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Health Insurance

General Terms & Conditions

Health Insurance

Division of
Palma Companhia de Seguros, SA

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INTRODUCTORY CLAUSE

1. This Contract is entered into between Palma Companhia de Seguros, SA., hereinafter referred to as the insurance company, and the Policy Holder, and is to be governed by the general conditions, the special conditions and the particular conditions, in accordance with the statements contained in the proposal and individual health questionnaires, which served as its basis and are an integral part thereof.

2. The personalisation of this contract is described in the particular conditions, which contain the special conditions expressly agreed upon and their territorial scope, the identification of the parties and their domicile, the details of the Policy Holder, the insured persons, the insured sum, and the amount of the premium or the formula for its calculation.

CHAPTER I

DEFINITIONS, SUBJECT MATTER AND GUARANTEES OF THE CONTRACT, COVERAGES AND EXCLUSIONS

1st CLAUSE - Definitions

For the purposes of this contract the following words and/or expressions have the fallowing meanings:

Access to the Network - Provision of healthcare services, covered by this contract, delivered by network provider(s), to which the insured person has access, paying in full the respective costs, as set out in the particular conditions.

Accident - A fortuitous, sudden and abnormal event, caused by an external event beyond the control of the insured person, which causes bodily injury that is clinically and objectively proven.

Additional Minutes - A document that formalises an alteration to the policy.

Household - A group of persons who live permanently with the insured person and are economically dependent on him/her and who are ascendants, spouse or children, stepchildren and adoptive children (including "foster" children). Stepchildren, adoptive children (including "foster" children) cannot be older than 18 years of age at the time of application for or renewal of the policy (or 24 years of age if it can be proved that the child or stepchildren are continuing their education on a full-time basis). For all purposes of this policy, a spouse is deemed to be a person who lives with the insured person under conditions similar to those of spouses and on a permanent basis.

Hospital Environment - Set of infrastructural resources, technical resources, technological and human resources that ensure that each procedure is carried out with quality and safety, including the capacity to respond effectively to sudden events threatening the life of the insured person, and which should exist in hospital or equivalent structures.

Policy – A document that is the title of the insurance contract, consisting of the respective general, special and particular conditions, the insurance proposal and the personal health questionnaire. All alterations that are done during the validity term of the policy will be recorded in additional minutes.

Open Policy – A group insurance policy in which the number of people to be insured is variable. It starts with a specified minimum number of members, and during the contract's validity term the additions and exclusions requested by the Policy Holder will take place. The contract is in force while the number of adhesions is justifiable, at the sole discretion of the insurance company, for its existence.

Authorisation - Consent to provide health care, requested by the insured person at the clinical services of the insurer.

Membership Form - Document filled in by the insured person, in a group insurance, in which he/she identifies him/herself and expresses the wish to join the policy.

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Insurance Sum - Maximum amount of co-payment of health expenses per insured person, set for each of the contacted coverages and specified in the particular conditions.

Membership Card – Personal and non-transferable card, which identifies the insured person and allows access to health care provided within the network(s).

Membership Certificate – A document issued by the insurer to each of the insured persons, proving their inclusion in the group insurance.

Outpatient Surgery - A planned surgical procedure, performed under general, loco-regional or local anaesthesia, in a hospital environment, safely and in accordance with good medical practice, with admission and discharge within 24 hours.

Coinsurance - Amount to be paid by the insurer for each health expense covered by the policy, computed after deducting the excess under the terms set out in the specific conditions.

Special Conditions - Provisions that add to, specify and clarify the general conditions, prevailing over these last in the interpretation of the contractual terms.

General Conditions - Provisions outlining the general principles of the contract and its framework.

Specific Conditions - Clauses that complement the general and special conditions of a contract, so that it can be adapted to a particular case.

Co-payment - Amount to be paid by the insured person for each use of the network.

Illness – An involuntary change in the state of health, not caused by accident, and clinically and objectively proven.

Pre-existing Illness or Injury - Illness or injury of which the insured person should have known or could not have been unaware, either from evidence of symptoms or from having received medical advice or treatment in respect of it, prior to the policy inception date.

Congenital Illness or Malformation - Illness and/or malformation that is diagnosed or detected during pregnancy and up to 30 days after birth.

Sudden Illness - Unintentional, unexpected and acute alteration to the state of health, which poses a risk of death or loss of function for the insured person, requiring immediate medical assistance in a hospital environment.

Chargeback - Return to the Policyholder of all or part of the insurance premium already paid.

Deductible - Amount or number of days payable by the insured person, the amount, period or method of calculation of which is set out in the specific conditions.

Implant - Material (prosthesis, orthosis, apparatus) and/or substance with a therapeutic purpose or to correct a morphological alteration, to be placed in the organism of an individual.

Injury - Morphological or functional involuntary change in the state of health, caused by accident, which is medically and objectively proven.

Doctor/Dentist - a graduate of a medical or dental school recognised by the law of the country where treatment is given and who, in the course of certain treatment, does so within the limits of his or her licence and training.

Minor Surgery - Any surgical procedure which meets the following cumulative criteria:

- No need of an operating theatre to be performed
- Do not demand a complete change of clothing by the surgeon;
- Is performed under local anaesthesia
- No need for special recovery care.

Grace Period - Period of time between the date of acceptance of the insured person and the date on which certain insurance coveragesc may become in force.

Insured Person – A person whose health is insured, identified in the particular conditions of the policy.

Premium - Amount paid by the Policyholder to the insurer in return for agreed cover.

In-Network Benefits - healthcare services, guaranteed by this contract, carried out in network provider(s), in which the co-participation of healthcare expenses is directly borne by the insurer, in accordance with the provisions of the special and particular conditions.

Reimbursement Benefits - Health care services guaranteed by this insurance contract, in which the health care expenses are paid by the insured person, and subsequently co-funded by the insurer, under the terms set out in the special and particular conditions.

Insurance Proposal - Document by which a prospect states his/her intention to take out an insurance contract.

Prostheses and Orthotics - Devices that totally or partially replace a limb or organ or help to fulfil its function, in whole or in part.

Individual Health Enquiry - Document attached to the insurance proposal, through which each prospective insured person states the elements necessary for the insurer to assess the risk.

Insurer - Palma Companhia de Seguros, S.A., the entity legally authorised to operate health insurance and who underwrites the present contract.

Group Insurance - Contract entered into for a group of persons related to the Policyholder by a relationship other than that of insurance.

Group Contributory Insurance - Group insurance where the insured persons contribute, in whole or in part, to the payment of the premium.

Non-contributory Group Insurance - Group Insurance where the Policyholder bears the full premium payment.

Personal Insurance - A contract entered into for an individual person or for a family unit or a group of people living in a common economy.

Customer Service - Customer support service, through which the Policyholder and the insured persons can get the necessary assistance.

Assistance Service - Information and service support, provided on behalf of the insurer by an assistance company.

24-hour Customer Service - Service available at any time of the day or night, limited to a minimum diagnosis capacity, namely general medical consultation and basic auxiliary diagnosis exams.

Medically Necessary Services - Health care services appropriate for the treatment of illness or accident falling within the guarantees of the contract, whose necessity and validity is clinically and objectively established.

Claim/occurrence - The event or series of events resulting from the same cause, capable of trigger the guarantees of the contract.

Policyholder - The person, natural or legal, who enters into a contract with the insurer, being responsible for the payment of the premium.

Transplant - Placement in the body of an individual of an organ, tissue or cells, whether from the individual himself or from another individual, for therapeutic purposes or to correct a morphological alteration.

Hospital Unit - Establishment legally authorised to provide health care services, with permanent medical, surgical and nursing assistance, including entities with inpatients and recovery rooms.

2nd CLAUSE - **Object of the Contract**

1. The present contract guarantees to the insured person, in the event of a claim arising during its term, a set of coverages in the field of health care, which may include reimbursement benefits, in-network benefits and assistance services, as set out in these general conditions, in the special conditions and in the applicable specific conditions.

2. The present contract of insurance does not guarantee any medical or medication expenses claimed by the public health services (Mozambican or South African) or by any other health sub-system of which the insured person is a beneficiary.

3rd CLAUSE - **Basis of the Contract**

The insurance proposal, signed by the respective policyholder, the individual health questionnaire for each insured person and, in the case of Group Insurance, the enrolment form for each insured person, as well as all the clinical documentation necessary for the insurer to accept the risk, constitute the basis of this contract and form an integral part thereof, determining, in particular, the risk covered.

4th CLAUSE - **Scope of the Guarantees**

1. Concerning the insured persons

The beneficiaries of the guarantees conferred by this contract are the insured persons named in the particular conditions, after express acceptance by the insurer. Acceptance of the insurance in respect of each insured person is officialised through the issue by the insurer of the membership card, in group insurance, of the individual membership certificate, and some coverages may be subject to waiting periods, to deductibles and to maximum amounts of indemnity, as provided for in these general conditions, in the special conditions and in the particular conditions of the policy.

2. As regards to the scope of coverage

Under the terms and within the limits set out for this purpose in the special and particular conditions, the insurance contract may guarantee the following coverage:

A. Mozambique

- **I.** Hospitalisation;
- **II.** Medical Emergencies in Mozambique;
- **III.** Normal childbirth, caesarean section and involuntary termination of pregnancy;
- **IV.** Outpatient Clinic;

B. Extension to South Africa

- **X.** Hospitalisation;
- **XI.** Normal childbirth, caesarean section and involuntary termination of pregnancy;
- **XII.** Outpatient Clinic;
- **XIII.** Stomatology;
- **XIV.** Medicines.

The covers effectively contracted for are set out in the particular conditions.
The insurance contract may also provide for other coverages, as long as they are duly identified in the particular conditions and defined in a special condition of its own.

3. With regard to the system of benefits

The guarantees provided by this contract may be in the form of instalments on the network, instalments by reimbursement or in the combined form of instalments on the network and instalments by reimbursement. When the respective special condition is contracted, the form of access to the network shall also be applicable.

The contracted modality will be set out in the relevant special or particular conditions.

3.1 Scheme of benefits within the network
In this modality, the insurer guarantees the insured person access to a set of healthcare services offered in the network of Palma Companhia de Seguros, SA, whose conditions of use are set out in these general conditions and in the applicable special conditions, under the terms and limits fixed in the particular conditions.

The network(s) includes health care services in medical and surgical specialties, complementary diagnostic resources, services, complementary techniques and therapies and hospitalization.

Access to certain network service(s) may require authorization from the insurer. When the insured person uses such services without the necessary prior authorization, or when he/she uses any other service without identifying himself with his membership card, the reimbursement benefit scheme will apply to the expenses.

In the network benefits scheme, the insured person shall pay the excess stated in the special conditions. When, due to the unavailability of the computer system or any other duly justified reason not attributable to the insured person, it is not possible to process the amount of the excess and/or co-payment, the insured person will pay the health expense in full and subsequently send it to the insurer, in order for the respective reimbursement to be made.

Information on the providers that are part of Palma Companhia de Seguros, SA network is available and constantly updated at www.bettercare.co.mz.

3.2 Reimbursement benefit scheme
In this plan, the insurer guarantees the reimbursement of expenses by the insured person with health care, at providers or services not included in the Palma Companhia de Seguros, SA network, under the terms and limits set out in these general conditions, in the special conditions and in the applicable particular conditions.

The reimbursement will be made according to the following criteria:

a) Medical consultations: the insurer will reimburse the insured person the amount paid for each consultation, up to the maximum amount specified in the particular conditions.

b) Other medical fees: the insurer will reimburse the insured person the amount of expenses paid with medical fees, related to medical procedures other than consultations, up to the amount resulting from the application of the number of points corresponding to each medical procedure, subject to the valuation parameters of medical and surgical procedures in accordance with the table of relative values established in the table of values of medical procedures, which can be found on the website www.bettercare.co.mz, up to the maximum amount stated in the particular conditions or in the personal insurance certificate.

c) Other expenses: for all expenses guaranteed by the contract and not included in sub-paragraphs a) and b), the insurer will reimburse the insured person under the terms and limits set out in the particular conditions.

3.3 Network acces scheme
In this plan, the insurer guarantees access by the insured person to health care services, provided by network providers, with the insured person paying the full cost, under the terms and within the limits fixed in the special and particular conditions.

5th CLAUSE - **Exclusions**

Except when expressly agreed to the contrary in the particular conditions or in the special conditions actually contracted, expenses arising from the fallowing events are excluded from the insurance coverage:

1. Labour accidents, accidents in the course of work and occupational diseases;

2. Accidents and diseases with coverage by compulsory insurance;

3. Accidents resulting from natural disasters, acts of war, declared or undeclared, terrorism, sabotage and public order disturbances;

4. Accidents arising from participation in sports competitions and related training, whether professional or amateur;

5. Accidents arising from the practice of land motor sports; mountain biking; martial arts, fighting and boxing; parachuting, including free fall, paragliding and hang gliding; jumps or inverted jumps with body suspension mechanism ("bungee jumping"); bullfighting and bull or reindeer shooting; hunting of wild animals or animals known to be dangerous; horse riding; motor boating and water skiing; water sports practised on boards; descending torrents or currents caused by watercourses; diving; underwater hunting; sports practised on snow or ice; mountaineering and climbing; slide and abseiling; caving;

6. Accidents or illnesses resulting from attempted suicide or self-mutilation, participation in betting or challenges, intervention in duels and brawls or the commitment of intentional or seriously culpable or unlawful acts by the insured person;

7. Acts performed by doctors and other health professionals who are spouse, parents, children or siblings of the insured person;

8. Alcoholism and diseases resulting from excessive consumption of alcoholic beverages;

9. Hospital care for purely social reasons;

10. Consequences of unjustified delay or negligence attributable to the health care provider or the insured person in seeking medical assistance, or of refusal or non-compliance with prescribed treatment;

11. Consultations and treatments in fields not approved by the Order of Physicians;

12. Consultations or medical examinations that are necessary for the issue of certificates, avowals, statements, certificates or information of any type of document that does not have assistential or therapeutic purposes;

13. Correction of congenital diseases or malformations, except for newborn babies whose pre-adhesion is carried out in accordance with clause 17.2 (a);

14. Expenses for services that are not medically necessary;

15. Expenses paid by persons accompanying the insured person, except in the case of hospitalisation of minors up to the age of fourteen years or citizens with congenital or acquired disabilities;

16. Sexual dysfunction, except as a result of illness covered by the policy;

17. Infectious contagious diseases, when in a situation of epidemic declared by the official authorities;

18. Diseases or after-effects resulting from radioactivity, including consequences of the use of bacteriological weapons and/or chemical agents;

19. Diseases, injuries or deformations pre-existing at the date of entering into the insurance contract;

20. Gymnastics, swimming, massages and other similar, except those resulting from illness or accident covered by the contract;

21. Infertility and medically assisted reproductive treatment including, but not limited to, consultations, examination, testing, infertility treatment, artificial insemination methods, in vitro fertilization or embryo transfer procedures and the consequences of their application, except where life is at risk;

22. Voluntary interruption of pregnancy, including medical conditions arising there from;

23. Surgical procedures to correct snoring disorders, except in the case of apnoea;

24. Contraceptive measures and family planning as well as expenses incurred to reverse the effects of a voluntary sterilization surgery;

25. Pathologies or treatments related, directly or indirectly, to human immunodeficiency virus (HIV) infection;

26. Mental health disorders whether or not resulting from another illness needing hospitalisation, sessions of psychology, psychoanalysis, psychotherapy, hypnosis and sleep therapy as well as chronic psychiatric treatment;

27. Transplants and implants, particularly dental implants;

28. Surgical or laser refractive treatments of vision, specifically in cases of myopia, astigmatism and hyperopia;

29. Nursing care provided at home;

30. Chronic haemodialysis treatments;

31. Weight loss treatments and/or surgery;

32. Treatments and/or surgery for sex change;

33. Experimental treatments or those requiring medical certification;

34. Aesthetic or cosmetic treatments or surgeries, as long as they are not caused by an accident covered by the insurance or are not caused by an illness suffered during the term of the contract and justifying them;

35. Drug-related treatment;
36. Treatments related, directly or indirectly, to hepatitis virus infection, with the exception of those resulting from hepatitis A;

37. Spa treatments and stays at spas, sanatoriums, nursing homes, assisted living facilities, convalescent homes, nursing homes, drug and/or alcohol treatment centres and other similar establishments;

38. Misuse and/or abuse of medicines;

39. Use of non-prescribed narcotics and drugs or abuse of such drugs when prescribed by a doctor, misuse of medicines, alcoholism and diseases resulting from excessive alcohol consumption;

40. Consultations and treatment in non-regulated fields.

5th CLAUSE - **Territorial Scope**

Unless otherwise agreed upon in the special conditions or in the particular conditions, the insurance is only valid for healthcare provided in Mozambique, although some covers may be extended to South Africa, Portugal and India, or to another country, as provided for in the particular conditions and under the terms of these general and special conditions.

CHAPTER II

DECLARATION OF RISK, INITIAL AND SUPERVENING

7th CLAUSE - **Initial risk disclosure**

1. The Policy Holder and the insured person are required, before signing the contract, to accurately disclose all the circumstances that they know and reasonably should have as significant interest for the insurer to be able to assess the risk.

2. Paragraph 1 shall also apply to circumstances not requested to be mentioned in a questionnaire supplied by the insurer.

3. In the event of a wilful or negligent breach of the provisions of paragraph 1, the insurer may choose to annul, terminate or amend the contract.

8th CLAUSE - **Omissions or Inaccurate Statements**

1. The contract is voidable and the insurer is entitled to reimbursement of the indemnities already paid, as well as to receive the premiums due, if the insured has intentionally omitted any circumstance of which he is aware and which could have influenced the execution of the contract.

2. The insurer shall lose the right to cancel the contract if, after two months from becoming aware of the omissions or misstatements of the policyholder, the insurer fails to notify the policyholder.

3. If there has been no bad faith from the insured, the contract is reduced, i.e. it is considered underinsurance.

4. If omissions or inaccurate statements have been found at the time of the claim, the indemnity shall be reduced in proportion to the premium agreed and what it would have been had the risk been accurately stated.

5. If the contract covers different risks, the provisions of the preceding paragraph shall apply only to those to which the omission or inaccuracy relates, unless the insurer proves that it would not have entered into the contract without the inaccurate part.

9th CLAUSE - **Nullity of the Contract**

1. The contract is void if at the time of its acceptance, the risk has ceased to exist or a claim has been made.

2. In the first case, the insurer is not entitled to the premium, while in the second case it is not required to indemnify the insured, but is entitled to the premium.

CHAPTER III

PAYMENT AND CHANGE OF PREMIUMS

10th CLAUSE - **Payment of Premium**

1. The initial premium or initial instalment is due on the date of the signature of the contract. Failure to pay the initial premium or the first instalment thereof on the due date shall result in immediate termination of the contract as from the date of signing of the contract.

2. The following premiums or fractions are due on the dates set out in the policy.

3. The insurer will notify the Policyholder, in writing, up to 30 days before the date on which the next premiums or instalments are due. If, however, it has been agreed to pay the premium in instalments with a periodicity inferior to quarterly, the insurer may choose not to send the aforementioned notice, in which case, the contractual document will state the due dates of the instalments, their amounts and the consequences any lack of payment.

4. In the event of non-payment of the premiums or following instalments on the date specified in the notice, the Policyholder will be in default for a period of 30 days, and the insurer will be entitled to suspend the contract's guarantees. The insurer shall notify the policyholder of such suspension of the contract's guarantees, by registered letter, and grant him/her a new deadline to pay the amounts due..

5. After the new deadline granted by the insurer without paying the premium, the insurer may terminate the contract, without prejudice to the right to premiums for the period during which the contract was in force.

6. During the term referred to in paragraph 5, the contract shall remain in full force and effect.

7. Non-payment, on the date stated in the notice, of an additional premium, as long as it results from a request by the Policy Holder to change the guarantee that does not mean the worsening of the risk, will determine that the change will be without effect, maintaining the contractual conditions in force prior to that request, unless the subsistence of the contract proves to be impossible, in which case it is considered terminated on the due date of the unpaid premium.

8. The provisions of the previous numbers shall apply to the payment of the premiums or fractions due by each of the members of the group insurance, when this insurance is contributory and the Policyholder and the insurer have agreed that the corresponding payment shall be made to the insurer by the member.

11st CLAUSE - **Premium Splitting**

Upon agreement between the insurer and the Policyholder, the payment of the annual insurance premium, may be divided into monthly, quarterly or half-yearly instalments.

12nd CLAUSE- **Modification of Premium**

1. If there is no change in the risk, any change in the premium applicable to the contract may only be made on the following annual due date, by means of a notice from the insurer to the Policy Holder at least 30 days prior to the contract renewal date.

2. However, there will be an automatic alteration of the contract premium whenever there is a change in the age group of the insured person, and for this purpose the age of the insured person on the first day of each insurance year will be considered.

13rd CLAUSE - **Premium Reversal**

When, due to amendment or termination of the contract, the premium is due under the terms of the law to be reversed or refunded, it shall be calculated under the following terms:

a. In the event that the request is from the insurer, the insurer will return to the Policyholder a portion of the premium, calculated proportionally to the unexpired period of time up to the due date;

b. If the request is taken by the Policyholder, the insurer will return to the Policyholder a part or percentage of the premium indicated in the Policy Particular Conditions, calculated proportionally to the unexpired period of time up to the maturity date, less the cost of issuing the policy;

c. If there are claims relating to the persons to be excluded, no reimbursement shall be processed.

CHAPTER IV

COMMENCEMENT OF EFFECT, DURATION AND AMENDMENTS TO THE CONTRACT

14th CLAUSE - **Contract Start and Duration**

1. This contract shall become effective at midnight on the day immediately after the insurer accepts the proposal, provided that the premium or initial fraction is paid, unless, by agreement of the parties, another date is fixed for its effectiveness, which, however, may not be earlier than the day the proposal is received by the insurer. In the case of group insurance, the guarantees of the contract come into effect at midnight on the day stated in the individual subscription certificate.

2. The contract, in the case of individual insurance where the Policy Holder is a natural person, is deemed to be accepted on the 15th day after the date of receipt of the proposal by the insurance company, unless in the meantime the prospective Policy Holder is notified of the refusal or of its anticipated approval, or of the need to gather essential details for the assessment of the risk, and the approval in this case, being dependent on the submission and analysis of the requested details. Acceptance will be confirmed by the insurance company by written notification (or by any other means of which a permanent record is kept) to the Policy Holder's address or by the issuing of the membership card and relevant specific conditions.

3. The particular conditions state the coverages subject to a waiting period, as well as to deductibles and maximum amounts of compensation, in accordance with the provisions of these general conditions and of the special conditions of the policy.

4. The contract may be signed for a term of one year, to be continued for the following years, or for a fixed and defined period, its duration being set out in the particular conditions.

5. Where the contract is entered into for a fixed and specific duration, it shall terminate at midnight on the last day of that duration.

6. When the contract is entered into for a period of one year and continues for the following years, it shall be deemed to be successively renewed, unless either of the parties has terminated it, in writing or by any other means that leaves a durable record, at least 30 days before the end of the term of the annuity, or if the premium for the subsequent annuity or the first instalment thereof is not paid.

7. Without prejudice to the provisions of clauses 19 and 28, the benefits guaranteed by the insurer solely relate to each period of validity of the contract, with no extension of the guarantees beyond the due date and only the benefits agreed upon or the expenses incurred during each year of validity of the contract being guaranteed.

15th CLAUSE - **Start and Duration of the Guarantees**

1. Only insured persons whose age conforms to the limit set by the insurer and who have completed their individual health questionnaire may be admitted to insured persons.

2. The contract's guarantees shall become effective after the expiry of the waiting periods specified for each cover in the special conditions or in the particular conditions, which shall be counted as of the date of subscription of each insured person.

3. In the event of an accident or sudden illness requiring urgent in-patient or out-patient hospital treatment, waiting periods are not applicable.

16th CLAUSE - **Membership Card**

1. To benefit from the services guaranteed by the present contract in the network(s), the insured person must present his/her membership card and an identification document with a photo. In case of loss of the membership card, the insured person or the Policyholder, must report it to the insurer through the customer service, within a maximum of 48 hours, in order for it to be cancelled and a new card to be issued.

2. The membership card is the property of the insurer and can only be used by its holder, under the terms and for the purposes set forth in this contract.

17th CLAUSE - **Amendments to the Contract**

1. For the Insurer

Any change of cover, capital, deductibles, waiting periods and premiums, for the following year, must be notified by the insurance company to the Policy Holder at least 60 days before the contract's maturity date. The Policy Holder must accept or refuse the proposal within 30 days, after which the proposed amendment is deemed to have been approved, if the premium is paid for the subsequent annuity or the first part thereof. If the proposal is not accepted by the Policy Holder, the contract must be considered as terminated by the insurance company, for the end of the year in progress.

2. For the Policyholder

Amendments to the contract at the request of the Policyholder will comply with the following:

a. The inclusion of insured persons that are part of the household is requested through communication to the insurance company, with the completion of a proposal and individual health questionnaire. The inclusion of newborn babies in a contract where at least one of the parents is the insured person is accepted without waiting periods, without pre-existing conditions and without excluding illnesses and congenital malformations, as long as a pre-enrolment has been made by the 6th month of pregnancy. To apply these conditions, definitive subscription must be made within the first 30 days of the child's life, by filling in a proposal and an individual health questionnaire.

b. Exclusion of insured persons shall be requested by notifying the insurer at least 30 days prior to the effective date. The insurer shall charge back the premium paid for the unexpired period.

c. The transfer of the titleholder of the purchased plan is requested by the Policy Holder through communication to the insurance company, at least 30 days before the effective date, including the acceptance of the Insured Person who will be the titleholder of the new contract, beginning the same on the following day, with the completion of the proposal, but without the need for a new individual health questionnaire.

d. The change of the contracted plan is requested by the Policyholder, through notification to the insurance company, at least 90 days prior to the due date, within the scope of the plans on offer. From the starting date of the new plan, the following are considered as waiting periods related to new coverages or to capital increases in the coverages of the previous plan.

18th CLAUSE - **Right of Free Termination**

1. The Policy Holder, who is a natural person, has a period of 30 days, as from the reception of the policy, to terminate the contract, by means of written notice, on paper or any other durable form available and accessible to the insurance company.

2. The term referred to in no. 1 shall be counted from the date of signature of the contract, provided that the Policyholder has at that date, on paper or on another durable medium, all the relevant information about the insurance that must be part of the policy.

3. The exercise of the right of free cancellation shall terminate the contract, ceasing all obligations arising there from, with effect from the date of signature of the contract, and the insurer shall be entitled to:

a. Have the value of the premium calculated pro rata temporis, to the extent that it has borne the risk until the termination of the contract;

b. To the amount of reasonable expenses supported with medical exams, whenever such amount is contractually charged to the Policy Holder.

19th CLAUSE - **Termination of the Contract and Exclusion of the Insured Person**

1. The insurance contract may be terminated by either party, at any time, with a valid reason, under provisions of the general terms.

2. Termination of the contract due to the lack of payment of the premium shall be subject to the provisions of the applicable legal and contract provisions.

3. Termination of the contract is effective at midnight of the day it takes place.

4. In contributory group insurance, the insured person may be excluded from the insurance when he/she fails to deliver to the Policy Holder or to the Insurer, depending on what is agreed upon, the amount intended for the payment of the premium. In this case, the rules on non-payment of premiums regarding subscription will apply, with the necessary adaptations.

5. The insured person may also be excluded when he/she or a beneficiary, with his/her knowledge, engage in fraudulent actions to the detriment of the insurer or the Policyholder.

6. The exclusion of the insured person provided for in the preceding number 5 has no retroactive effect and shall be effected, by written notification, with a prior notice of 8 days, by the insurer.

20th CLAUSE - **Expiration of the Contract**

1. The insurance contract shall automatically expire on its expiry date, in the case of insurance contract signed for a fixed and specified period of time.

2. In the case of insurance contracted for one year and to be continued for the following years, each subscription shall automatically expire:

- **a.** At the end of the insurance annuity when the insured person no longer meets the conditions that allowed him/her to join the insurance group;
- **b.** At the end of the annuity in which the insured person reaches the age limit set by the insurer in the particular conditions;
- **c.** At the end of the annuity in which the insured person ceases to be part of the family household, or in the case of a child or adopted child, ceases to be covered by the official scheme for granting child benefit.

CHAPTER V

INSURER'S MAIN BENEFIT

21st CLAUSE - **Insured amounts and deductibles**

1. The maximum amounts guaranteed by this policy, as well as the contracted deductibles, are stated in the special conditions and are in force in each policy annuity.

2. The insurer guarantees to the insured person the payment of the expenses paid, up to the contracted limit, during each period of validity of the contract.

3. Unless otherwise agreed, in cases of maturity adjustment, the guaranteed values are proportional to the time at risk.

22nd CLAUSE - **Subrogation**

1. Once the indemnity is paid, the insurer is, under the provisions of the law, subrogated to all the rights of the insured person against the third party responsible for the loss, until such time as the amount of the indemnity is reached, and the insurer undertakes to do whatever is necessary to enforce these rights.

2. The insured person shall be liable for damages for any wilful act or omission that may prevent or impair the exercise of those rights.

23rd CLAUSE - **Offsetting of Credits**

When paying any amount under this contract, the insurer, whenever allowed by law, may discount any amounts due by the Policyholder or the insured person.

24rd CLAUSE - **Coexistence of Contracts**

1. The Policy Holder and/or the Insured are required to inform the Insurer, under penalty of being held liable for losses and damages, of the existence of other insurances with the same scope and guarantee.

2. If, on the date of the claim, there is more than one insurance contract with the same cover and object, this policy will only operate in the event of non-existence, nullity, ineffectiveness or insufficiency of previous insurances.

CHAPTER VI

OBLIGATIONS AND RIGHTS OF THE PARTIES

25th CLAUSE - **Obligations of the Policy Holder and the Insured Person**

1. In the event of a claim covered by this contract, the Policy Holder and the insured person, under penalty of being held liable for losses and damages, are required to:

- **a.** Take the measures within their reach to avoid worsening the claim;
- **b.** Notify the insurer, in writing, of the claim within 8 days of its occurrence;
- **c.** Carry out, whenever requested to do so, exams that will be paid for by the insurer at doctors designated by the insurer, ceasing the responsibility of the insurer if the insured fails to do so;
- **d.** Authorise, in the context of a claim giving rise to a request for provision or reimbursement of health care under the insurance contract, the doctors and other professionals or health care institutions to which he has had recourse, to provide the doctor designated by the insurer with the information requested by the latter concerning his state of health and the clinical services provided.

2. Under the reimbursement scheme, the Policy Holder and the insured person are also required to present the original receipts of the expenses to the insurance company, within 120 days from the date they were paid. Whenever the originals have been used by the insured person to request reimbursement of expenses from another entity, photocopies may be presented, provided that they are accompanied by a statement issued by the same entity that proves the total amount of the expense and the amount of the reimbursement. Likewise, whenever the insured person needs to present the originals for the purposes of a subsequent request for reimbursement from another entity, he/she will present photocopies of the originals, accompanied by a statement issued by the insurance company to prove the total amount of the expense and the amount of the reimbursement.

3. The insurer shall not be liable for the consequences of delay or negligence attributable to the insured person in seeking assistance, nor shall it be liable if the insured person refuses to follow the prescribed treatment.

4. The Policy Holder and the insured person are liable in legal terms for losses and damages, in cases of fraud, simulation and misrepresentation to justify health expenses or in any other use of malicious means, which aim at an abusive use of the contract to obtain an illegitimate benefit.

26th CLAUSE - **Liability to prove**

The liability of proving the truthfulness of the statements shall rest on the insured person, and the insurer may require from him the appropriate means of proof within his reach.

27th CLAUSE - **Obligations of the Insurer**

The insurer is required to fulfil its commitments to the Policyholder and insured persons in a timely manner, namely:

a. Provide the membership card referred to in clause 16, as well as making available information on the services of the network(s);

b. Examine with promptness and diligence the requests for authorisation, deciding on them within a period not exceeding 5 working days, as from the date on which all the required data is received for their assessment;

c. Reimburse the benefits, within a maximum period of 30 working days from the date on which the calculation of the contributions to be paid was made, as stipulated in the specific conditions. If, after this period, the insurer, in possession of all the necessary data for the reimbursement of the benefits, has not fulfilled this obligation, for any unjustified reason or for reasons ascribed to it, the insurer will incur in delay, and the indemnity will bear interest at the legal rate in force at the time.

28th CLAUSE - **Responsibility of the Insurer in the Event of Non Renewal of the Contract**

1. In the event of non-renewal of the contract, or in the case of group insurance, in the event of non-renewal of the insured person's membership, the insurer shall, for a period of 2 years and until the insurance capital available in the annuity in which the contract or membership in the case of group insurance ceased, be required to pay the benefits contractually due, as a result of manifest illness or accidents occurring during the period of validity of the policy, provided that they are covered by the insurance.

2. The obligation set out in the previous number only applies in relation to illnesses or accidents that happened and were covered during the period of validity of the guarantees, provided that the relevant notice is made to the insurer within 30 days immediately after the end of the contract, unless there is just cause for impediment.

CHAPTER VII

MISCELLANEOUS PROVISIONS

29th CLAUSE - **Communications and Notifications between the Parties**

1. The communications and notifications between the Policy Holder and the insured person provided for in this policy will be deemed valid and fully effective if they are made in writing or by any other form of which a durable record is kept at the registered office of the insurer.

2. However, the change of address or headquarters of the Policy Holder or the insured person, must be communicated to the insurer within 30 days after the date they take effect, otherwise the communications or notifications that the insurer may make to the outdated address will be deemed valid and effective.

3. The communications and notifications of the insurer, as provided for in this policy, are considered valid and fully effective if made in writing or by any other means of which a durable record is kept, to the last address of the Policy Holder or of the insured person stated in the contract, or notified in the meantime under the terms of the previous number.

30th CLAUSE - **Effectiveness in relation to Third Parties**

Any exceptions, invalidities and other provisions that, in accordance with the present contract or the law, may be raised against the Policy Holder or the insured person will also be raised against any third party who benefits from it.

31th CLAUSE- **Currency**

1. The insurance contract may be signed in the current national currency or in foreign currency, in accordance with the monetary and exchange legislation in force in the Country.

2. Without prejudice to whether the insured (capital/value) is expressed in the national currency in force or in foreign currency, any indemnity to which it may give rise shall be paid in the national currency in force.

32th CLAUSE - **Exchange Rate Fluctuation**

1. It is agreed between the parties that in case of exchange rate fluctuation higher than 5% of the metical in relation to the American dollars, the Insurer has the right to issue a compensatory receipt from the date in which the fluctuation occurs until the end of the contract, on a pro-rata temporis basis.

2. The reference values to be considered for the effects of the present clause will be measured fortnightly on the first and sixteenth days of each month through a review of the average values of the previous fortnight. The reference values used will be those published by the Commercial Banks.

33th CLAUSE - **Applicable Law**

The law applicable to the present contract is the Mozambican law.

34th CLAUSE - **Complaints**

Any claim relating to this contract or the obligations and rights hereunder may be submitted directly to the insurer or through the insurance supervisory authority.

35th CLAUSE - **Arbitration**

Disputes arising under this contract may be submitted to arbitration, to be carried out in accordance with the law.

36th CLAUSE - **Jurisdiction**

The appropriate court for settling any dispute arising from this contract shall be that of the place of issue of the policy, without prejudice to the provisions of Mozambican law with regard to territorial jurisdiction for the fulfilment of obligations.

SPECIAL CONDITIONS

Common Provisions

In so far as not specifically regulated herein, the provisions of the general conditions of health insurance shall apply to the following special conditions.

A. MOZAMBIQUE

I- HOSPITALISATION

1) Covers

of expenses incurred in Mozambique, as listed below, with diagnostic or therapeutic acts, the performance of which requires the specific means and services of a hospital environment, with hospitalization for a period of 24 hours or more. However, even if the hospital stay lasts less than 24 hours, payment of the above-mentioned expenses is also guaranteed and this special condition applies to expenses related to:

a. Accommodation and use of the necessary infrastructures to perform the medical procedures (daily room, operating theatre and equipment);
b. Medical and nursing fees, related to the provided assistance;
c. Medicines, materials and all products associated with the care provided;
d. Auxiliary diagnostic exams, associated to the medical procedures performed;
e. Osteosynthesis material and intra-surgical prostheses;
f. Stomatological, dental and maxillo-facial surgery resulting from an accident covered by the contract;
g. Cytostatic chemotherapy and radiotherapy treatments, even if carried out as outpatients.

2) Exclusions

In addition to the exclusions provided for in the general conditions, this special condition does not cover the following expenses:

a. Resulting from minor surgery, whatever the length of stay in the hospital unit;
b. Resulting from normal childbirth, caesarean section and pregnancy voluntary interruption;
c. Made by persons accompanying the insured person, except in the case of hospitalisation of underage up to fourteen years of age or citizens with congenital or acquired deficiency;
d. Expenses of a private nature.

3) Benefit Scheme

The covers of this special condition are guaranteed under the network benefits scheme and/or under the reimbursement benefits scheme, as defined in the specific conditions or in the individual subscription certificate. For in-network benefits, approval is always required, which must be requested through the Customer Support Service. However, expenses related to medical fees are covered under both the network benefits scheme and the reimbursement benefits scheme, limited to the amount specified in the individual terms and conditions or in the individual membership certificate.

II- MEDICAL EMERGENCIES IN MOZAMBIQUE

1) Coverage

The covers afforded by this special condition will only apply in the event of a medical emergency in Mozambique.

2) Exclusions

Treatment expenses are expressly excluded.

3) Benefit Scheme

Cover for this special condition is guaranteed under the network benefits scheme, and should be requested through the customer support service.

A. TELEPHONE ASSESSMENT OF THE NATURE AND SEVERITY OF THE EVENT

If the Insured Person is hospitalised, the insurer guarantees through its medical team and in conjunction with the Insured Person's Assistant Physician, an evaluation of the nature and severity of the clinical condition, as well as the monitoring of its progress, making this information available to the family if requested.

B. EMERGENCY MEDICAL ADVICE AND INFORMATION

In the event of an emergency, the insurance company guarantees the Insured Person the possibility of contacting the medical advice and information telephone service, which will provide its support, with a view to adopting measures aimed at improving the health of the Insured Person, being able to activate the available rescue means suitable for such situations.

The medical advice and support provided under this special condition is aimed at identifying the symptoms that the Insured Person reports to the service by telephone, which will suggest the use of the most appropriate means for the type of condition reported, with the possible indication of the need to resort to on-site medical care or other type of action. The liability of this cover is therefore limited to the liability arising from this type of medical act in the non-face-to-face circumstances in which it is carried out.

C. EMERGENCY TRANSPORT OF THE INSURED PERSON TO THE APPROPRIATE HOSPITAL UNIT

The insurer guarantees, whenever it is justifiable by the Insured Person's state of health, the right to

a. Emergency ambulance transport to the nearest hospital unit;
b. Transport from the hospital unit in which you are admitted to another hospital unit that is indicated for you;
c. Transport back to your usual home, after medical discharge.

D. TRANSPORT OF THE INSURED PERSON BY COMMERCIAL AIRCRAFT

If the Insured Person requires treatment that cannot be provided in a hospital in Mozambique, the insurer will arrange for transfer by commercial aircraft to a hospital in South Africa, Portugal or India where the necessary medical care can be provided. Each evacuation will be decided and supervised by the insurer's medical team.

As an alternative and with the agreement of all parties, the transport may be to South Africa or another country in the region, if this solution meets the conditions for the treatment of the Insured Person.

Under the terms and within the limits set out in the Specific Conditions, the payment of overnight accommodation expenses incurred by a companion of the Insured Person during the hospitalisation of underaged up to the age of fourteen or of citizens suffering from a congenital or acquired handicap is also covered.

This guarantee has a maximum limit of three overnight stays per claim and per annuity.

E. REPATRIATION OF THE ILL INSURED PERSON OR HIS MORTAL REMAINS TO MOZAMBIQUE OR THE COUNTRY OF HIS NATIONALITY

Se a Pessoa Segura tiver sido transportada ao abrigo da garantia de transporte da Pessoa Segura por avião comercial, a seguradora garantirá o seu repatriamento para Moçambique ou país da sua nacionalidade, quando tal for clinicamente aconselhável ou caso faleça em consequência da doença que deu origem ao referido transporte.

III- NORMAL CHILDBIRTH, CAESAREAN SECTION AND INVOLUNTARY PREGNANCY INTERRUPTION

1) Coverage

The present special condition guarantees, within the terms and limits set forth in the specific conditions, the payment of expenses incurred in Mozambique for acts of diagnosis or therapy, inherent to normal childbirth, caesarean section and involuntary pregnancy interruption, requiring the specific means and services of a hospital environment.

This special condition covers expenditure incurred for:

a. Accommodation and use of the infrastructures necessary to perform the medical procedures (daily room, operating theatre and equipment);
b. Medical and nursing fees related to the assistance provided;
c. Materials and all products associated with the care provided;
d. Auxiliary diagnostic examinations of the insured person carried out during the period of hospitalisation;
e. Medicines administered to the insured person during hospitalisation.

2) Exclusions

The necessary expenses for the newborn baby, after the mother's discharge, are only guaranteed if the Policy Holder requests the insurance company to pre-enrol until the 6th month of pregnancy, complemented by permanent enrolment up to 30 days after birth. In this case, once the inclusion of the newborn baby as an insured person has been accepted, the corresponding premium will be due as from birth.

In addition to the exclusions provided for in the general conditions, this special condition does not cover the following:

a. Expenses of a private nature;
b. Accompanying persons.

3) Benefit Scheme

The covers of this special condition are guaranteed under the network benefits scheme and/or the reimbursement benefits scheme, as agreed upon in the specific conditions or in the individual subscription certificate. For in-network benefits, authorisation is always required, which must be requested via the Customer Support Service. However, expenses related to medical fees are covered under both the network benefits scheme and the reimbursement benefits scheme, limited to the amount of k as stated in the individual terms and conditions or in the individual membership certificate.

IV- OUTPATIENT

1) Coverage

This special condition guarantee, under the terms and within the limits set forth in the specific conditions, the payment of expenses incurred in Mozambique for diagnostic or therapeutic procedures that do not require the specific means and services of a hospital environment, even if performed in such an environment.

This special condition covers expenditure paid for:
a. Consultation fees;
b. Medical and nursing fees for other medical procedures carried out on an out-patient basis;
c. Materials and products associated with medical procedures performed on an outpatient basis;
d. Auxiliary diagnostic tests;
e. Physical medicine and rehabilitation treatments, including speech therapy, if prescribed by a physician.

2) Exclusions

In addition to the exclusions provided for in the general conditions, this special condition does not guarantee:

a. Stomatological consultations, treatment, surgery and prostheses;
b. Orthoptic exercises;
c. Prostheses and orthotics;
d. Medicines.

3) Benefit Scheme

The covers of this special condition are guaranteed under the network benefits scheme and/or the reimbursement benefits scheme, as set out in the particular conditions or in the individual subscription certificate.

Access to the services covered by this special condition requires prior authorisation for the following cases:

3.1. Consultations

a. Genetics;
b. Home visits.

3.2. Auxiliary diagnostic tests and therapeutic procedures

a. Polysomnography;
b. Nuclear magnetic resonance;
c. Invasive methods of diagnosis and therapy in cardiology;
d. Invasive methods of vascular diagnosis and therapy;
e. Hemodialysis;
f. Radiotheraphy;
g. Physical medicine and rehabilitation treatments.

V- STOMATOLOGY

1) Coverage

The present special condition guarantees, under the terms and within the limits set forth in the specific conditions, the payment of expenses incurred in Mozambique for diagnostic or therapeutic procedures of a stomatological nature.

This special condition covers expenditure incurred for:

a. Fees for medical consultations;
b. Medical and nursing fees for other medical procedures performed on an out-patient basis;
c. Materials and all products associated to the medical procedures performed;
d. Accommodation and use of the necessary infrastructures for the medical procedures performed in a hospital environment (daily room, operating room and equipment);
e. Medication administered during hospitalization.

2) Exclusions

Apart from the exclusions provided for in the general conditions, this special condition does not cover:

a. Orthodontic appliances and related moulds and studies;
b. Treatments carried out using precious metals;
c. Rehabilitation of missing teeth or rehabilitated teeth with prosthesis at the date of the contract;
d. Stomatological prostheses.

3) Benefit Scheme

The covers of this special condition are guaranteed under the network benefits scheme and/or the reimbursement benefits scheme, as set out in the particular conditions or in the individual subscription certificate.

VI- PROSTHESES AND ORTHOTICS

1) Coverage

The present special condition guarantees, under the terms and within the limits fixed for this purpose in the special conditions, the payment of expenses incurred in Mozambique for prostheses or orthotics, provided that they are prescribed by a doctor of the speciality or an optometrist.

2) Exclusions

Apart from the exclusions provided for in the general conditions, this special condition does not guarantee:

a. Stomatological prostheses;
b. Optometric tests;
c. Medical belts, elastic stockings and orthopaedic mattresses;
d. Equipment acquisition or rental;
e. Orthopedic shoes;
f. Isolated acquisition of eye frames;
g. Loss, theft, robbery or breakage of ocular orthotics.

3) Procedures

As regards to prostheses of an ophthalmic nature, the cover provided by the present special condition is accepted by the insurer if are followed the procedures described below:

a. In the first submission of expense for ocular lenses, they shall only be reimbursed when accompanied by the relevant prescription issued by a doctor or optometrist. In the following cases, the reimbursement
of expenses shall only be paid when there is a change in the correction with respect to the previous prescription;
b. Eye frames are only reimbursed when purchased together with eye lenses, provided that these are also reimbursable;
c. The period of three years is considered as the useful life for frames and lenses, after which they become reimbursable, even if there is no change in the correction in relation to the previous prescription. This period of life is not applicable to disposable contact lenses;
d. In the case of children under 16 years of age, frames and lenses may be reimbursed without the aforementioned alterations, as long as the medical prescription clearly states the need to change glasses as a result of their growth;
e. Cases of theft, robbery, loss or breakage of glasses or lenses will never be considered, except when resulting from an accident covered by the contract, provided that the relevant accident report is accompanied by a document proving the physical injuries caused to the insured person, drawn up by the doctor or hospital unit that provided assistance.

3) Benefit Scheme

The covers of this special condition are guaranteed on a reimbursement basis.

VII- MEDICINES

1) Coverage

This special condition guarantees, within the terms and limits set out in the specific conditions, the payment of expenses incurred in Mozambique for medicines, classified as such by the appropriate authority of the Ministry of Health, provided that they are prescribed by a doctor, to treat an illness or accident covered by the policy.

2) Exclusions

Apart from the exclusions provided for in the general conditions, this special condition does not cover:

- **a.** Shampoos, soaps, medicated pastes and similar;
- **b.** Aesthetic, cosmetic and hygiene products;
- **c.** Dietetic, homeopathic or manipulated products;
- **d.** Contraceptives and intrauterine devices;
- **e.** Vaccines, with the exception of allergological ones;
- **f.** Child feeding;
- **g.** Sanitary and antiseptic articles;
- **h.** Dressing material;
- **i.** Obesity Treatment Products.

3) Benefit Scheme

This cover operates only on a reimbursement scheme.

VIII- CLINIC SERVICE LINE

1) Coverage

The present Special Condition guarantees to the Insured Person, through an online or telephone request, the possibility of obtaining support and advice for the adoption of measures aimed at improving their health.

According to the provisions of the Policy Particular Conditions and at the option of the Insured Person, the answer may be:

- By telephone contact on enquiry;
- By email address;
- Through a mobile application (app).

This service is provided by a team of specialists (doctors and nutritionists). The advice and support provided under this Special Condition is aimed at identifying the signs and symptoms reported by the Insured Person. The specialist support service will be responsible for suggesting the use of the most appropriate means for the type of situation, indicating whether it requires on-site medical care or other type of actions. The responsibility of this cover is therefore limited to the responsibility arising from this type of medical intervention in the non-face-to-face circumstances in which it is carried out.

The services included in this cover are as follows:

a) CONSULTATION BY PHONE OR E-MAIL
A consultation by telephone or e-mail allows the Insured Person to consult a medical team specialised in General Practice/Family Medicine.

In the e-mail consultation, the insured person can send images and medical examinations so that the doctors can evaluate the particular medical condition.

b) SECOND MEDICAL OPINION
The aim of the service is to help you decide on the appropriate treatment to follow with peace of mind and safety. The service allows you, in case of diagnosed illness, to get a second opinion from a team of doctors and nurses, specialised in General Practice/Family Medicine, by simply calling them.

c) NUTRITIONAL ADVICE
The Nutritional Counselling service is aimed at carrying out consultations related to food or diet, carried out by a team of specialists in nutrition and dietetics, who may be requested to analyse Auxiliary Diagnostic Tests, medical reports, menus, etc.

d) HEALTHY HABITS TEST

The Healthy Habits Testing service is an online test that allows the Insured Person to obtain:

- Report on their health status with tailor-made recommendations;
- Cardiovascular risk assessment;
- Tailor-made dietary lifestyle recommendations.

The service includes the possibility of medical opinion on the report, when the Insured Person considers it necessary, which can be requested online or by telephone.

2) Extensions

In addition to the exclusions set out in the General Conditions, this Special Condition does not guarantee:

1) Possible damages due to delays or difficulties in accessing this service as a result of malfunctioning telecommunications networks;

2) Any consequences of delay or negligence attributable to the Insured Person in resorting to medical assistance, as well as the consequences of deficient, incorrect or inaccurate information provided by him/her or by third parties under his/her instructions;

3) Any consequences of non compliance, by the Insured Person, with the instructions provided through the service.

3) Benefit Scheme

The covers of this special condition are guaranteed under the network benefits scheme.

B. SOUTH AFRICA

IX – EXTENSION TO SOUTH AFRICA – INPATIENT CARE

1) Coverage

The present special condition guarantees, within the terms and limits fixed for the purpose in the specific conditions, the payment of expenses incurred in South Africa, for diagnostic or therapeutic procedures, the performance of which requires the specific means and services of a hospital environment with hospitalisation for a period of 24 hours or more. However, even if the hospital stay is for a period of less than 24 hours, payment of the above-mentioned expenses is also guaranteed when arising from out-patient surgery, the value of which is set out in the particular conditions.

This special condition covers expenses made in respect of:

a. Accommodation and use of the infrastructures necessary to carry out medical procedures (per diem, operating theatre and equipment);
b. Medical and nursing fees, related to the assistance provided;
c. Medicines, materials and all products associated with the care provided;
d. Auxiliary diagnosis exams, associated to the medical acts performed;
e. Osteosynthesis material and intra-surgical prostheses;
f. Stomatology, dental medicine and maxillofacial surgery surgeries resulting from an accident covered by the contract;
Cytostatic chemotherapy and radiotherapy treatments, even if carried out on an out-patient basis.

2) Exclusions

In addition to the exclusions provided for in the general conditions, this special condition does not guarantee expenses:
a. Arising from small surgery, whatever the period of stay in the hospital unit;
b. Resulting from normal childbirth, caesarean section and involuntary interruption of pregnancy;
c. Carried out by companions of the insured person, except in the case of hospital admission of under aged up to fourteen years old or citizens with congenital or acquired disabilities;
d. Expenses of a private nature.

3) Benefit Scheme

The covers of this special condition are guaranteed under the network benefits scheme and/or the reimbursement benefits scheme, as set out in the particular conditions or in the membership certificate. For in-network benefits, authorisation is always required, which must be requested through the Customer Support Service.
Reimbursement is only guaranteed at 100% for expenses with services provided by providers in the network. To this end, these special condition guarantees the insured person the right to access the medical network in South Africa.

X- EXTENSION TO SOUTH AFRICA - NORMAL CHILDBIRTH, CAESAREAN SECTION AND INVOLUNTARY TERMINATION OF PREGNANCY

1) Coverage

This special condition guarantees, within the terms and limits set forth in the specific conditions, the payment of the costs incurred in South Africa for diagnostic or therapeutic procedures, associated to normal childbirth, caesarean section and involuntary termination of pregnancy, which requires the specific means and services of a hospital environment.

This special condition covers expenditure incurred for:
a. Accommodation and use of the infrastructures necessary to carry out the medical procedures (per diems, operating theatre and equipment);
b. Medical and nursing fees related to the assistance provided;
c. Materials and all products associated with the care provided;
d. Auxiliary diagnostic tests of the insured person carried out during the period of hospitalization;
e. Medicines administered to the insured person during the hospital stay.

2) Exclusions

The necessary expenses for the newborn baby, after the mother's discharge, are only guaranteed if the Policy Holder requests the insurance company to pre-enroll until the 6th month of pregnancy, completed with full enrolment up to 30 days after birth. In this case, once the inclusion of the newborn baby as an insured person has been accepted, the corresponding premium will be due as from birth.

In addition to the exclusions set out in the general conditions, this special condition does not guarantee
a. Expenses of a private nature;
b. Expenses for accompanying persons.

3) Benefits Scheme

The covers of this special condition are guaranteed under the network benefits scheme and/or the reimbursement benefits scheme, as set out in the specific conditions or in the membership certificate. For in-network benefits, authorisation is always required, which must be requested through the Customer Support Service.

Reimbursement is only guaranteed at 100% for expenses with medical procedures carried out with providers in the network. To this end, the present special condition guarantees the insured person the right to access the medical network in South Africa.

XI – EXTENSION TO SOUTH AFRICA - OUTPATIENT CLINIC

1) Coverage

The present special condition guarantees, under the terms and within the limits fixed for the purpose in the specific conditions, the payment of expenses made in South Africa for diagnostic or therapeutic procedures that do not require the specific means and services of a hospital environment, even if they are performed there.

This special condition covers expenditure incurred for:
a. Fees for medical consultations;

b. Medical and nursing fees for other medical services provided on an out-patient basis;
c. Materials and products associated with medical procedures performed on an out-patient basis;
d. Auxiliary diagnostic tests;
e. Physical medicine and rehabilitation treatments, including speech therapy, if prescribed by a physician.

2) Exclusions

In addition to the exclusions provided for in the general conditions, this special condition does not guarantee:

a. Stomatological consultations, treatments, surgery and prostheses;
b. Orthoptic exercises;
c. Prostheses and orthotics;
d. Medicines.

3) Regime de prestações

The covers of this special condition are guaranteed under the reimbursement benefit scheme, as set out in the particular conditions or in the membership certificate.

The guarantee is only for the reimbursement of 100% of expenses for services provided by providers within the network. For this purpose, the present special condition guarantees the insured person the right of access to the medical network in South Africa.

Access to the services guaranteed by this special condition requires prior authorisation for the following cases:

3.1. Consultas
a. Genetic;
b. Home Consultations.

3.2. Exames auxiliares de diagnóstico e meios terapêuticos
a. Polysomnography;
b. Nucleat magnetic resonance;
c. Invasive methods of diagnosis and therapy in cardiology;
d. Invasive methods of vacular diagnosis and therapy;
e. Hemodialysis;
f. Radiotherapy;
g. Physical medicine and rehabilitation treatments.

XII- EXTENSION TO SOUTH AFRICA - STOMATOLOGY

1) Coverage

This special condition covers expenses paid in South Africa for diagnostic or therapeutic treatment of dental diseases. Only 100% reimbursement is guaranteed for expenses incurred for procedures carried out at providers in the network of providers. For this purpose, the present special condition guarantees the insured person the right of access to the South African medical network.

This special condition covers expenditure made for:
a. Medical fees;
b. Auxiliary diagnostic tests;
c. Stomatological prostheses;
d. Materials and all products associated to the medical services performed;
e. Accommodation and use of necessary infrastructures for the medical acts performed in hospital environment ("per diem", operating room and equipments);
f. Medication administered during hospitalization.

2) Exclusions

In addition to the exclusions provided for in the general conditions, this special condition does not guarantee:

a. Orthodontic apparatus and the respective moulds and studies;
b. Treatments carried out using precious metals;
c. Rehabilitation of missing teeth or rehabilitated teeth with prosthesis at the date of the contract.

3) Benefit Scheme

The covers of this special condition are guaranteed under the reimbursement benefit scheme, as set out in the particular conditions or in the membership certificate.
Only 100% reimbursement of expenses is guaranteed for procedures carried out with providers in the network of providers. To this effect, the present special condition guarantees the insured person the right to access the medical network in South Africa.

XIII- EXTENSION TO SOUTH AFRICA - MEDICINES

1) Coverage

This special condition guarantees, under the terms and within the limits set out in the particular conditions, the payment of expenses paid in South Africa for medicines, classified as such by the appropriate authority of the Ministry of Health, provided they are prescribed by a doctor for treatment of illness or accident that is covered under the policy.

2) Exclusions

Apart from the exclusions provided for in the general conditions, this special condition does not guarantee:

a. Shampoos, soaps, medicated pastes and similar;
b. Aesthetic, cosmetic and hygiene products;
c. Dietetic, homeopathic or manipulated products;
d. Contraceptives and intrauterine devices;
e. Vaccines, with the exception of allergological ones;
f. Child feeding;
g. Sanitary and antiseptic articles;
h. Dressing material;
i. Obesity Treatment Products.

3) Benefits Scheme

This cover operates only under the reimbursement benefit scheme

C. EXTENSION ABROAD

XIV- EXTENSION TO INDIA AND PORTUGAL

1) Coverage

3.1. Territorial Scope

Risks are covered anywhere in the world except in the country of nationality of the Insured Person.

3.2. Guarantees

This Special Condition guarantees the Insured Person, when travelling or travelling abroad for no more than 30 days, the right to an Assistance Service in case of accident or illness declared during the journey, under the terms and limits set forth in this Special Condition, with the following services:

a) Admission and Information - In case of illness declared during the trip or accident that requires the hospitalisation or treatment of the Insured Person, duly justified, in a hospital or clinic, the Insurer will take care of the necessary procedures for the admission of the Insured Person in the hospital unit chosen by the Insured Person, as well as undertake to provide information about the hospital or clinic most appropriate for his/her situation.

b) Medical Expenses - In case of illness declared during the trip or accident during the trip, the Insurer guarantees, up to the maximum amount of coverage specified in the particular conditions for inpatient and outpatient benefits respectively, the payment of expenses relating to:

- Hospitalisation; Doctor's fees and consultation fees;
- Medicines classified as such and prescribed by a doctor;
- Ambulance transport or other means of transport that the severity of the situation justifies, from the place of the incident to the nearest hospital or clinic.

c) Medical Control - If the Insured Person is hospitalised, the Insurer's medical team will follow his/her clinical evolution, keeping in contact with the doctor in charge and his/her family, whenever the clinical condition so justifies.

d) Follow-up of hospitalised Insured Person - If the Insured Person is hospitalised and his/her state of health does not recommend his/her repatriation, the Insurer bears the expenses as defined in the particular conditions of the policy.

e) Expenses with children abroad - The Insurer guarantees the payment of expenses for the custody of children under 15 years of age, for a maximum period of 10 days, as well as their return home, if the Insured Person in charge of them dies or is hospitalised, or guarantees the payment of a travel ticket (round trip) to a member of the relevant family who can take care of them.

f) Repatriation or medical transport - In the event of illness declared during the trip or accident, the Insurer guarantees the payment of transport expenses by the appropriate means, for the Insured Person who has suffered a serious bodily injury, to the hospital centre prescribed by the medical team or to their usual home, after prior control by the Insurer's medical team, in contact with the attending physician, to determine the most convenient measures to take. If the Insured Person is admitted to a hospital centre far from their home, the Insurer guarantees the payment of the costs of their subsequent transport, when appropriate, to their home. The means of transport to be used by the Insurer may be the regular commercial airline according to the urgency and seriousness of the case.

g) Repatriation after death - In the event of the death of the Insured Person, the Insurer guarantees the payment and handling of formalities at the place of death and the cost of transporting the body to the place of burial in Mozambique, excluding the cost of purchasing a wooden coffin. In case the Insured Persons accompanying the Insured Person at the time of death cannot return by the means initially foreseen, the Insurer shall pay the transportation expenses for their return to the departure airport in Mozambique.

2) Benfit Scheme

The covers of this Special Condition are guaranteed under the scheme of benefits in the network of providers, and should be requested through the Customer Support Service.