;
  - organ requiring stem cell treatment.
- parallel or alternative treatments to a transplant, where the report states that transplant is the best medical option for the treatment of the disease under analysis, but cannot be carried out for any reason, whether personal or logistical;

d) with aesthetic/cosmetic surgery, in all its variants, regardless of medical recommendation, whether referring to any procedure for the augmentation, reduction, lifting or removal of a part of the body, even if it aims to improve or correct a structural defect - including the removal of scars, birthmarks or conditions usually associated with old age, such as arthrosis.

e) **contracted in Portuguese territory. However, expenses of medicines allowed, under the terms of the cover, after treatment abroad and return to Portugal, whether related to diagnoses, treatments or services of any nature, shall be accepted.**
f) **incurred where the insured person does not have a permanent residency in Portugal, regardless of the country where they were incurred. The insured person shall be considered not to be absent from Portuguese territory where they stay in Portuguese territory for more than 13 consecutive weeks during a 12-month period. Otherwise, they shall be considered as not having permanent residency in Portugal;**
g) **with medicines (even after the insured person returns to Portugal):**
   - **where they are not prescribed by a doctor or supplied by a licensed pharmacist;**
   - **where the costs are already covered by the National Health Service or any health insurance; where medicines are partially cost-shared, the amounts paid by the insured person shall be clearly segregated from the co-paid amounts in the reimbursement request;**
   - **where the costs are due to the administration of these medicines (applicable only to cover medicines expenses after returning to Portugal);**
h) **with continuing, palliative and/or long-term care, where the insured person's health condition allows them to travel back to Portugal, but chooses not to do so. These types of recovery and convalescence expenses are always excluded, even if they are medically recommended, are provided on a home, outpatient or inpatient care, inside or outside hospital units, including nursing homes or homes for the elderly, even if these units are located abroad;**
i) **that are non-medical or not directly related to medical care, and are not specifically provided for, such as, for example, all expenses with personal items, telephone or other communications, interpreters, even where arising from services provided to the insured person, the persons accompanying the insured person, relatives or assistants. Any costs incurred with the purchase or rental of wheelchairs, special beds, air purifiers, air conditioners or other equipment of a similar nature are also excluded;**
j) **with any kind of prostheses, orthopaedic appliances, girdles, bandages, crutches, artificial limbs or organs, wigs (even where their use is deemed necessary during chemotherapy treatment), orthopaedic shoes, hernia trusses and other similar equipment or items, with the exception of breast prostheses as a result of a mastectomy and heart valve prostheses as a result of heart valve surgery.**

12. Online medicine

Cost-sharing scheme: in-network

What is covered

This cover guarantees remote support and advice provided by doctors or other health professionals, whether by phone, video, email or app, according to the services available and the insured person's option.
Remote medical advice is given taking into account the signs and symptoms reported by the insured person, and it is up to the specialist to indicate the most appropriate therapy for the situation.
Notwithstanding the need for in person care or other actions, this cover is limited only to liabilities arising from the following remote counselling services:

a) telephone consultation with a general practitioner. Where there is a referral for a specialty consultation available via telemedicine, the insured person may subsequently be contacted by

the specialist doctor. In any case, the insured person will be able to send images and/or examination reports so that the doctors can better assess the clinical situation.

b) video consultation, a service through which the insured person can:
- remotely schedule contact with a doctor in advance, choosing the day and time;
- upload images and exams to their personal area so that the doctor can study the clinical situation before the video consultation;
- be contacted by a doctor via video consultation on the scheduled date and time, in order to obtain clinical support and advice and subsequently adopt measures aimed at improving their health.

c) second opinion, which allows the insured person, after being diagnosed, to have access to the opinion of medical specialists and obtain, in a short period of time, a written report with the opinion of one or more specialists, based on the medical information provided, which is essential to request the service.

What is not covered

In addition to the general exclusions, this cover does not cover any potential:

a) damages for delays or difficulties in accessing the service due to problems in the telecommunications networks;

b) consequences of delay or negligence attributable to the insured person, including deficient, incorrect or inaccurate information provided by them or by third parties on their instructions;

c) consequences of the failure of the insured person to comply with the instructions provided by the service.

13. Mental health

Cost-sharing scheme: in-network **and** out-of-network

What is covered

This cover guarantees mental health medical benefits, according to the option chosen by the insured person, and includes the following medical care:
remote consultations for psychology, sleep and stress management provided by doctors or other health professionals. In addition, if contracted, this cover guarantees the insured person, under the terms and within the limits set out in the policy schedule, the payment of expenses relating to:

a) psychology, psychotherapy and psychiatry consultations. **The sub-limit of this guarantee is within the capital of the outpatient care cover.**

b) psychiatric hospitalization, subject to prior authorization. This includes medical and nursing fees, medicines, materials and all required products for the care provided, as well as complementary diagnostic and therapeutic means. **The sub-limit of this guarantee is within the capital of the inpatient care.**

What is not covered

In addition to the general exclusions, this cover does not cover expenses:

a) with biological therapies (for example, electroconvulsive therapy and transcranial stimulation);

b) related to the person accompanying the insured person accommodation;

c) of personal or non-clinical nature;

d) **inherent to vocational psychology, career development psychology, work, social and organizational psychology.**

14. OneCare Assistance

Cost-sharing scheme: in-network

What is covered

This cover guarantees the insured person a range of services provided at home. It can be reached by telephone and may include a prior screening process. The time taken between the request and its arrival at the insured person's home depends on factors such as accessibility, traffic of similar requests and the sorting itself. Travel shall require adequate accessibility for motor vehicles and that it is not considered dangerous for the human resources involved. Assistance may be conditioned by phenomena such as disasters, epidemics and adverse weather conditions, provided they are unexpected and unavoidable. It includes the following services:

14.1. Home care

14.1.1. Doctor at home

No limit, every day, 24 hours a day

Valid when travelling: mainland Portugal and islands

Co-payment: €15 per act (1 free medical act per year)

It consists of a doctor visiting the customer at home for the purposes of observation, diagnosis and, if necessary, consequent therapy and prescription of medicines. It entails the existence of a change in the patient's health condition, as long as it is not life-threatening, including transportation to a hospital, when necessary. Any illness that is not considered to be mild or moderate, or that is considered to be a medical emergency or chronic illness, shall be excluded from the scope.

14.1.2. Home nursing

No limit, every day between 9 a.m. and 6 p.m.

Valid when travelling: Lisbon and Porto	**Valid when travelling:** rest of the country
Copayment: €15 per act (1 free medical act per year)	**Copayment:** €20 per act (1 free medical act per year)

This category includes providing nursing care in all specialties, by promoting communication with the customer's reference health teams, drawing up reports on the health status evolution, in order to achieve effective coordination in the various areas. This includes nursing care independent or dependent on a medical prescription, such as:

- injections - IM, SC, 1D and IV;
- serotherapy;
- bandages;
- immobilization bandages;
- stitches and staples removal;
- enemas;
- nasogastric tube-associated care;

- fitting, maintenance and replacement of bags for any type of stoma;
- aerosol therapy;
- aspiration of secretions;
- irrigations, washes, application of ophthalmic therapy;
- assessment of vital signs, blood glucose, blood pressure, temperature and pain;
- oxygen therapy.

14.1.3. Clinical analysis at home

No limit, on working days between 9 a.m. and 6 p.m.

Valid when travelling: Lisbon and Porto **Copayment:** €15 per act (1 free medical act per year)	**Valid when travelling:** rest of the country **Copayment:** €20 per act (1 free medical act per year)

Following a medical prescription, the insurer, through the Assistance Service, shall provide, up to the limit set in the policy schedule, that a health technician visits the insured person's home to take blood and urine for clinical analysis. The cost of the analyses shall be borne by the insured person or under the outpatient care cover, where applicable.

14.1.4. Physiotherapy/speech therapy at home

No limit, on working days between 9 a.m. and 6 p.m.

Valid when travelling: Lisbon and Porto **Copayment:** €15 per act (1 free medical act per year)	**Valid when travelling:** rest of the country **Copayment:** €20 per act (1 free medical act per year)

Upon presentation of a medical prescription, the insurer, through the Assistance Service, shall provide, up to the limit set in the policy schedule, physiotherapy or speech therapy sessions at the insured person's home. The Assistance Service shall bear the costs of physiotherapy fees up to the limit set out in the Policy Schedule, and the insured person shall bear the cost of materials.

14.1.5. Home delivery of medicines

No limit, every day between 9 a.m. and 6 p.m.

Valid when travelling: Lisbon and Porto **Copayment:** €15 per act (1 free medical act per year)	**Valid when travelling:** rest of the country **Copayment:** €20 per act (1 free medical act per year)

Following a medical prescription, and at the request of the insured person, the insurer, through the Assistance Service, shall send medicines to the insured person's home. The cost of medicines shall be borne by the insured person.

14.2. Assistance to people

14.2.1. Home support services

No limit, on working days between 9 a.m. and 6 p.m.

Valid when travelling: Lisbon and Porto	**Valid when travelling:** rest of the country
Co-payment: €15 per hour	**Co-payment:** €20 per hour

This service includes a range of support services when the insured person is recovering from an illness or accident covered by the policy, including:

- **hygiene, comfort and elimination care**, such as bathing, partially assisted by a family helper where the insured person needs help because of reduced mobility, as well as help with personal hygiene (brushing teeth, shaving and physiological needs) and assistance with dressing and undressing;
- **feeding care**, such as preparing meals appropriate to the secured person's state of health and helping them to eat, providing any technical aids that may be available in their home for this purpose. **This service does not include enteral feeding;**
- **basic household chores**, consisting of helping with everyday life important basic household chores, such as: taking care of clothes, tidying the bathroom, bedroom and kitchen.
- **mobility care**, such as helping with walking aids available at the customer's home to promote movement. In the case of wheelchair mobility, it also includes help with transfer;
- **trips abroad**, including accompanying the insured person to medical appointments and/or other therapies, as well as cultural, religious, social and recreational activities, helping with the necessary day-to-day shopping or going to hairdressers, manicure and pedicure, according to their needs.

14.2.2. Aesthetics and beauty at home

On working days, between 9 a.m. and 6 p.m.

Valid when travelling: Lisbon and Porto	**Valid when travelling:** rest of the country
Co-payment: €15 per service	**Co-payment:** €20 per service

The insurer, through the Assistance Service, shall provide that a duly qualified professional visits the insured person's home to carry out the following services, limited to the materials/consumables and portable equipment:

a) haircut and styling;
b) simple manicure and exclusive nail polish application;
c) simple pedicure with skin removal and exclusive nail polish application;
d) simple face makeup.

The costs of the service shall be borne by the insured person.

14.2.3. Non-urgent transportation

Limit: 2 requests per year

Valid when travelling: Lisbon and Porto	**Valid when travelling:** rest of the country
Co-payment: €15 per service	**Co-payment:** €20 per service

The insurer, through the Assistance Service, shall provide that the insured person be transported by ambulance or taxi to health facilities for complementary diagnostic tests, consultations, hospitalizations and discharges. For the purposes of calculating the limit of this guarantee, a journey means the journey between the insured person's location and the nearest health unit, within a maximum radius of 50 km, and the return journey.

14.2.4. Driving license renewal certificate

No limit

Valid when travelling: Lisbon and Porto **Co-payment:** €15 per act

The insurer, through the Assistance Service, shall provide the necessary aptitude assessment and subsequent issue of the driving licence renewal documents.

14.2.5. Access to orthopaedic equipment

No limit

Valid when travelling: mainland Portugal and islands

Co-payment: agreed prices

Service that includes helping the insured person finding suppliers of orthopaedic equipment, for rental or purchase.

14.3. Household utilities

On working days, between 9 a.m. and 6 p.m.

Valid when travelling: mainland Portugal and islands

Limit: 2 services per annuity

Home shopping delivery, which includes organising and bearing the groceries delivery costs to the insured person's home, provided that they have previously requested the Assistance Service. The costs of the groceries purchased shall be borne by the insured person**.**

Laundry and ironing services with home collection and delivery. Thelaundry and ironing costs shall be borne by the insured person.

School transport for minors, including organizing and bearing the cost of transport to and from the policyholder's home and school, when travelling within the same municipality. This guarantee may only be activated at the request of the policyholder, and with the prior agreement of the child's legal guardian.

Veterinary home visits, including logistics and the cost of travelling to the insured person's home. The costs of consultations and treatment shall be borne by the insured person. Acceptance of the service for dangerous or potentially dangerous animals and animals other than dogs and cats shall be subject to the insurer's conditional acceptance.

Keeping a pet in a kennel or cattery. The insurer, through the Assistance Service, shall bear the cost of moving and keeping dogs and cats (subject to a conditional assessment for dangerous or potentially dangerous animals) in a kennel or cattery, up to a limit of 5 days' stay per occurrence.

On working days, between 9 a.m. and 6 p.m.

Valid when travelling: mainland Portugal and islands, and **only where the insured person is incapacitated or in inpatient care**

Limit: 1 service per annuity

Vehicle periodic inspection service where the insured person is incapacitated or in inpatient care for a period exceeding three months. The insurer shall organize the vehicle inspection (light category only) at the closest inspection centre for the vehicle of which the insured person is proven to be the owner. The insured person shall provide all the necessary documentation for the vehicle to be accepted at the inspection centre, and shall bear the cost of the inspection.

What is not covered

a) **home nursing services do not cover the cost of specific use materials and consumables, such as bandages for advanced wound treatment, waterproof dressings, technical aids, accessories for oxygen therapy or serotherapy, colostomy bags or long-term bladder and nasogastric tubes;**
b) **for the analysis home collection service, costs are not guaranteed;**
c) **the cost of renting or purchasing the materials associated with the service of access to orthopaedic equipment is not guaranteed;**
d) **at home physiotherapy services do not include any consumable or equipment. Physiotherapists provide elastic bands and some basic consumables on a case-by-case basis.**

15. Access to the medical network

Cost-sharing scheme: in-network

What is covered

This cover guarantees the right of access to the agreed medical network, excluding the stomatology network, with the respective special price lists, including diagnostic or therapeutic acts, the insured person bearing the full cost. This access includes exclusively:

- fees for emergency or specialty medical consultations;
- other outpatient procedures, including the respective medical and/or nursing costs, as well as associated products and/or materials;
- complementary diagnostic tests;
- physical medicine and rehabilitation treatments, including speech therapy;
- surgery with or without hospitalization.

The list of the medical network providers is available for consultation at www.my.aegon-santander.pt, where you can see reference prices, set at any time by the insurer.

What is not covered

a) **access to any medical act in the field of stomatology;**
b) **access to any special price in health units outside the agreed network;**
c) **expenses associated with any medical act, inside or outside the agreed network, or incurred inside the network without using the card or the network access number;**

In addition to the above exclusions, no other exclusions shall apply to this cover, including the general exclusions.

16. Access to the stomatology network

Cost-sharing scheme: in-network

What is covered

This cover guarantees the right of access to the agreed stomatology medical network, with the respective special price lists, including diagnostic or therapeutic acts, the insured person bearing the full cost. This access includes exclusively:

- stomatology medical consultations fees;
- stomatology treatments;
- prostheses and orthotics.

The list of the medical network providers is available for consultation at www.my.aegon-santander.pt, where you can see reference prices, set at any time by the insurer.

What is not covered

a) **access to any medical act outside the field of stomatology;**
b) **access to any special price in health units outside the respective agreement networks;**
c) **expenses associated with any medical act, inside or outside the agreed network, or incurred inside the network without using the card or the network access number;**

In addition to the above exclusions, no other exclusions shall apply to this cover, including the general exclusions.

17. Access to the health and well-being network

Cost-sharing scheme: in-network

What is covered

This cover guarantees the right to access a specific health and wellness network at favourable prices, and includes treatments in alternative medicines, beauty and leisure, the insured person bearing the full cost. This access includes services in the following areas:

- nutrition;
- psychology;
- acupuncture;
- homeopathy;
- gyms and *health clubs*;
- childbirth preparation courses;
- cryopreservation of stem cells;
- optics.

The list of the medical network providers is available for consultation at www.my.aegon-santander.pt, where you can see reference prices, set at any time by the insurer.

What is not covered

a) **access to any special price in health units outside the respective agreement networks;**
b) **expenses associated with any act in the indicated areas, inside or outside the agreed network, or incurred inside the network without using the card or the network access number;**

In addition to the above exclusions, no other exclusions shall apply to this cover, including the general exclusions.

18. Preventive medicine

Cost-sharing scheme: in-network

What is covered

This cover guarantees, pursuant to the policy schedule, the scheduling of an online consultation and subsequent appointment, in the agreed network, of a set of diagnostic tests (check-up) appropriate to the age and gender of each insured person. The costs of these medical procedures shall be borne by the insurer, provided they are authorised by the insurer and are carried out at the appropriate intervals.

What is not covered

a) **tests other than those listed under "preventive medicine", available at www.aegon-santander.pt;**
b) **tests scheduled not authorised by the insurer or outside the agreed network, unless so indicated and approved by the insurer.**

19. Extension abroad

Cost-sharing scheme: out-of-network

What is covered

The insured person - with permanent residency in Portugal - is covered outside national territory, in the event of an occasional stay abroad, exclusively for expenses falling within the scope of inpatient and outpatient care covers, using the same capital as these covers, the reimbursements made thus being deducted from the sum insured of each of them according to the respective framework, as if they had occurred in Portuguese territory.
An occasional stay shall last up to 60 days. Stays longer than 60 days shall be submitted in advance and accepted by the insurer.

What is not covered

In addition to the general exclusions, this cover does not cover expenses:

a) **which constitute specific exclusions from inpatient and outpatient covers;**
b) **for travel and accommodation;**
c) **arising from oncological diseases.**

20. Travel medical assistance

Cost-sharing scheme: in-network

What is covered

This cover guarantees the insured person, when travelling abroad for no more than 60 days, the right to the following assistance services:

20.1. Medical, surgical, pharmaceutical and inpatient care expenses

Deductible: €50

Limit: €5000

If, as a result of an accident or illness occurred during the period of validity of the policy, the insured person requires medical, surgical, pharmaceutical or hospital assistance, the insurer, through the

assistance services, shall pay for it, up to the respective limits, or reimburse, subject to prior agreement and justification:

- medical and surgical fees and expenses;
- pharmaceutical expenses prescribed by a doctor;
- inpatient care costs;

In the event of surgery, the insurer, through its assistance services, shall only be responsible where it is urgent and cannot be postponed until the insured person returns to Portugal.

20.2. Transportation or medical repatriation of the injured and sick

Deductible: no deductible

Limit: no limit

Where the insured person suffers any injury or falls ill during the period of validity of the policy, as long as the medical situation so justifies it, the insurer, through the assistance services, shall take care of:

- the cost of ambulance transportation to the nearest clinic or hospital;
- monitoring, by its medical team in collaboration with the treating doctor of the injured or sick insured person, in order to determine the best treatment procedures and the most appropriate means for their possible transfer to a more suitable Hospital Centre or to their home;
- of the cost of such transfer by the most appropriate means of transport, provided that the originally planned means of transport cannot be used and the return date cannot be met.

The means of transport to be used will be decided by the insurer's medical team through the assistance services.

20.3. Accompanying the hospitalized insured person

Deductible: no deductible

Limit: €75 per day, maximum €750

Where the insured person is in inpatient care and their condition is not favourable to immediate repatriation or return, the insurer, through the assistance services, shall bear the costs of a hotel stay for a family member or a person designated by the insured person, who is already accompanying the insured person, so that they stay with the insured person, up to the limit provided.
Where the insured person is under the age of 18 and is participating on a trip organised by the school, the sum limits established for this cover shall allow for the reimbursement of accommodation and food expenses, while maintaining the established limits.

20.4. Return transport ticket for a family member and their stay

Deductible: no deductible

Limit: stay €75 per day, maximum €750

Where inpatient care exceeds five days and it is not possible to activate the guarantee provided for in no. 3, the insurer, through the assistance services, shall cover the costs incurred by a family member with the return ticket by train, in first class, or by plane, in tourist class, from Portugal, in order to stay with the insured person, and shall also be responsible for the costs of the stay, up to the established limit.
In the event that the insured person is under 18 and is participating of a trip organised by the school, the period from which the guarantee can be activated shall becomes two days, and the sum limit established above shall allow for the reimbursement of accommodation and food expenses.

20.5. Extension of hotel stay

Deductible: no deductible

Limit: €75 per day, maximum €750

Where, after the illness or accident, the insured person's condition does not justify any inpatient care or medical transport, and where their return cannot take place on the initially-planned date, the insurer, through the assistance services, shall cover the actual costs incurred in hotel accommodation, by the insured person and the person accompanying them, where applicable and up to the limit indicated above.

20.6. Transportation or repatriation of the deceased insured person

Deductible: no deductible

Limit: no limit

The insurer, through the assistance services, shall bear the costs of all formalities to be carried out at the place of death of the insured person, as well as those relating to their transportation or repatriation to the burial site in Portugal.
Where an insured person has died following inpatient care, and the guarantee provided for in no. 4 has been activated, the insurer, through the assistance services, shall also bear the costs of transporting the family member back home, in Portugal.

20.7. Assistance in the event of luggage theft abroad

Deductible: no deductible

Limit: no limit

Where luggage and/or personal belongings are stolen, the insurer, through the assistance services, shall assist the insured person in reporting the matter to the authorities, where requested.
Both in the case of theft and loss or misplacement of the said belongings, if they are found, its dispatch to the place where the insured person is, or to their home, shall also covered.

20.8. Advance of funds abroad

Deductible: no deductible

Limit: €1500

Where stolen and lost luggage or monetary valuables are not recovered within 24 hours, the insurer, through the assistance services, shall advance the funds needed to replace the missing goods up to the established limit.
The sums advanced shall be reimbursed to the insurer via the assistance services within a maximum of 15 (fifteen) days of returning to Portugal.

20.9. Delayed baggage claim

Deductible: 24 hours

Limit: €1500

The insurer, through the assistance services, shall reimburse the insured person for the expenses arising from any delayed baggage claim during air travel, namely the purchase of clothing and/or hygiene items, up to the established limit and provided that the delay exceeds 24 hours.
This guarantee shall exclude any delay that may occur when luggage arrives at the airport of origin, which shall always be the same as the insured person's country of residence

20.10. Flight delay

Deductible: 12 hours

Limit: €300 per day, maximum €600

The insurer, through the assistance services, shall reimburse the insured person for the costs incurred with accommodation caused by delays in aircraft departures, up to the limit established above, provided that the delay exceeds 12 hours.
Events for which the airline is responsible and which are caused by breakdowns of its aircraft, including subcontracted aircraft, are expressly excluded from this guarantee.

20.11. Loss of connecting flights

Deductible: 12 hours

Limit: €300 per day, maximum €600

Where the insured person misses a connecting flight due to delays in the plane's arrival, the insurer, through the assistance services, shall cover the cost of accommodation up to the established limit.

20.12. Missed flight due to public transport failure

Deductible: 12 hours

Limit: €300 per day, maximum €600

Where the cardholder misses their flight due to a delay in regular public transport services, the insurer, through the assistance services, cover the accommodation and food costs up to the established limit.

What is not covered

This cover does not cover the reimbursement arising from expenses related to:

a) **medical, surgical and inpatient care in Portugal;**
b) **stomatology;**
c) **obstetrics;**
d) **the purchase and/or fitting of prostheses, orthotics, contact lenses and the like;**
e) **childbirth and complications due to pregnancy, unless unforeseeable during the first 26 weeks, in the case of the guarantees provided for in points a) and b);**
f) **injuries or illnesses diagnosed before the start of the trip;**
g) **mental illness or any psychiatric illness;**
h) **claims resulting from a disease or pathological condition existing before the start of the trip, as well as injuries resulting from surgical interventions or other medical acts not arising from any accident covered by the contract, except for acute episodes of such diseases and where the reason for the trip was not such treatment;**
i) **the suicide or attempted suicide of the insured person, and its consequences, as well as other intentional acts committed against them;**
j) **malicious or criminal acts, or acts contrary to public order of which the policyholder or the insured person is the material or moral author or accomplice;**
k) **actions or omissions carried out by the insured person under the influence of narcotics, without a medical prescription, or alcoholic beverages to a degree that could constitute a criminal offence;**
l) **prostheses, orthotics, glasses and contact lenses, as well as dental expenses;**
m) **accidents resulting from the practice of professional or amateur federated sports and their respective training, as well as the practice of other "special" sports, such as mountain climbing, boxing, karate and other martial arts, bullfighting, parachuting,**

paragliding, hang-gliding, all the so-called extreme sports, caving, underwater fishing and hunting, winter sports such as skiing and snowboarding, any sports involving motorized vehicles (two-wheeled or otherwise), motor boating and other similarly dangerous sports;

n) childbirth and complications due to pregnancy, unless unforeseeable and occurring during the first six months;
o) the urn and the burial or funeral ceremony;
p) accidents arising from natural disasters, such as cyclonic winds, earthquakes, tsunamis, and other phenomena with similar effects or lightning action;
q) assaults, strikes, labour disturbances, riots and any other type of public disorder, uprising, acts of terrorism and sabotage or insurrection;
r) revolution, civil war, invasion and war declared or not against a foreign country, hostility between foreign nations, with or without declaration of war, and warlike acts arising directly or indirectly from these hostilities;
s) claims resulting from the use by the insured person of aircraft or vessels not belonging to commercial lines, or routes, including transportation by military aircraft;
t) accidents resulting from explosions or any other phenomena directly or indirectly related to the disintegration or fusion of atomic nuclei, as well as the effects of radioactive contamination;
u) treatments in spas or on beaches and, in general, change of scenery and rest cures, as well as aesthetic treatments;
v) preventive medicine, vaccines or similar, including medical fees;
w) physical rehabilitation and physiotherapy carried out without the agreement of the assistance services' medical team;
x) medical expenses related to treatments started in the country of residence or nationality;
y) medical, surgical and inpatient care in Portugal due to illness, regardless of the place or origin of the illness, including those carried out during the trip;
z) services that have not been requested from the assistance services, or expenses that have not been incurred with their agreement, except in cases of force majeure or proven material impossibility;
aa) pandemics and epidemics.

Santander
Entidade Distribuidora

IDENTIFICATION OF THE INSURANCE AGENT

Banco Santander Totta, S.A., with registered office at Rua Áurea n.º 88, 1100-063 Lisboa, registered with the CRC of Lisbon under NIPC 500 844 321 and with share capital of €1,391,779,674. Insurance agent no. 419 501 250, registered on 21/01/2019 and authorized to distribute life and non-life insurance. Information and other registration details available at www.asf.com.pt.

The Insurance Agent distributes Life insurance for Insurance Companies Santander Totta Seguros - Companhia de Seguros de Vida, S.A. and Aegon Santander Portugal Vida - Companhia de Seguros de Vida, S.A., and Non-Life insurance for Insurance Companies Aegon Santander Portugal Não Vida - Companhia de Seguros S.A., Ageas Portugal, Companhia de Seguros, S.A., and MAPFRE Santander Portugal - Companhia de Seguros, S.A.

The Insurance Agent does not hold any direct or indirect interest in the voting rights or capital of the aforementioned Insurance Companies.

Banco Santander Totta, S.A. and Santander Totta Seguros - Companhia de Seguros de Vida, S.A. are part of the Santander Group, both held through qualifying holdings, directly or indirectly, by Banco Santander, S.A.

Santander Totta Seguros - Companhia de Seguros de Vida, S.A., in turn, holds 49% of the share capital of Aegon Santander Portugal Vida - Companhia de Seguros de Vida, S.A., and Aegon Santander Portugal Não Vida - Companhia de Seguros S.A., as well as 49.99% of MAPFRE Santander Portugal - Companhia de Seguros, S.A.

As Insurance Agent, Banco Santander Totta, S.A. acts in the name and on behalf of the Insurance Company(ies). However, it is not authorized to receive premiums to be delivered to the Insurance Company(ies). Thus, any payment in this regard by the Policyholder, regarding insurance contracts distributed by Banco Santander Totta, S.A., must be made by bank transfer and/or deposit in the respective Insurance Company(ies) open account with the credit institution Banco Santander Totta, S.A.

Banco Santander Totta S.A. does not enter into contracts and, in its capacity as Insurance Agent, only carries out the preparatory acts for such execution, and the formalization of such contracts only takes place after intervention of the Insurance Company(ies).

The Insurance Agent's intervention involves providing assistance throughout the term of the insurance contract.

Banco Santander Totta, S.A., as Insurance Agent, receives from the Insurance Company(ies) or insurance brokers, in relation to the insurance contracts it distributes and by way of commission, part of the insurance premium, and possibly, in some cases, other economic advantages granted in connection with the insurance contract. This payment has no impact on the amount of the premiums charged by the Insurance Company(ies) to Customers.

The Customer has the right to request information on the remuneration received by Banco Santander Totta, S. A. for the distribution service provided, and accordingly, to receive such information upon request.

The Customer has also the right to lodge complaints against the Agent with the Insurance and Pension Funds Supervisory Authority. The Customer may also submit complaints to Banco Santander Totta, S.A., at any branch, or through the following means: SuperLinha (+351 217 807 364, from Portugal or abroad), NetBanco or Santander's App, by e-mail to netbancoparticulares@santander.pt or netbancoempresas@santander.pt, as the case may be, or by letter to Rua da Mesquita, n.º 6, 1070-238 Lisboa, according to the information available at www.santander.pt/contactos.

You can also submit complaints via Customer Service by e-mail to atencaoaocliente@santande.pt, in the Complaints Book available at any Banco Santander Totta, S.A. branch or at www.livroreclamacoes.pt. Without prejudice to resorting to the courts, the Customer has the right to resort to out-of-court dispute resolution processes, by resorting to the Arbitration Centres to which the Insurance Agent has subscribed, in accordance with the information available in "Alternative Dispute Resolution for Consumer Disputes" at www.santander.pt.

Please be advised that when the protection insurance is presented, detailed explanations are provided in accordance with the Insurance Agent's professional criteria. In insurance-based investment products, the Insurance Agent provides impartial and personal advice as part of the Investment Advisory Service. In this area, annual Cost, Charge and Incentive Reports will be sent to Customers, identifying all the costs and charges incurred by the Customer with these insurance-based investment products and the incentives applied, as well as the Suitability Assessment Report, which assesses whether the insurance-based investment products contracted under the Investment Advisory continue to correspond to the Customer's preferences, objectives and other individual characteristics, taking into account possible changes in the characteristics of the products, and/or fluctuations in the Customer's assets. Without prejudice to resorting to the courts, the Customer has the right to resort to out-of-court dispute resolution processes, by resorting to the Arbitration Centres to which the Insurance Agent has subscribed, in accordance with the information available in "Alternative Dispute Resolution for Consumer Disputes" at www.santander.pt.

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