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# CUIDA HEALTH INSURANCE

**GENERAL AND SPECIAL POLICY CONDITIONS**

**General Conditions**

1. An insurance contract is entered into between FORTALEZA Seguros - Companhia de Seguros SA, hereinafter referred to as the Insurer, and the Policyholder mentioned in the Specific Conditions, which is governed by the present General Conditions and by the Specific Conditions, as well as, if contracted, by the Special Conditions.
2. The individualized drafting of this contract is made in the Specific Conditions, containing, among others, the identification of the parties and their domicile, the Insured Person's details, the details of the Insurer's representative for claim purposes, and the definition of the premium or the formula for its calculation.
3. The Special Conditions provide for the coverage of other risks and or guarantees in addition to those provided for in these General Conditions and need to be specifically identified in the Specific Conditions.

**Clause 1 DEFINITIONS**

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

1. **Concerning the Entities involved in the health insurance contract**

**INSURER:** Fortaleza Segura - Companhia de Seguros, S.A., an entity legally authorized to practice the Insurance activity and which signs, together with the Policyholder, the insurance contract.

**CUIDA**

Exclusive brand of the Health product managed by Fortaleza Seguros - Companhia de Seguros S.A.

**POLICYHOLDER**

Entity that enters into the insurance contract with the Insurer, being responsible for the payment of the Premium.

**INSURED PERSON**

Natural person identified in the Specific Conditions and holder of an Individual Certificate of Insurance, whose health or physical integrity is insured, and who is the beneficiary of the Policy guarantees.

**HOUSEHOLD**

The group of people identified in the Specific Conditions or in the Individual Certificate who live in a common economy and include, besides the Policyholder, in the case of individual insurance, or the Subscriber, in the case of group insurance, his/her spouse or partner, as well as his/her descendants or ascendants in a direct or collateral line up to the 2nd degree, who are economically dependent on the Policyholder or on the Subscriber.

For all intents and purposes of this policy, a spouse is a person who lives with the insured person under conditions similar to those of spouses and on a permanent basis, and stepchildren and adopted children (including foster children).

1. **Concerning the documents which**

**regulate and are part of the contract**

**POLICY:** Document that titles the contract signed between the Policyholder and the Insurer, of which the agreed General, Special and Specific Conditions are an integral part, as well as the additional Addenda to the contract. All the amendments that occur during the validity period of the contract will be written in an Additional Addendum

**GENERAL CONDITIONS:** Set of clauses that define and regulate generic and common requirements inherent to the insurance contract.

**SPECIAL CONDITIONS:**

Clauses which, by completing or specifying the General Conditions, are of general application to certain coverages, when contracted, prevailing

over them in interpretation of the contractual terms.

**SPECIFIC CONDITIONS:**

Document containing the specific elements of each insurance contract, which is embodied in an Individual Certificate, and complements the General and Special Conditions of the contract, so that it is adapted to each particular contract.

**ADDITIONAL ADDENDUM:**

Document that formalizes an amendment to the Policy.

1. **Concerning the health insurance subscription:**

**FORTALEZA SEGUROS HEALTH INSURANCE - CUIDA:**

Health insurance contract signed between the Insurer and the Policyholder, titled by the issue of a Policy, by which the Insurer guarantees to the Insured Persons access to the in-network health care providers, under the terms and limits agreed upon with them, determining the financing criteria expressly indicated, or the partial repayment of health expenses borne with out-of-network Entities, under the terms and limits set forth in the Policy's Specific Conditions.

**FORTALEZA SEGUROS HEALTH INSURANCE PROPOSAL - CUIDA**

Document, under the Insurer's standard form, to be filled out and signed by the Policyholder or by each Subscriber (Subscription Form), containing the essential information for the acceptance of the insurance contract or the individual subscription. This document is an integral part of the Policy when issued and binds all parties, that is, the Policyholder, each Subscriber, and the Insurer.

**INDIVIDUAL HEALTH QUESTIONNAIRE**

Form containing a set of indicators related to health data, in order to set up a profile and clinical history that allow the correct assessment of the risk, to be taken by the Insurer, whose completion and signature by the Subscriber is equivalent to an exact personal declaration concerning his/her health data, attached to the insurance proposal.

**SUBSCRIPTION FORM**

Document filled out by the insured person, in group insurance, in which he/she identifies him/herself and expresses his/her wish to subscribe to the policy.

**INDIVIDUAL SUBSCRIPTION CERTIFICATE**

Document issued by the Insurer for each of the insured persons, proving their inclusion in the group insurance.

**Medical act:** Act performed by a physician legally qualified by the respective Medical Association, which includes the promotion of health, the prevention and treatment of diseases, as well as the rehabilitation of people who are subject to his/her intervention and may determine complementary procedures performed by other health professionals.

1. **Concerning the amounts referred to in the health insurance contract:**

**PREMIUM**

Price paid by the Policyholder to the Insurer for risk coverage, through the contracting of insurance. In a group insurance under a contributory scheme, the Premium may be borne, in whole or in part, by the Insured Persons.

**REVERSAL**

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

**INSURED CAPITAL**

The Insured Capital represents the maximum amount of the benefit to be paid by the Insurer per claim or per insurance annuity for each person insured, defined for each of the coverages contracted and indicated in the Specific Conditions, depending on what is set out in the contract.

**INSURANCE EXCESS**

Amount which, in the event of a claim, shall be payable by the Insured Person, according to the coverage and the Capital, and the amount of which is set out in the Specific Conditions or in the Individual Certificate.

**COPAYMENTS**

Amount payable by the Insured Person for each medical act or set of medical acts, under the terms set out in the Specific Conditions or in the Individual Certificate.

**INDEX**

Change, if contracted, of the Capital guaranteed and of the corresponding Premium, in accordance with an index expressed in the Specific Conditions or Individual Certificate.

**CAPITATION PAYMENTS**

Amount paid directly to the health care provider by the Insurer within the scope of the agreed benefits, without prejudice to the possibility of demanding Copayments or excesses from the Insured Persons.

**COINSURANCE BY REIMBURSEMENT**

Amount reimbursed by the Insurer, after deducting the applicable Excesses and Copayments, to the Insured Person or paid to the healthcare provider where a Statement of Personal Responsibility has been issued.

**STATEMENT OF PERSONAL RESPONSIBILITY**

Document issued by the Insurer, which expresses the assumption of responsibility for the charges inherent to the performance of a given medical act or procedure, under the terms and limits of the applicable insurance coverage, up to the maximum of the guaranteed and available Capital.

1. **Concerning the guarantees of the health insurance contract**

**SUBSCRITPION CONDITIONS**

Those set out in the Specific Conditions or in the Individual Certificate for each Insured Person, Household, or Insured Group.

**NETWORK ACCESS**

Provision of healthcare services, ensured by this contract, performed by network provider(s), to which the insured person has access in accordance with the provisions of the Specific Conditions.

**AGREED BENEFITS**

Guarantee of financing the access, under the conditions set forth in the Policy, of the Insured Person to an integrated network of approved physicians and health units, according to the list or recommendation of the CUIDA Line or the one published in the Insurer's website for consultation, of free choice and access subject to the utilization criteria set forth in the CUIDA Guide, namely the intervention of the Attending Physician or the need for referral to a medical specialty or the authorization of acts and procedures.

**COMPENSATION BENEFITS**

Guarantee of partial reimbursement of expenses incurred as a result of an event covered by the Policy's guarantees.

**IN-NETWORK SERVICES**

Health care services, guaranteed by this contract, carried out at network provider(s), in which the coinsurance of health expenses is directly borne by the Insurer, as provided for in the Special and Specific Conditions.

**REIMBURSEMENT BENEFITS**

Health care services guaranteed by the present insurance contract, in which the health expenses are paid by the insured person, being subsequently cofinanced by the Insurer, as provided for in the Special and Specific Conditions.

**OCCURRENCE/CLAIM**

All events or series of events susceptible of triggering the operation of the contract guarantees.

**ACCIDENT**

A fortuitous, sudden, and abnormal event, due to an external cause beyond the control of the Insured Person, which causes bodily injury to the Insured Person, which is clinically and objectively proven and can trigger the coverages of the contract.

**DISEASE**

Any involuntary change in the state of health, not caused by accident and diagnosed by a doctor, clinically and objectively proven.

**PRE-EXISTING ILLNESS OR INJURY**

The pathological condition or injury that the Insured Person could not have been unaware of, due to the evidence of the symptoms or due to having received medical advice or treatment, or of which he/she should have been aware of, prior to the insurance contract's effective date, namely due to having been subject to clinical investigation, previous treatment or other medical act, or due to the manifest existence of specific signs or symptoms of the pathology in question on the date of the subscription, for which a diagnosis, although not definitive, has already been set forth.

**DISEASE OR CONGENITAL MALFORMATION**

Disease or malformation present at birth, as a result of

hereditary factors or conditions occurring during pregnancy up to the moment of birth. The congenital disorder maybe evident or recognized immediately after birth or discovered later in life, without prejudice to its nature.

**SUDDEN ILLNESS**

Unintended, unexpected and acute alteration to the state of health, involving risk of death or loss of function for the insured person, requiring immediate medical assistance in a hospital environment

**PHYSICIAN / DENTIST**

A graduate of medical or dental school, legally authorized to practice the profession as recognized by the law of the country where the treatment is provided and who, in providing this treatment, does so within the limits of his or her license and training.

**IMPLANT**

Material (prosthesis, orthosis, orthodontic appliance) and/or substance with therapeutic purpose or for correction of morphological alteration, to be placed in the organism of an individual.

**PROSTHESES AND ORTHOTICS**

Devices that totally or partially replace a limb or organ or help it to fulfil, in whole or in part, its function.

**TRANSPLANT**

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

**INJURY**

Unintentional change in the state of health, morphological or functional, caused by accident, clinically and objectively proven.

**MINOR SURGERY**

Any surgical intervention meeting the following cumulative criteria:

* + It does not require an operating room to be performed;
	+ It does not require complete a change of clothing by the surgeon;
	+ It is performed under local anesthesia;
	+ It does not require special recovery care.

**HEALTH UNIT**

Establishment, whether or not part of the National Health Service, whose purpose is to provide any medical or other health care services, and which is licensed under the applicable legal terms, including Entities with inpatient or recovery rooms, generalized Entities for inpatient and outpatient services and also specialized Entities for outpatient services and complementary means of diagnosis and

treatment, irrespective of the name and legal form adopted, including Hospitals, Clinics and Centers for complementary means of diagnosis and treatment.

**HOSPITAL UNIT**

Establishment legally authorized to provide health care services, with permanent medical, surgical, and nursing assistance, including Entities with inpatients and recovery rooms

**MEDICAL ACT**

Act performed by a physician legally qualified by the respective Medical Association, which includes the promotion of health, the prevention and treatment of diseases, as well as the rehabilitation of people who are subject to his/her intervention and may determine complementary procedures performed by other health professionals.

**HOSPITAL ENVIRONMENT**

Set of infrastructural means, differentiated technical, technological, and human resources, which allow performing each act with quality and safety, including the ability to respond effectively to sudden events that endanger the life of the safe person, and which must exist in hospital or equivalent structures.

**MEDICAL EMERGENCY**

Situation of imminent risk to life or intense suffering therefore requiring immediate medical treatment.

**MEDICAL URGENCY**

It is a state in which there is no immediate risk to life or health, which, however, if not attended to within a certain period can turn into a Medical Emergency situation.

**OUTPATIENT SURGERY**

Scheduled surgical intervention, performed under general, locoregional or local anesthesia, in a hospital environment, safely and in accordance with good medical practice, with admission and discharge within 24 hours.

**K COEFFICIENT**

Weighting coefficient for the valuation of medical acts, used in the medical procedure price table.

**MEDICALLY NECESSARY SERVICES**

Services that are consistent with the patient's clinical presentation in accordance with the protocols and standards recognized by the medical community within the scope of insurance.

**ELIGIBLE HEALTH EXPENSES**

Expenses directly related to medical or surgical acts, of a diagnostic or therapeutic nature, performed by duly qualified health professionals, as a result of clinical diagnosis and always under medical supervision and guidance, which determines and limits the scope of liability of the intervening parties.

**INELIGIBLE HEALTH EXPENSES**

Expenses not considered within the scope of insurance, such as charges arising from acts performed without a medical prescription, as well as the acquisition of goods, even if prescribed by a doctor, the usefulness of which is not exhausted by the therapeutic purpose, such as, for example, cosmetics, mattresses, chairs, pillows, dehumidifiers, vacuum cleaners, air conditioners, bicycles, weight-training equipment and whirlpool baths, sunglasses, among others. This definition includes all consumables, as goods whose usefulness is exhausted through use, but which do not have a therapeutic purpose or cannot be objectively justified by medical prescription. Unless expressly stated otherwise, no non-surgical prostheses or orthotics are considered eligible for Insurance. Likewise, Copayments or Excesses from another Policy with FORTALEZA Seguros in force for the same Insured Person, up to the limit of the corresponding Copayment in the Policy activated, shall not be considered eligible.

**GRACE PERIOD**

The period of time between the date on which the insured person subscribes and the date on which certain insurance coverages may be activated.

**INDIVIDUAL INSURANCE**

Insurance subscribed for natural persons which, although it may include within the scope of the coverage a Family Member, does not constitute a Group Insurance.

**GROUP INSURANCE**

Insurance of a group of persons connected to each other and to the Policyholder by a common bond or interest other than that of insurance.

**GROUP INSURANCE ON A CONTRIBUTORY BASIS**

Group Insurance in which the Insured Person/Subscribers bear, in whole or in part, the payment of the amount corresponding to the premium due by the Policyholder.

**NON-CONTRIBUTORY GROUP INSURANCE**

Group Insurance where the Policyholder contributes

in full for the payment of the Premium.

**INSURABLE GROUP**

A group of persons linked to each other and to the Policyholder by a common bond or interest other than that of the actual enforcement of the insurance.

1. **Concerning the Integrated Health Care System of Fortaleza Seguros - CUIDA Network**

**CUIDA INTEGRATED HEALTH CARE SYSTEM - FORTALEZA SEGUROS AGREED NETWORK**

Organization that articulates the direct financing, under agreed terms and limits, of the Insured Person to the providers in the agreed network, namely physicians, hospitals, clinics, centers of complementary diagnostic and therapeutic means, with which there is an agreement for the provision of services to the insured person, directly covered by the Insurer on behalf of the Insured Person.

**AGREED NETWORK**

Set of entities providing contracted services under the scope of the integrated healthcare system of FORTALEZA Seguros, including health care professionals and health unit managers.

**CUIDA 24/24 LINE**

Continuous telephone support to the Insured Person guaranteeing a service to record information on the complaints received, as well as the susceptibility of the situation needing medical assistance and its degree of urgency, suggesting the most adequate means for the situation and also alerting to the signs and symptoms that should imply other types of actions. This act shall not constitute, under any circumstance, a medical act or a clinical diagnosis, through which the Insured Person may also be directed to the most adequate care, with the purpose of improving his/her health and, if necessary, forwarding to the tele-consultation, and information of integrated preventive informative actions, within the scope of the contractual relationship existing between the Insured Person and FORTALEZA Seguros.

**PHARMACIES NETWORK**

Access to the network of member pharmacies that provide various services with direct coinsurance according to the contracted coverage. The member pharmacies are duly identified in the CUIDA Guide available on the FORTALEZA Seguros website.

**CUIDA HEALTH INSURANCE CARD**

A personal and non-transferable card, which identifies the insurance holder before the Insurer and the FORTALEZA Seguros’s CUIDA Network, in order to allow him/her access to the health care system, recording, should he/she use his/her own device, the medical appointments, medical acts and other means used.

**REFERENCING**

Necessary requirement to book specialty appointments and to carry out Complementary Diagnostic and Therapeutic Means within certain specialties, which consists in their express indication by an in-network Physician, or another Attending Physician. The in-network Physician may self-refer, which consists in the referral to the same specialty with a view to the patient's subsequent follow-up, within the limits provided for in the Specific Conditions.

**AUTHORISATION**

Act through which the Insurer's clinical services allow access to coverage for inpatient services, some therapeutic acts, some complementary diagnostic means and also assistance services to the Insured Person, without which they cannot be financed or reimbursed. Consent for healthcare services, requested by the Insured Person to the Insurer's clinical services.

**PHYSICIAN / DENTIST**

A graduate of medical or dental school recognized by the law of the country where treatment is provided and who, in providing treatment, does so within the limits of his/her license and training.

**IN-NETWORK PHYSICIAN**

Doctor in any of the specialties recognized by the competent Medical Association who has been contracted by the CUIDA Network to provide health care within the scope of his/her specialty.

**IN-NETWORK PRIMARY CARE PHYSICIAN**

Physician who has joined the CUIDA health care provider network and is qualified in the specialties of General Practice, Internal Medicine, Obstetrics-Gynecology, Pediatrics, Ophthalmology, Stomatology and Dentistry.

**IN-NETWORK MEDICAL SPECIALIST**

Doctor in a specialty other than those included in the

primary care network and who has joined the CUIDA healthcare provider network.

**FORTALEZA SEGUROS NETWORK ATTENDING PHYSICIAN – CUIDA NETWORK**

Physician accessible and available via telephone from the Network Line - Tele-consultation - with knowledge of the Insurers' procedures and who, in together with the CUIDA Line, assists in the prompt and adequate enjoyment of the health plan benefits, ensuring more adequate management of the health needs of CUIDA customers.

**CUSTOMER SERVICE**

Customer service, through which the Policyholder and the insured persons can obtain the clarifications they require.

**ASSISTANCE SERVICE**

Information and service support provided by a service company on behalf of the Insurer.

**PERMANENT CUSTOMER SERVICE**

Service available at any time of the day or night, limited to a minimum diagnostic capacity, namely general practice medical appointment and basic auxiliary diagnostic tests.

**MEDICALLY NECESSARY SERVICES**

Health care services, suitable for the treatment of illness or accident falling within the guarantees of the contract, whose necessity and validity is clinically and objectively verified.

**TELE-CONSULTATION**

Telemedicine modality, which consists of a medical appointment carried out remotely, not in person, by telephone or other technological means of communication that allows audio contact between the health professional and the Insured Person.

**VIDEO-CONSULTATION**

Telemedicine modality, which consists of a medical appointment carried out at a distance, not in person, through a mobile or fixed video call application, between the health professional and the Insured Person.

**Clause 2 OBJECT**

Under this contract, the Insurer guarantees the Insured Person coverage in the field of health care, integrating, separately or jointly, agreed benefits,

compensation benefits and assistance services, identified in the Policy's Specific Conditions and whose scope is defined in the respective Special Conditions and in these General Conditions.

This insurance contract is set forth between Fortaleza Seguros - Companhia de Seguros, SA, hereinafter referred to as the Insurer, and the Policyholder, and is governed by the general, special, and specific conditions, in accordance with the statements contained in the proposal and individual health questionnaires that serve as its basis and are an integral part of it.

The individualized drafting of this contract is made in the Specific Conditions, containing, the special conditions expressly contracted and their territorial scope, the identification of the parties and their respective domiciles, the data of the Policyholder, the insured persons, the insured capital, and the determination of the premium or the formula for its calculation.

**Clause 3**

**BASIS OF THE CONTRACT**

1. The Insurance Proposal, the Individual Subscription Form, the Individual Health Questionnaire for each Insured Person, as well as the clinical documentation necessary for the Insurer to accept the contract or the individual subscription, constitute the basis of the insurance contract and are an integral part of the Policy.
2. The Policyholder shall inform the Insured Persons about the contracted coverages and their exclusions, the obligations, and rights in case of a claim, as well as about the amendments to the contract, in accordance with the specimen prepared by the Insurer, under the penalty of incurring third-party liability under the general terms.

**Clause 4**

**SCOPE OF COVER**

The insurance contract may guarantee, under the terms and limits set forth for this purpose in the Special and Specific Conditions, the following coverages:

**A - Base Covers**

* + Inpatient - INPATIENT CLINICAL CARE
	+ Outpatient - OUTPATIENT CLINICAL CARE
		- Tele-consultation

**B - Complementary Covers**

* Natural childbirth and caesarean section;
* Ophthalmology
* Stomatology and Dental Medicine
* Medicines;
* Delivery of medicines
* Home Care
* Prostheses and Orthotics
* Medical Emergencies in Angola, Evacuation and
* Repatriation
* Repatriation to the country of origin following death
* Funeral Expenses

**C - COVERAGE EXTENSION**

* 2nd Medical Opinion

**D - TERRITORIAL EXTENSION**

**Medical assistance abroad**

* Access to medical services abroad
* Extension to the Portuguese Medical Network
* Extension to the Namibian Medical Network

**E - OTHER SUPPLEMENTARY SERVICES**

* CUIDA Line - 24/7 Service

The covers effectively contracted are set out in the Specific Conditions.

The insurance contract may also include other covers, provided that they are duly identified in the Specific Conditions and defined by its own special condition.

**Clause 5**

**INITIAL RISK DISCLOSURE OBLIGATION**

1. The Policyholder or the Insured Person is obliged, before the conclusion of the contract, to precisely declare all the circumstances that he/she knows and reasonably should have as significant for the assessment of the risk by the Insurer.
2. The provision in the preceding paragraph is also applicable to circumstances whose mention is not requested in a questionnaire

eventually supplied by the Insurer for this purpose.

1. The Insurer that has accepted the contract, except in the case of malice on the part of the Policyholder or the Insured Person with the purpose of obtaining an advantage, cannot benefit from:
	1. the absence of any answer to a question in the questionnaire;
	2. an imprecise answer to a question formulated in too general terms;
	3. evident inconsistency or contradiction in the answers to the questionnaire;
	4. the fact that its representative, at the time of the

conclusion of the contract, knows it to be inaccurate or to having been omitted;

* 1. circumstances known to the Insurer, especially when they are public and notorious.
1. Before the conclusion of the contract, the Insurer shall clarify the eventual Policyholder or the Insured Person about the duty referred in paragraph 1, as well as the scheme of its non-fulfilment, under the penalty of incurring in civil liability, under the general terms.

**Clause 6**

**WILFUL NON-COMPLIANCE WITH THE DUTY OF INITIAL RISK DISCLOSURE**

1. In case of a willful non-compliance with the duty referred to in paragraph 1 of the previous article, the contract is voidable by means of a declaration sent by the Insurer to the Policyholder.
2. If no claim has occurred, the statement referred to in the preceding paragraph shall be sent within three months from the date of knowledge of such non-fulfilment.
3. The Insurer is not required to cover a Claim that occurs before becoming aware of the willful non-compliance referred to in paragraph 1 or during the period set forth in the previous paragraph, following the general regime of voidability.
4. The Insurer is entitled to the premium due until the end of the period referred to in paragraph 2, unless there has been intent or gross negligence on the part of the Insurer or its representative.
5. In the case of malice on the part of the Policyholder or the Insured Person with the intention of obtaining an advantage, the Premium is due until the end of the contract.

**Clause 7**

**NEGLIGENT NON-COMPLIANCE WITH THE DUTY OF INITIAL RISK DISCLOSURE**

1. In case of negligent non-compliance with the duty referred to in paragraph 1 of Clause 4, the Insurer may, by statement, send it to the Policyholder within a period of three months from its knowledge:
	1. propose an amendment to the contract, setting a deadline of no less than 14 days for the dispatch of the acceptance or, if it admits it, a counterproposal;
	2. terminate the contract, demonstrating that under no circumstances does it conclude contracts to cover risks relating to the omitted or inaccurately stated fact.
2. The contract ceases its effects 30 days after the sending of the statement of termination or 20 days after the receipt by the Policyholder of the proposal for amendment, should he/she not respond or reject it.
3. In the case referred to in the preceding paragraph, the premium shall be returned on a *pro rata temporis* principle taking into account the coverage obtained.
4. If, before termination or amendment to the contract, a Claim occurs, the occurrence or consequences of which have been influenced by a fact in respect of which there have been negligent omissions or inaccuracies:
	1. the Insurer covers the claim in proportion to the difference between the premium paid and the premium that would have been due if, at the time of the conclusion of the contract, it had known about the omitted or inaccurately stated fact;
	2. the Insurer, proving that under no circumstances would it have concluded the contract if it had known the omitted or inaccurately stated fact, does not cover the Claim and is only bound to return the Premium.

**Clause 8**

**TERRITORIAL SCOPE**

1. Unless otherwise provided for in the Special or Specific Conditions, the territorial scope of this contract is limited to Angolan territory, although some coverage and services may be extended to Portugal, or to other countries, as provided for in the Specific Conditions and under the terms of the General and Special Conditions.
2. The guarantees of the insurance contract shall be suspended for the period during which, in respect of any

Insured Person, absence abroad, lasting more than 60 days, such suspension taking effect from the date of its commencement, even if the Insurer only knows of the absence at a later date, unless otherwise requested and expressly stated by the Insurer for the extension of the guarantee.

**Clause 9**

**INSURED PERSONS**

1. They benefit from the guarantees provided by this contract to all Insured Persons who meet, cumulatively, the following conditions at the date of their inclusion in the Policy, after express acceptance by the Insurer:
	1. complete the Individual Health Questionnaire truthfully and accurately;
	2. are accepted by the Insurer in accordance with its acceptance criteria according to the risk assessment parameters in force;
	3. Accept the rules for the activation of the insured guarantees and the use of the CUIDA Integrated Health Care System - Agreed Network - FORTALEZA Seguros.
2. The acceptance of the insurance in relation to each Insured Person is confirmed by the Insurer, through the issue of the Policy or Individual Certificate, with subsequent delivery of an Access Card to the Agreed Network - CUIDA Card. Some coverages may be subject to certain grace periods, exclusions, excesses and maximum amounts of compensation, as provided for in these general conditions, in the Special Conditions and in the Specific Conditions of the policy, for each Insured Person.
3. In the conclusion, execution and termination of the insurance contract, the Insurer's own practices and techniques of risk assessment, selection and acceptance are considered, based on rigorous statistical and actuarial data considered relevant.

**Clause 10**

**COVERAGES AND MODALITIES**

1. The coverages are defined in the Special Conditions, integrating the insurance contract those that are referred to in the Specific Conditions.
2. The coverages include the modalities of benefits agreed upon (benefits within the network), compensation benefits (by reimbursement), assistance services, under the Network access regime, under the terms of the following clauses and the respective Special Conditions.
3. The contracted modality(ies) will be stated in the Specific Conditions of the Policy.

**Clause 11**

**AGREED BENEFITS**

1. Within the scope of the agreed benefits, the Insurer guarantees the Insured Persons direct access to physicians, hospitals or health units, centers for complementary means of diagnosis and other health services which, at each moment, are part of the CUIDA Integrated Health Care System, Agreed Network, whose conditions of use are set forth in the Policy and in the CUIDA Support Guide, available and permanently updated at [**www.fortalezaseguros.ao,**](http://www.fortalezaseguros.ao/) in the terms and limits set forth in the Policy's Specific Conditions.
2. The network(s) includes healthcare services of medical and surgical specialties, auxiliary means of diagnostic, complementary technical and therapeutic services and hospitalization.
3. In relation to services that are not contracted with the health care providers referred to in the previous paragraph, the compensation benefit scheme provided for in the following Clause shall apply (reimbursement benefits), as long as they are guaranteed within the coverages and limits contracted in the policy.
4. The financing conditions include maximum limits, as well as copayments or excesses payable by the Insured Person, in relation to specific medical acts, regardless of the capital insured or available at any given time. The Insured Person shall bear the coinsurances, copayments and excesses set forth in the Policy’s Specific Conditions.
5. The activation of the coverages provided for in the Specific Conditions is subject to the analysis of the clinical file and depends on the express authorization of the Insurer's clinical services, which shall exclusively obey medical criteria, in accordance with the principles of good clinical practice.
6. Access to certain network services may require prior authorization from the Insurer. When the Insured Person uses these services, without having

the Insurer's authorization, the expenses will be subject to the reimbursement benefit scheme, provided that they are guaranteed within the coverages and limits agreed upon in the policy.

1. When the Insured Person uses any provider within the network or service, without identifying himself/herself with his/her CUIDA Card, the expenses will be reimbursed, unless there is a duly justified reason not attributable to the Insured Person.
2. When, due to unavailability of the computer system or any other duly justified reason not attributable to the Insured Person, it is not possible to process the excess and/or the copayment or to access the services, the Insured Person shall bear the health expenses in full and send it later to the Insurer for the respective reimbursement, as long as they are guaranteed within the coverages and limits contracted in the policy.
3. The Insurer will provide the Insured Person with the CUIDA Guide, a support Guide with the list of service providers that integrate the CUIDA Network, available and permanently updated in [www.FortalezaSeguros.ao](http://www.FortalezaSeguros.ao/). It is up to the Insured Person to choose the appropriate Entity for his/her condition, except for specialty appointments and complementary diagnostic and therapeutic means that require Referral or Authorization.
4. When the Insured Person uses an Entity which is not part of the CUIDA Network, the regime foreseen in the following Clause shall apply (reimbursement benefits).
5. Under no circumstances shall replacement of Policy Capital be considered, whatever the cause.

Single: Information on the providers that make up the CUIDA Network in Angola is available and constantly updated at [**www.fortalezaseguros.ao**.](http://www.fortalezaseguros.ao/)

**Clause 12**

**COMPENSATION BENEFITS**

**REIMBURSEMENT BENEFITS**

1. The Insurer undertakes, under the terms and within the limits set forth in the General, Special and Specific Conditions, to reimburse the expenses made by the Insured Person at clinical service providers not included in the CUIDA Network, subject to the valuation parameters of medical acts in accordance with the commonly accepted and practiced tables of values related to medical acts.
2. When the Insured Person resorts to an Entity belonging to the CUIDA Network in the modality of compensation benefits, he/she shall be entitled to the reimbursement amount foreseen in the Special and Specific Conditions.
3. Under no circumstances shall replacement of Policy Capital be considered, whatever the cause.

**Clause 13**

**NETWORK ACCESS REGIME**

In this modality, the Insurer guarantees access by the insured person to health care services, provided by network providers, with the insured person bearing in full the respective costs, under the terms and limits set forth in the Special and Specific Conditions.

**Clause 14 ASSISTANCE**

The Insurer, under the terms and limits of the territorial scope of this contract and as set forth in Special Conditions, guarantees the provision of assistance services in Angola and abroad, in relation to accidents or illnesses guaranteed by the Policy.

**Clause 15 EXCLUSIONS**

1. Benefits arising from the following shall always be excluded from this contract:
	1. diseases, injuries or functional alterations, pre- existing complaints or that are the consequence of accidents that occurred before the date of commencement or subscription of the insurance;
	2. traffic accidents, accidents at work or occupational diseases, as well as other accidents and diseases covered by other compulsory insurances;
	3. infectious diseases, when in a situation of epidemic or pandemic declared by the health authorities;
	4. any pathologies resulting, directly or indirectly, from the action of the Human Immunodeficiency Virus (HIV) or the virus itself;
	5. mental health disorders, unless otherwise agreed for medical appointments on

psychiatry under the terms set out in the Specific Conditions. Any benefits are also excluded

resulting from psychological assistance, medical appointments or psychoanalytic, hypnotic and sleep therapy treatment, as well as psychiatric hospital admissions;

* 1. treatments related to physical, cognitive or language development, learning or behavioral problems such as dyslexia, attention deficit or hyperactivity;
	2. disorders resulting from alcohol intoxication, excessive drinking and resulting illnesses, use of narcotics or drugs not prescribed by a doctor, or misuse of medicines;
	3. misuse of medicines;
	4. illness or injury as a result of any malicious or seriously culpable acts of the Insured Person, self- inflicted or resulting from illegal acts committed by the Insured Person, intervention in duels and brawls;
	5. any method of birth control and family planning and voluntary interruption of pregnancy, as well as all medical acts related thereto, or performed to reverse the effects of a voluntary sterilization surgery performed;
	6. sexual dysfunction, whatever the cause, except as a result of an illness covered by the policy;
	7. infertility medical appointments, treatment and testing, as well as methods of artificial insemination and fertilization, in vitro fertilization or embryo transfer procedures and their consequences, except in the case of life-threatening events;
	8. any treatment:
1. or surgical intervention performed with the intention of improving personal appearance or removing healthy body tissue and its consequences;
2. or sclerosing therapy for chronic lower limb insufficiency;
3. or cosmetic or reconstructive surgery and their consequences, except if included in the treatment of

malignant disease or as a result of an accident occurring while the Policy is in force;

1. of obesity correction, weight loss treatment and similar and their consequences.
	1. treatments, surgery and other acts intended for the correction of diseases or congenital malformations, unless otherwise expressly agreed upon under the terms stipulated in the Specific Conditions in respect of new born babies guaranteed by the Insurer's Policy from birth;
	2. hemodialysis treatments for chronic pathologies;
	3. Treatments related, directly or indirectly, to hepatitis virus infection, with the exception of those resulting from hepatitis A;
	4. organ transplants and their implications, unless otherwise expressly agreed in the terms of additional coverage when specially contracted;
	5. treatments in sanatoriums, spas, nursing homes, retirement homes and other similar establishments, hydrotherapy medical appointments and treatments, complementary medicine, homeopathy, osteopathy and chiropractic or similar practices, as well as any medical or therapeutic acts that are not recognized by the Angolan Medical Association;
	6. medicines that have not yet been authorized by the Appointing Authority;
	7. accidents occurring and illness contracted as a result of:
2. professional practice of sports and participation, as an amateur, in integrated sports competitions without championships and respective training;
3. participation in sporting competitions and their training with vehicles, whether or not powered (including skateboarding, mountain biking, rafting, hang-gliding, paragliding and microlighting);
4. practice of snow and water skiing, surfing, snowboarding, underwater hunting, scuba diving, hunting of dangerous animals or animals known to be dangerous, boxing, martial arts, parachuting, bullfighting, bull or reindeer shooting, barrage/horse jumping, caving, canyoning, river or torrent descents caused by watercourse unevenness, climbing, rappel and slide, mountaineering, caving, bungee-jumping and others

sports similar in their dangerousness;

1. natural cataclysms, acts of war, declared or undeclared, acts of terrorism, sabotage, public order disturbances and use of chemical or biological weapons;
2. consequences of exposure to radiation, including consequences of the use of bacteriological weapons and/or chemical agents.
	1. expenses incurred with doctors who are spouses, parents, children or siblings of the Insured Person;
	2. nursing care provided at home or in hospital not contemplated in the hospital's services, except for services at home if contracted by Special Condition and within the terms and limits set forth;
	3. procedures of an experimental nature, as well as all diagnostic and therapeutic procedures whose safety and clinical effectiveness are not also scientifically proven, in accordance with medical practice;
	4. Continued care, understood as clinical services that do not require admission to a hospital institution and can and should be provided internally in a unit of their own;
	5. expenditure on services that are not medically necessary, as well as hospital care and treatment for social reasons;
	6. transport expenses of the Insured Person related to physiotherapy and dialysis;

**aa)** 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;

**bb)** expenses incurred by the persons accompanying the Insured Person, except in the case of hospitalization of minors aged 14 or under;

**cc)** medical appointments and treatment in areas not recognized by the Angolan Medical Association(s);

**dd)** medical appointments or medical examinations that are necessary for the issue of certificates, statements, certificates

or information from any type of document that does not have an assistance or therapeutic purpose;

**ee)** medical appointments and treatment in areas not recognized by law.

1. Hospital and Surgical Assistance are always excluded from this contract:
	1. any and all surgical techniques intended to correct refractive errors of vision, including:
2. radial keratotomy;
3. photorefractive keratotomy (excimer/Lasik laser keratotomy);
4. Laser in situ keratomileusis;
5. insertion of intraocular phakic lenses;
6. myopia, astigmatism and hyperopia,
	1. surgical treatment of snoring disorders, except in the case of apnea, duly confirmed by a sleep study;
	2. breast augmentation or reduction in volume and its consequences, whatever the surgical indications or removal of breast prosthesis material, except in cases of treatment for oncological disease;
	3. treatments and Surgeries that are a direct consequence of procedures previously refused by the Insurer.
7. Unless expressly agreed otherwise in the Specific Conditions, the Individual Certificate or under a Special Condition, benefits arising from:
8. stomatology and dental medicine, except surgery as a result of an accident covered by this contract and occurring during its term;
9. implants and all related procedures, namely diagnostic and surgical templates, guided bone regeneration, transepithelial abutments, assembly in articulator, provisional and definitive crowns on implants, among others, unless otherwise agreed in the Specific Conditions;
10. medicines;
11. non-surgical prostheses and orthotics;
12. childbirth;
13. general health check-ups;
14. occupational therapy, physiotherapy, speech therapy, psychiatry, psychology;
15. Copayments or excesses resulting from medical acts or procedures guaranteed by another Policy of Fortaleza Seguros in force for the same Insured Person, presented to the Insurer under the compensation benefit scheme, up to the limit of the Copayment for the same medical act or procedure guaranteed by that same Policy;

**i)** home services.

**CLAUSE 16**

**GRACE PERIODS**

1. The applicable Specific Conditions and Special Conditions establish the periods between the date of commencement of insurance or, in the case of group insurance, subscription thereto, and the date on which the respective guarantees may be activated.
2. Unless otherwise specified, the following Grace Periods are set:

|  |  |
| --- | --- |
| **Coverage/Guarantee** | **Grace Period** |
| Inpatient - Inpatient Clinical Care | 90 days |
| Outpatient - Outpatient Clinical Care | 30 days |
| Vaccination | 30 days |
| Natural Childbirth and Caesarean Section | 365 days |
| Ophthalmology | 30 days |
| Stomatology and Dental Medicine | 30 days |
| Medicines | 30 days |
| Prostheses and Orthotics | 90 days |
| Home Care | 30 days |
| Medical Emergencies in Angola - Evacuation and Repatriation | Not applicable |
| Funeral Expenses | 180 days |

|  |  |
| --- | --- |
| Repatriation to the Country of Origin | Not applicable |
| 2nd Opinion | 30 days |
| Extension to the Portuguese Medical Network | in accordance with the applicable coverage |

1. Without prejudice to the provisions of the previous numbers, coverage in respect of benefits or medical acts arising from the following shall also be subject to a Grace Period of 12 months (365 days):
	1. surgical or other invasive treatments of benign prostatic hypertrophy;
	2. surgical or other invasive treatments of benign pathology of the uterus;
	3. surgical treatment of cystocele and rectocele;
	4. surgical treatment of varicose veins of the lower limbs;
	5. surgical treatment of herniated disc;
	6. hemorrhoidectomy and other treatments of hemorrhoidal disease as well as surgical treatment of perianal fistula;
	7. arthroscopic treatment of joint pathology;
	8. septoplasty;
	9. tonsillectomy, adenoidectomy, myringotomies with or without the application of ventilation tubes;
	10. rhino septoplasty, provided it is not for aesthetic reasons;
	11. surgical excision of benign lesions of the skin and subcutaneous cellular tissue;
	12. laser treatments for benign skin lesions;
	13. surgical treatment of sleep apnea;
	14. renal and vesicular lithotripsy;
	15. surgical intervention for gastroduodenal ulcer;
	16. hemorrhoidectomy;
	17. cholecystectomy;
	18. refractive treatments for myopia, astigmatism and hyperopia;
	19. ear, nose and throat operations;
	20. any surgical procedure on the knee;
	21. extraction of cysts, nevi, moles, warts and subcutaneous nodules;
	22. cataract treatments.
	23. Mastectomy or thyroidectomy for benign pathologies.

Single paragraph: The grace periods do not apply whenever the occurrence is the result of an accident within the scope of the Policy guarantees.

**CLAUSE 17**

**COMMENCEMENT AND DURATION OF THE CONTRACT**

1. As long as the premium or initial fraction is paid, this contract becomes effective as of zero o'clock of the day immediately after the proposal is accepted by the Insurer, except if, by agreement of the parties, another date is set forth for the contract to become effective, which, however, cannot be before the date the proposal is received by the Insurer, without prejudice to what is set forth regarding grace periods or other suspension periods. In the case of group insurance, the contract's guarantees come into force at midnight of the day indicated in the individual subscription certificate.
2. The contract, in case of individual insurance where the Policyholder is a natural person, is considered accepted on the 15th day after the date of reception of the proposal by the Insurer, unless in the meantime the prospective Policyholder is notified of the refusal or of its anticipated approval, or of the need to gather essential clarifications for the risk assessment, in which case approval depends on the sending and analysis of the requested elements. The acceptance will be confirmed by the Insurer in writing (or by any other means that remains a durable record) to the Policyholder's address or by the issuing of the CUIDA card by FORTALEZA Seguros and respective Specific Conditions.
3. The Specific Conditions identify the coverages subject to a grace period, as well as to excesses and maximum indemnity amounts, as provided for in the present general conditions and in the special conditions of the policy.
4. The duration of the contract is that stipulated in the Specific Conditions of the Policy, which may be for a fixed and determined period or for one year to be continued for the following years.
5. When concluded for a fixed period, the contract ceases its effects at midnight on the last day of the fixed period.
6. When it is concluded for one year and continues for the following years, it is considered automatically and successively renewed for annual periods, except if any of the parties terminates it, by registered mail or by any other means by which it is recorded in writing, with a minimum notice period of 30 days prior to the end of the annuity.
7. The benefits guaranteed by the Insurer exclusively pertain to each contract period, with no prolongation or extension of the guarantees beyond the maturity date, without prejudice to the provisions regarding non-renewal of the contract or subscription, termination or exclusion, where only the agreed benefits or expenses incurred during each year of the contract are guaranteed

**CLAUSE 18**

**COMMENCEMENT AND DURATION OF GUARANTEES**

1. Only insured candidates whose age respects the limit defined by the Insurer and provided that they have completed the respective individual health questionnaire may be admitted.
2. The guarantees of the contract shall become effective after the expiry of the grace periods indicated for each coverage in the special conditions or in the Specific Conditions, which shall be counted from the date of subscription of each insured person.
3. In case of accident or sudden illness requiring urgent inpatient or outpatient hospital treatment, grace periods are not applicable.

**CLAUSE 19**

**TERMINATION OF CONTRACT**

1. The guarantees provided by this contract automatically cease to produce their effects in relation to each Insured Person, unless expressly agreed otherwise, in the following cases:
	1. maturity of the annuity on which the Insured Person reaches the age limit set forth in the Specific Conditions;
	2. in the case of members of the Household, when they lose the status of dependents under the terms of

definition set out in Clause 1;

* 1. at the end of the annuity in which he/she loses the status of Subscriber or member of the group for which he/she subscribed to the insurance contract;
	2. failure to pay the Premium in accordance with the applicable legal terms;
	3. in the event of non-renewal of the contract or non- renewal of subscription.
1. This contract or, in the case of group insurance, the subscription to it, may be terminated by either party, on its annual maturity date, by registered letter or any other means on which a written record is kept, sent to the other party at least 30 days before the maturity date.
2. In case of non-renewal of the contract or non-renewal of the subscription, the liability of the Insurer ceases on the termination date, without prejudice to the provisions in the following paragraph.
3. In both cases provided for in the previous paragraph, the Insurer remains liable for the guaranteed benefits, for a period of two years and until the Insured Capital is exhausted in the last period of the contract, regarding diseases that appear during the contract period or accidents and other facts that generate compensation occurred during the same period, as long as they are covered by the contract and declared up to 30 days after its termination, except for a fair impediment.
4. The CUIDA Card is property of the Insurer, and its holder is obliged not to use it and to return it as soon as the insurance contract under which it was issued expires, under penalty of incurring in civil and criminal liability. In case of loss, abuse of confidence, theft or robbery of the card, the cardholder must report the event to FORTALEZA Seguros, within 72 hours, under penalty of incurring in civil liability in case of misuse.

**CLAUSE 20**

**PAYMENT OF PREMIUM**

1. The coverage of risks depends on the prior payment of the Premium.
2. The Premium corresponding to each period of duration of the insurance contract shall be due in full, notwithstanding that it may be paid in instalments, by agreement between

the Insurer and the Policyholder.

1. The payment of the annual insurance premium, by agreement between the Insurer and the Policyholder, may be divided into monthly, quarterly or half-yearly instalments, subject to fractioning charges.
2. Unless it has been agreed that the Insured Person pays the premium directly to the Insurer, the obligation to pay the premium rests with the Policyholder.
3. The initial Premium or fraction is due on the date of termination of the contract. In the case of group insurance, the initial Premium or fraction corresponding to each subscription is due on the date of its acceptance.
4. The next instalments of the initial Premium, the subsequent annuity Premium and successive instalments thereof shall be due on the dates set out in the contract.
5. The portion of the variable amount premium relating to value adjustment and, where appropriate, the portion of the premium corresponding to contract amendments shall be due on the dates indicated in the respective notices.
6. In the event of early termination of the insurance contract, for whatever cause, the premium or fraction due by the Policyholder will be calculated in proportion to the period elapsed up to the moment of termination, with a refund corresponding to the unexpired period if the Policyholder has already paid the entire premium or fraction, however, there will be no refund of premium for the unexpired period in relation to the Insured Person if there has been any OCCURRENCE / CLAIM under the Policy in the annuity.
7. The Policyholder or the Insured Person, as the case may be, indicates in the subscription form that he/she subscribes, or in a separate document, the International Bank Account Number (IBAN) relative to his/her bank account that he/she wishes to have debited for the amount of the Premium and credited for the value of the Insurer's benefits.

**CLAUSE 21**

**NOTICE OF PREMIUM PAYMENT**

1. During the term of the contract, the Insurer will give written notice to the Policyholder or the Insured Person, in case it has been agreed that he/she pays the premium directly to the Insurer, of the amount to be paid, as well as of the form and place of payment, at least 30 days before the date on which the premium or fractions thereof are due.
2. In insurance contracts where the payment of the premium is agreed in instalments of periodicity equal or inferior to three months and where the contractual documentation indicates the maturity dates of the successive premium instalments and the respective amounts to be paid, as well as the consequences of its non-payment, the Insurer may choose not to send the notice referred to in paragraph 1, in which case, the Insurer shall be responsible for proving the issue, acceptance and sending to the Policyholder of the contractual documentation referred to in this number.

**CLAUSE 22**

**FAILURE TO PAY THE PREMIUM**

1. Failure to pay the initial Premium, or the first fraction thereof, on the maturity date shall result in automatic termination of the contract from the date of its conclusion.
2. The lack of payment determines the automatic termination of the contract on the maturity date of:
	1. a fraction of the Premium over the course of an annuity;
	2. an additional premium resulting from an amendment of the contract based on a supervening increase in risk.
3. In contributory group insurance, when the Insured Person does not hand over to the Policyholder the amount intended for the payment of the Premium or, having agreed that the Insured Person pays the Premium directly to the Insurer, such payment does not take place, the Insured Person is excluded from the insurance coverage.
4. Failure to pay the premium for subsequent annuities, or the first fraction thereof, on the maturity date shall prevent the extension of the contract or the coverage of the Insured Person concerned.
5. Non-payment, by the maturity date, of an additional premium resulting from a contractual amendment shall render the amendment ineffective, and the contract or the coverage shall subsist with the scope and under the conditions which were in force prior to the said amendment, unless its subsistence proves impossible, in which case it shall cease on the due date of the unpaid premium.

**CLAUSE 23**

**PREMIUM CHANGE**

1. If there is no change in risk, any change in the premium applicable to the contract can only be made in the

next annual maturity date, by means of a notice from the Insurer to the Policyholder, with a minimum prior notice of 30 days before the contract renewal date.

1. However, there will be an automatic amendment 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.

**CLAUSE 24**

**REFUND OF PREMIUM**

When, by virtue of amendment or termination of the contract, there is due, under the terms of the law, a refund of the premium, it shall be calculated as follows:

1. If the initiative is taken by the Insurer, the latter will return to the Policyholder a part of the premium, calculated *pro- rata*to the remaining period up to the maturity date;
2. If the initiative is taken by the Policyholder, the Insurer will return to the Policyholder a part or percentage of the premium indicated in the Policy Specific Conditions, calculated proportionally to the unexpired period until the maturity date, deducted from the cost of issuing the policy;
3. If there are claims relating to the persons to be excluded, no reimbursement shall be processed.

**CLAUSE 25**

**ACCESS, PROCEDURES AND REGULARIZATION**

1. In the event of need for health care guaranteed by this contract, and depending on whether the benefits are contracted or compensation benefits, the Insured Person may have access to the CUIDA integrated health care system or have recourse, at their choice, to any physician, hospital or clinic in the event of need for hospitalization, and in either case they shall observe the prescriptions of the physician treating them and the procedures provided for in the following numbers.
2. In the case of Agreed Benefits, the Insured Person may:
	1. choose a physician from the CUIDA Network (agreed network);
	2. consult a physician of the CUIDA Integrated Health Care System (network) or contact

the CUIDA Line, which will refer you to a physician or health service appropriate to each case. If necessary, any of these contacts will refer you to a medical specialist or a healthcare unit in the CUIDA Network;

* 1. contact the CUIDA Line, from which a nurse registers the information regarding the complaints presented, as well as the susceptibility of the situation requiring medical assistance and the degree of urgency of the situation, suggesting the most appropriate means for the situation and also alerting to the signs and symptoms that should imply other types of actions, this act, under no circumstances, constituting a medical act or a clinical diagnosis.
1. In any of the cases provided for in the previous paragraph, in order to allow the application of the maximum extension of the respective coverages, the following procedure shall be followed by the Insured Person:
	1. identify himself/herself as a CUIDA Health Insurance holder or display his/her CUIDA Card before the service providers of the CUIDA Network;
	2. provide the information necessary for the correct assessment of his/her state of health;
	3. obtain a referral, when required under the terms of the respective coverage plan, to consult with a specialist in the CUIDA Network or to have complementary diagnostic and therapeutic procedures performed at a health care facility in the CUIDA Network;
	4. undergo examination by a physician designated by the Insurer if he/she considers it necessary.
2. Recourse to physicians who are not integrated in the CUIDA Network health units or who are not contracted with them is considered as a benefit outside the CUIDA Integrated Health Care System and is reimbursed as an compensation benefit, under the terms and limits of the coverages stated in the applicable Specific Conditions.
3. In the case of Compensation Benefits, the Insured Person may:
	1. communicate to the Insurer the clinical situation as well as the medical acts performed, sending jointly the medical report detailing them;
	2. undergo examination by a physician designated by the Insurer if he/she considers it necessary.
4. The reimbursement of expenditure incurred under this

contract is made after the supporting documents, valid according to the legal standards in force, have been delivered and the following procedures have been observed:

* 1. In case of an accident, reference is made to the date, time, place, parties involved, causes and consequences of the accident, witnesses, the official who drew up the report, and identification of the person or persons responsible;
	2. presentation, within a maximum period of 120 days from the date the expense was incurred, under penalty of forfeiting the right to reimbursement, of all original documents justifying the expenses incurred, detailing the services provided, accompanied by a medical prescription, although the Insurer may accept a copy if the Insured Person needs the originals for the purpose of requesting reimbursement from another Entity, in which case he/she must provide proof of the amount spent and the reimbursement received from that Entity;
	3. undergo examination by a physician designated by the Insurer if he/she considers it necessary.
1. In any of the circumstances foreseen in the previous paragraphs, the Insurer's clinical services are authorized by the Insured Person to obtain information, at any time, from the physicians who assist them and to obtain copies of clinical reports or any other documents related to the assistance provided, in strict observance of the duty of confidentiality and of the legislation in force.
2. Without prejudice to the provisions of the Special and Specific Conditions of the Policy, the amount reimbursed for medical expenses is the amount actually paid by the Insured Person and not reimbursed by another Entity, as long as the following procedures are observed:
	1. when original documents proving any expenditure are presented, a reimbursement percentage will be applied to the total amount of the expenditure;
	2. when documents coming from another Entity are presented, proving the expense and the corresponding coinsurance that the Insured Person has previously used, the reimbursement percentage will only apply to the remainder of the expense that was not coinsured.
3. Reimbursement of medical expenses may be subject to maximum coinsurance limits, regardless of the guaranteed and available Capital, in accordance with the applicable Specific Conditions.

**CLAUSE 26 SUBROGATION**

Up to the amount of the compensation paid as reimbursement, or up to the amount of the financing supported under the agreed benefits, the Insurer is subrogated in all the rights of the Insured Person against third parties who are liable for them, and the Policy Holder and the Insured Person are required to provide the Insurer with all relevant elements for the enforcement of such rights, under penalty of being held liable for losses and damages.

**CLAUSE 27**

**AMENDMENTS TO THE TERMS OF THE CONTRACT BY THE INSURER**

1. The Insurer may propose the amendment of the coverages, exclusions, insured capital, Excesses, Copayments, grace periods and Premiums, as well as the criteria to use the financing or reimbursement of health expenses, to be in force in the following year of the contract, as long as these alterations are communicated by the Insurer to the Policyholder or Insured Person 30 days before the contract or coverage renewal date.
2. Amendments are deemed accepted if the Policyholder or the Insured Person does not say anything within 15 days from the receipt of the proposal, and the proposed amendment is approved, and the policy is in force if the premium corresponding to the subsequent annuity or first paid fraction is paid.
3. If the amendments proposed by the Insurer are not accepted, the contract will expire on the date of renewal of the contract or of the coverage.
4. Insured capital, Premiums and Excesses may be subject to annual indexation, to be considered automatically at maturity of the policy, as provided for in the specific conditions.
5. Whenever they are based on age groups, the Premiums corresponding to amendments in the Insured Person's age group become due on the date of renewal of the contract.
6. The Insurer formalizes the amendments to the contract in a written document.

**CLAUSE 28**

**AMENDMENTS TO THE TERMS OF THE CONTRACT BY THE POLICYHOLDER**

1. The inclusion of insured persons that are part of the household is requested through communication to the Insurer, with completion of the proposal and individual health questionnaire. The inclusion of newborns in a contract insured by at least one of the parents is accepted without grace periods, without pre-existing conditions and without excluding congenital diseases and malformations, provided that pre-subscription is made up to the 6th month of pregnancy. In order to apply these conditions, definite subscription must be made within the first 30 days of the child's life, by filling out a proposal and individual health questionnaire.
2. Exclusion of insured persons is requested through communication to the Insurer at least 30 days prior to the effective date. The Insurer will reimburse the premium paid for the unexpired period.
3. The transfer of the contracted plan is requested by the Policyholder through communication to the Insurer, at least 30 days before the effective date, including the acceptance of the Insured Person who will be the holder of the new contract. The new contract will start the following day, with the completion of the proposal, but without the need for a new individual health questionnaire.
4. The change of the contracted plan is requested by the Policyholder, through communication to the Insurer, at least 60 days before the maturity date, within the scope of the marketed plans. From the starting date of the new plan, grace periods regarding new coverages or capital increases in the coverages of the previous plan are considered.

**CLAUSE 29**

**TERMINATION OF THE CONTRACT AND EXCLUSION OF THE INSURED PERSON**

1. The insurance contract can be terminated by either party, at any time, with just cause, under the general terms.
2. Termination of the contract for non-payment of the premium shall be subject to the provisions of the applicable legal and contractual provisions.
3. The contract resolution becomes effective at midnight of the very day it occurs.
4. The Policy Holder, who is a natural person, has 30 days, as of the reception of the policy, to terminate the contract, by means of written communication on paper or by any other means deemed to be a durable record;
	1. The aforementioned period begins on the effective date of conclusion of the contract;
	2. The performance of the right of free cancellation determines the termination of the contract, thus terminating all the obligations arising from it, with effect as of its signing, and the Insurer has the right to:
5. The premium amount calculated *pro rata temporis*, to the extent that it has borne the risk up to the termination of the contract;
6. The amount of expenses that you have incurred with medical exams whenever that amount is contractually charged to the Policyholder, as well as any future expenses, for any reason, related to and as a result of acts, exams, treatments, or others, arising from the period prior to the termination of the policy.
7. In contributory group insurance, the insured person can be excluded from the insurance when he/she does not deliver to the Policyholder or to the Insurer, depending on what is agreed upon, the amount destined for the payment of the premium, applying, with the necessary adaptations, the rules on the default of premium payment regarding subscription.
8. The insured person may also be excluded when he/she or a beneficiary, with his/her knowledge, commits fraudulent acts to the detriment of the Insurer or the Policyholder.
9. The exclusion of the insured person provided for in the preceding paragraph 5 has no retroactive effect and must be carried out, by written declaration, with a prior notice of 8 days, by the Insurer.

**CLAUSE 30**

**EXPIRATION OF THE CONTRACT**

1. The insurance contract shall automatically expire on its maturity date, in the case of insurance entered into for a fixed and determined period.
2. In the case of insurance entered into for one year and to be continued for the following years, each subscription shall expire

automatically:

* 1. At the end of the insurance annuity when the insured person no longer meets the conditions that allowed him/her to subscribe the insurance group;
	2. At the end of the annuity in which the insured person reaches the age limit set forth by the Insurer in the Specific Conditions;
	3. At the end of the annuity in which the insured person ceases to be part of the household, or in the case of a child or adopted child, ceases to be covered by the official scheme for granting family allowance.

**CLAUSE 31**

**INSURANCE VALUES AND EXCESSES**

1. The maximum amounts guaranteed by this policy, as well as the contracted excesses, are stated in the Specific Conditions and are in force in each policy year.
2. The Insurer guarantees the insured person the payment of the expenses made, up to the contracted limit, in each contract period.
3. Unless otherwise agreed, in situations of maturity adjustment, the guaranteed amounts are proportional to the time at risk.

**CLAUSE 32**

**COORDINATION OF BENEFITS**

1. The Insured Person shall inform the Insurer of other insurances of a similar nature to that of this present contract as soon as he/she becomes aware of them, as well as when the claim is reported, so that, if necessary, the coordination of the agreed benefits or indemnities due under the various contracts may be carried out.
2. The fraudulent omission of the information referred to in the previous paragraph exonerates the Insurer from the respective benefit.
3. For the purposes of this clause, any systems allowing for the reimbursement or sharing of expenses similar in scope to those guaranteed by this contract, of which the Insured Person is the beneficiary, shall be deemed equivalent to insurance.

**CLAUSE 33**

**COEXISTENCE OF CONTRACTS**

1. The Policyholder and/or the Insured Person are obliged to inform the Insurer, under the penalty of being held liable for losses and damages, of the existence of other insurances with the same object and guarantee.
2. If, on the date of the claim, there is more than one insurance contract with the same object and coverage, this policy shall only operate in case of inexistence, nullity, ineffectiveness or insufficiency of previous insurances.

**CLAUSE 34**

**CLAIM SETTLEMENT**

When paying any amount under this contract, the Insurer, whenever permitted by law, may discount any amounts due by the Policyholder or the Insured Person

**CLAUSE 35**

**OBLIGATIONS OF THE POLICYHOLDER AND INSURED PERSON**

1. In the event of a claim covered by this contract, the Policyholder, and the insured person, under penalty of being held liable for losses and damages, are required to:
	1. Take the steps within their power to prevent the aggravation of the claim;
	2. Notify the Insurer, in writing, of the loss within the 8 days immediately following its occurrence;
	3. Perform, whenever requested, exams that will be paid for by the Insurer at physicians designated by him/her, ceasing his/her liability if he/she fails to do so;
	4. Authorize, within the scope of a claim that gives rise to a request for benefit or reimbursement for healthcare under the terms of the insurance contract, the physicians and other professionals or healthcare institutions that he/she has used, to provide the physician designated by the Insurer with the information requested by the latter regarding his/her state of health and the clinical services provided.
2. In the reimbursement benefit scheme, the Policyholder and the insured person are also required to present the original receipts of the expenses to the Insurer, within a

maximum of 120 days from the date they were incurred. Whenever the originals have been used by the insured person for application for reimbursement of expenses to another Entity, photocopies may be submitted, provided that they are accompanied by a statement issued by the same Entity that proves the total amount of the expense and the reimbursement amount. Likewise, whenever the insured person needs to submit the originals for the purpose of subsequent reimbursement application to another Entity, he/she shall submit for that purpose photocopies of those documents, accompanied by a statement issued by the Insurer to prove the total amount of the expense and the reimbursement amount.

1. The Insurer shall not be liable for the consequences of delay or negligence attributable to the insured person in seeking assistance, nor shall the Insurer be liable if the insured person refuses to follow the prescribed treatment.
2. The Policyholder and the insured person are liable in legal terms for losses and damages, in cases of fraud, simulation and falsehood 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.

**CLAUSE 36**

**OBLIGATIONS OF THE INSURER**

It is the Insurer's obligation to punctually fulfill its commitments towards the Policyholder and the insured persons, namely:

* 1. To supply the CUIDA card, as well as making available information about the network(s) services;
	2. To promptly and diligently analyze the authorization requests, deciding on them within a period not longer than 5 working days, as of the date on which all the necessary elements for their appreciation are received;
	3. To reimburse the benefits, within a maximum of 30 working days from the date on which the coinsurances to be paid were calculated, as stipulated in the Specific Conditions, and if in possession of all the indispensable elements for their reimbursement.

**CLAUSE 37**

**COMMUNICATIONS AND NOTIFICATIONS**

1. The communications or notifications provided for in this Policy

will be considered valid and fully effective if made, by registered mail or any other means with a written record, including electronic records, to the Insurer's head office or to the address of the Policyholder or the Insured Person stated in the contract.

1. In the event of a change of address, the Policyholder or the Insured Person shall inform the Insurer within 30 days from the date of the change, otherwise the communications or notifications that the Insurer may make to the last known address will be considered valid and effective.
2. All documentation containing clinical information may only be made available through authorized medical practitioners and service providers, safeguarding the appropriate confidentiality and secrecy regarding personal and health data.

**CLAUSE 38**

**EFFECTIVENESS IN RELATION TO THIRD PARTIES**

Any exceptions, invalidity and other provisions that, according to this contract or the law, may be invoked against the Policyholder or the insured person, will also be invoked against any third party that benefits from it.

**CLAUSE 39 CURRENCY**

1. The insurance contract may be taken out in national currency in force 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/Amount) is expressed in the national currency in force or in foreign currency, any compensation to which it may give rise shall be paid in the national currency in force.
3. For reimbursement expenses which are made in foreign currency, the compensation shall be paid at the exchange rate for national currency published by the Banco Nacional de Angola on the date of occurrence.
4. In the event that the insured (Capital/Amount) is expressed in foreign currency, the indemnity shall be paid in the national currency in force, the counter value being calculated on the basis of the exchange rate of the national currency in force/foreign currency, published by the Banco Nacional de Angola on the date of occurrence of the claim when the Exchange Rate Fluctuation Clause is applicable, or at the exchange rate of the national currency in force/foreign currency

in force on the date of conclusion of the insurance contract or of renewal of the annuity, if the respective exchange rate considered therein is lower than that in force on the date of occurrence of the claim, in situations where the Exchange Rate Fluctuation Clause is not applicable.

**CLAUSE 40**

**EXCHANGE RATE FLUCTUATION**

1. It is agreed between the parties that in the event of an exchange rate fluctuation of more than 5% of the Angolan National Currency in relation to US dollars, the Insurer has the right to issue a compensatory receipt from the date on which the fluctuation occurs until the termination of the contract, on a *pro rata temporis* basis.
2. The reference values to be considered for the purposes of this clause shall be checked fortnightly on the first and sixteenth days of each month by analyzing the average values for the previous fortnight. The reference values used will be those published by the BNA - Banco Nacional de Angola - on its website.

**CLAUSE 41 CUIDA CARD**

1. To benefit from the services guaranteed by this contract in the network(s), the insured person must present his/her CUIDA card and a valid identification document with photograph (passport, identity card, driving license, and in the case of newborns without identity card, birth certificate). In case of loss of the CUIDA card, the insured person or the Policyholder must communicate it to the Insurer through the Customer Support Service, within 72 hours, in order to have it cancelled and a new card issued.
2. The CUIDA card is the property of the Insurer and can only be used by its holder, under the terms and for the purposes foreseen in this contract.

**CLAUSE 42 PERSONAL DATA**

1. The processing of personal data is carried out by the Insurer and its subcontractors with the unequivocal consent of the data subject, and its processing is necessary for the performance of the insurance contract and for the purposes of managing the provision of medical care or treatment or the management of health services, and is

carried out by health professionals who are bound to secrecy or by persons who are also subject to professional secrecy.

1. The Insurer is responsible for the treatment and guarantee of adequate data security measures, with the purpose set forth in the previous paragraph, and the Insured Persons are guaranteed the right to access and rectify them.

**CLAUSE 43 COMPLAINTS**

The presentation of any complaint related to this contract or to the obligations and rights arising from it, can be made directly to the Insurer or through the Angolan Institute of Insurance Supervision, the authority that supervises the Insurance activity.

**CLAUSE 44 BURDEN OF PROOF**

The burden of proof of the truthfulness of the statements shall be borne by the insured person, and the Insurer may require from him/her the appropriate means of proof that are within his/her reach.

**CLAUSE 45**

**APPLICABLE LAW AND COMPETENT JURISDICTION**

1. When the parties have not chosen, within the legal limits, another applicable law, this contract is governed by Angolan Law.
2. The competent jurisdiction to settle disputes arising from this contract is the one determined in the Civil Law.

**CLAUSE 46 ARBITRATION**

1. If, with regard to questions of an exclusively medical nature, the Insured Person's right to the Insurer's benefits is disputed, there may be recourse to arbitration.
2. In the case set out in the previous paragraph, each party shall designate a physician to represent it, and the designated parties shall agree on the designation of another physician who shall preside.
3. The costs of arbitration shall be borne by each party for the arbitrator it appoints and half for the presiding arbitrator.

**SPECIAL CONDITIONS**

**Common provisions**

In the part not specifically regulated herein, the provisions contained in the General Conditions of the CUIDA health insurance of FORTALEZA Seguros apply to the Special Conditions indicated below.

**A - BASIC COVERAGES**

## INPATIENT SPECIAL CONDITION INPATIENT CLINICAL CARE

1. Under the terms of this Special Condition, when the coverage is subscribed to, the payment of the following expenses is guaranteed, under the terms and limits set forth in the Specific Conditions, after the Grace Period has been completed, for diagnostic or therapeutic acts, the performance of which requires the specific means and services of a hospital environment, with hospitalization for 24 hours or more. Even if the hospital stay is for a period of less than 24 hours, the payment of the above-mentioned expenses is also guaranteed, when arising from outpatient surgery, duly justified and accepted by the Insurer.
2. The Insurer undertakes to :
	1. within the scope of the Agreed Benefits (network), finance the access of the Insured Person to providers of clinical services related to clinical care in hospital environment integrated in the CUIDA Network, under the terms and within the limits set forth in the Specific Conditions; for in-network provision, authorization is always required;
	2. within the scope of compensation benefits, reimburse the Insured Person for expenses incurred with clinical assistance that requires specific means and services in a hospital environment, under the terms and within the limits set forth in the Specific Conditions.
3. The scope of this coverage includes the provision of hospital care, including outpatient hospital care, as long as the need for a hospital environment to carry out the care is medically proven.
4. Notwithstanding the provisions of **CLAUSE 16 - GRACE PERIODS,** the Inpatient coverage is subject to a 90-day Grace Period.
5. Fundable or reimbursable expenses under the CUIDA Network are those incurred in payment for medical, surgical or diagnostic acts requiring specific means and services indispensable in a hospital environment to be carried out, namely:
	1. fees related to acts performed in a hospital environment, such as physician, surgeon, anesthesiologist, aide, and instrumentalist fees;
	2. Complementary Diagnostic and Therapeutic means associated with acts performed in a hospital environment;
	3. medicines when administered during the period of hospitalization and associated with the acts performed;
	4. materials, equipment and products when associated with acts performed in a hospital environment;
	5. accommodation in a ward and use of facilities necessary to perform the acts in a hospital environment, such as hospital stay, operating room, recovery room and equipment;
	6. ambulance transport, to and from the hospital, as long as the Insured Person's state of health justifies it;
	7. osteosynthesis material and surgically implanted prostheses (Intra-surgical);
	8. stomatological, dental and maxillofacial surgery resulting from an accident covered by the policy;
	9. ophthalmological surgeries resulting from an accident covered by the policy;
	10. cytotoxic chemotherapy and radiotherapy treatments, even if carried out in outpatient clinics;
	11. involuntary termination of pregnancy by medical recommendation;
	12. other acts or procedures contained in the agreed terms of closed prices, where applicable.
6. The Coinsurance, Reimbursements, Insured Capitals, Excesses and Copayments are set forth in the Specific Conditions.
7. Expenses of a private nature or which are not of a clinical nature are not reimbursable.
8. If there is a Medical Emergency (life-threatening) or Medical Urgency (not life-threatening, but needs immediate treatment and hospitalization), in which it is not possible to ask for pre-authorization before attendance, Fortaleza Seguros guarantees the first 24 hours of hospitalization that are considered necessary for stabilization and definition of the diagnosis. Should it be later confirmed that the event or pathology that originated the claim is excluded by the general and/or special conditions of the policy, the expenses assumed by the Insurer may be reimbursed by the policyholder after evaluation and decision by Fortaleza Seguros.

Should Fortaleza Seguros wish to exercise the right of recourse referred to above, the policyholder must return the amount within 30 days from the date of notification.

1. Apart from the exclusions set out in the General Conditions, the present condition does not guarantee expenses:
	1. resulting from minor surgery, regardless of the length of stay in the hospital unit;
	2. arising from natural childbirth, caesarean section and voluntary interruption of pregnancy;
	3. stomatological, dental and maxillofacial surgery not resulting from an accident covered by the policy;
	4. ophthalmological surgeries not resulting from an accident covered by the policy;
	5. incurred by the persons accompanying the Insured Person, except in the case of hospitalization of minors aged 14 or under;
	6. Expenses of a private nature.

**SPECIAL OUTPATIENT CONDITION - OUTPATIENT CLINICAL CARE**

This special condition guarantees, under the terms and limits set forth for such purpose in the Specific Conditions, after the Grace Period has been completed, the payment of expenses incurred with diagnostic or therapeutic acts, which do not require the specific means and services of a hospital environment, even if performed therein.

1. Under the terms of this Special Condition, when the coverage is contracted, the Insurer undertakes to:
	1. within the scope of the Agreed Benefits, finance the Insured Person's access to outpatient clinical service providers integrated in the CUIDA Network, under the terms and with the limits fixed in the Specific Conditions;
	2. within the scope of Compensation Benefits, reimburse the Insured Person for expenses incurred with outpatient medical care, under the terms and within the limits set out in the Specific Conditions.
2. Expenses incurred in payment for medical, surgical or diagnostic acts that do not require specific means and services in a hospital environment for their performance, even if performed in a hospital, constitute expenses that can be financed under the regime of access to integrated or reimbursable clinical service providers:
	1. medical appointments;
	2. medical fees relating to acts performed in a non-hospital environment;
	3. complementary diagnostic and therapeutic means performed in a non-hospital environment;
	4. materials and equipment when associated with specific acts and used during their performance;
	5. nursing fees related to acts performed in a non- hospital environment;
	6. ambulance transport, to and from health units, as long as the Insured Person's state of health justifies it.
3. When explicitly contracted and included in the Policy's Specific Conditions, expenses that can be financed under the regime of access to integrated or reimbursable clinical service providers, those incurred in payment for medical, surgical or diagnostic acts that do not require specific means and services in a hospital environment to be performed, even if they occur there, are also included:
	1. Nutrition consultations;
	2. Psychological and psychiatric consultations;
	3. Physiotherapy;
	4. Speech therapy and kinesiotherapy
	5. Prenatal, when birth coverage is contracted.
4. Notwithstanding the provisions of **CLAUSE 16 - GRACE PERIODS,** the Outpatient coverage is subject to

to a 30-day Grace Period.

1. The Coinsurance, Reimbursements, Insured Capitals, Excesses and Copayments are set forth in the Specific Conditions.
2. Access to the services guaranteed by this special condition requires prior authorization in the following cases:
	1. Medical appointments of:

**a.** Genetics.

* 1. Auxiliary diagnostic examinations and therapeutic means of:
		1. Polysomnography;
		2. Special treatments and examinations;
1. Nuclear magnetic resonance and CAT (computerized axial tomography);
2. Invasive means of cardiac diagnosis and therapy;
3. Invasive means of vascular diagnosis and therapy;
4. Hemodialysis;
5. Radiotherapy;
6. Physical and rehabilitation medicine treatments.
7. Tele-consultation
	1. Coverage

This Special Condition guarantees the Insured Person, through a telephone request, the possibility of obtaining support and advice for the adoption of measures to improve their health, as it is a non-presential medical appointment using information and communication technologies.

This service is provided by a team of physicians. 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 liability of this coverage is therefore limited to the liability arising from this type

of medical act in the non-face-to-face circumstances in which it is performed.

* 1. The services included in this coverage are:

## MEDICAL APPOINTMENT BY TELEPHONE OR VIDEO CONFERENCE

In the video conference medical appointment, the insured person can send images and medical exams so that the doctors can assess the respective clinical situation.

* 1. Exclusions

Apart from the exclusions set out in the General Conditions, this Special Condition does not guarantee:

Possible damages due to delays or difficulties in accessing this service as a result of anomalies in the telecommunications networks;

Any consequences of delay or negligence attributable to the Insured Person in seeking 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;

Possible consequences of the non-compliance, by the Insured Person, with the indications provided through the service.

* 1. Benefit scheme

The coverages of this special condition are guaranteed through the benefit scheme in the agreed network.

1. Exclusions

Apart from the exclusions set out in the General Conditions, this special condition does not guarantee:

Medical appointments, treatments, surgery and prostheses in the dental field;

Medical appointments, treatments, surgery and prostheses in the ophthalmologic field;

Orthoptic procedures; Prostheses and orthoses; Medicines;

This special condition also guarantees, under the terms and

limits set forth for this purpose in the Specific Conditions, access to the following services:

# B - COMPLEMENTARY COVERAGES

## SPECIAL CONDITION - NATUAL BIRTH AND CAESAREAN SECTION

1. Under the terms of this Special Condition, when the coverage is subscribed to, the Insurer undertakes to finance the Insured Person's access to clinical service providers for childbirth, which require the specific means and services of a hospital environment, with cause for exclusion of illegality and if, in the case of the normal period of gestation, childbirth occurs after the end of the Grace Period, under the terms of the following numbers and with the limits set forth in the Specific Conditions:
	1. within the scope of the agreed benefits, ensure the Insured Person's access to integrated clinical service providers. For in-network services, authorization is always required.
	2. within the scope of compensation benefits, reimburse the Insured Person for the expenses incurred.
2. Constitute reimbursable expenses, or fundable under the regime for access to integrated clinical service providers, those incurred in payments for:
	1. obstetrician's fees;
	2. anesthetist, assistant and instrumentalist’s fees, when justified;
	3. pediatric medical fees for the duration of the confinement of the mother under this Special Condition;
	4. complementary means of diagnosis carried out during the period of hospitalization;
	5. medicines when administered during the period of hospitalization;
	6. materials, products and equipment when associated with the acts performed during the period of hospitalization;
	7. accommodation facilities necessary to perform the acts (operating room, recovery room, delivery room, infirmary);
	8. hospital stay of the newborn for the duration of the mother's hospitalization under this Special Condition;
	9. ambulance transport, to and from the hospital, as long as the mother's state of health justifies it.
3. Notwithstanding the provisions of **CLAUSE 16 - GRACE PERIODS,** the Childbirth coverage is subject to a 365-day Grace Period.
4. The Coinsurance, Reimbursements, Insured Capitals, Excesses and Copayments are set forth in the Specific Conditions.
5. Exclusions

The necessary expenses for the newborn baby, after the mother's discharge, are only guaranteed if the Policyholder requests the Insurer to pre-subscribe until the 6th month of pregnancy, complemented with a definitive subscription until 30 days after birth. In this case, once the inclusion of the newborn baby as an insured person is accepted, the corresponding premium will be due as from its birth.

Apart from the exclusions set out in the General Conditions, this special condition does not guarantee

1. Expenses of a private nature;
2. Expenses for accompanying persons.

## SPECIAL CONDITION - OPHTHALMOLOGY

This special condition guarantees, within the terms and limits set forth in the Specific Conditions, the payment of expenses incurred, after the end of the Grace Period, with diagnostic or therapeutic acts of an ophthalmologic nature.

1. Under the terms of this Special Condition, when the coverage is contracted, the Insurer undertakes to:
	1. within the scope of the Agreed Benefits, finance the Insured Person's access to ophthalmology clinical service providers integrated in the CUIDA Network, under terms and with the limits fixed in the Specific Conditions;
	2. within the scope of Compensation Benefits, reimburse the Insured Person for expenses incurred for ophthalmology medical care, under the terms and within the limits set out in the Specific Conditions.
2. Eligible or reimbursable expenses under the CUIDA Network access scheme are those incurred

in the case of:

* 1. Medical fees;
	2. medical appointments;
	3. auxiliary diagnostic tests;
	4. complementary diagnostic and therapeutic means;
	5. materials and all products associated with medical acts;
	6. accommodation and use of the infrastructures necessary to perform the medical acts performed in a hospital environment (hospital stay, operating room and equipment).
		+ In the event of and as a result of an accident, hospitalization coverage is guaranteed;
	7. medicines administered during hospitalization;
1. Expenses incurred with the purchase of ocular lenses for which the coverages guaranteed by this special condition are accepted by the Insurer through the application of the procedures indicated below are also guaranteed:
	1. In the first presentation of expenses for ocular lenses (from 2 diopters onwards), it will only be reimbursed when supported by the respective prescription made by a physician or optometrist. In the following cases, the Coinsurance of expenses will only occur when there is a change in the correction in relation to the previous prescription;
	2. The useful life of lenses is considered to be three years, after which they become reinsurable, even if there is no change in the correction compared to the previous prescription. This useful life period does not apply to disposable contact lenses;
	3. In the case of minors under 16 years of age, lenses may be reinsurable without the aforementioned change, provided that the prescription explicitly states the need to change the strength as a result of their growth;
	4. Cases of theft, robbery, loss, or breakage of lenses

will never be considered, except when resulting from an accident guaranteed by the contract, provided that the respective accident report is accompanied by a document proving the physical injuries caused to the insured person, prepared by the physician or hospital unit that provided assistance.

1. Ophthalmology coverage is subject to a 30-day grace period, except for Prostheses where a 90-day grace period applies.
2. The guarantees provided for in this Special Condition allow for the setting of Excesses, as well as minimum and maximum amounts to be reimbursed, duly stipulated in the Specific Conditions.
3. Exclusions

Apart from the exclusions set out in the General Conditions, this special condition does not guarantee:

* Frames;

## SPECIAL CONDITION - STOMATOLOGY AND DENTISTRY

This special condition guarantees, within the terms and limits set forth in the Specific Conditions, the payment of expenses incurred, after the end of the Grace Period, with diagnostic or therapeutic acts of a stomatological nature

1. Under the terms of this Special Condition, when the coverage is contracted, the Insurer undertakes to:
2. within the scope of the Agreed Benefits, finance the Insured Person's access to stomatology and dentistry clinical service providers integrated in the CUIDA Network, under terms and with the limits fixed in the Specific Conditions;
3. within the scope of Compensation Benefits, reimburse the Insured Person for expenses incurred with medical care in stomatology and dental medicine, under the terms and within the limits set out in the Specific Conditions.
4. Eligible or reimbursable expenses under the CUIDA Network access scheme are those incurred in the event of:
	1. Medical fees;
	2. medical appointments;
	3. auxiliary diagnostic tests;
	4. complementary diagnostic and therapeutic means;
	5. materials and all products associated with medical acts;
	6. accommodation and use of the infrastructures necessary to perform the medical acts performed in a hospital environment (hospital stay, operating room and equipment).
		* In the event of and as a result of an accident, hospitalization coverage is guaranteed;
	7. medicines administered during hospitalization.
5. Stomatology and Dentistry coverage is subject to a 30-day grace period.
6. The guarantees provided for in this Special Condition allow for the setting of Excesses, as well as minimum and maximum amounts to be reimbursed, duly stipulated in the Specific Conditions.
7. Exclusions

Apart from the exclusions set out in the General Conditions, this special condition does not guarantee:

* 1. Orthodontic appliances and their molds and studies;
	2. Treatments performed using precious metals;
	3. Rehabilitation of missing teeth or teeth rehabilitated with prosthesis at the date of the contract;
	4. Stomatological prostheses.

## SPECIAL CONDITION - MEDICINES

1. In the terms of this Special Condition, the Insurer, upon contracting the coverage, is obliged to reimburse the Insured Person, under the terms and limits set out in the Specific Conditions, after the end of the Grace Period, for expenses incurred with the purchase of medicines, classified as such by the competent authority of the Ministry of Health, as long as they are prescribed by a doctor for the treatment of an illness or accident that is covered by the policy.
2. Expenses incurred in payment of the following do not constitute reimbursable expenses:
	1. non-prescription medicines (over-the-counter);
	2. Vaccines, except when their coverage has been expressly contracted and is provided for in the Specific Conditions of the Policy, under the terms of the applicable Special Condition;
	3. child nutrition;
	4. dietetic, natural, supplements and manipulated, homeopathic products;
	5. aesthetic and cosmetic products, general hygiene, including oral and dental hygiene;
	6. sanitary and antiseptic items;
	7. wound dressing material;
	8. sanitary and antiseptic items, shampoos, soaps, medicated pastes and similar;
	9. products for the treatment of obesity.
3. Medicines coverage is subject to a 30-day grace period.
4. The reimbursement of the expenses incurred is subject to the verification of the following assumptions:

**a)** the medicines must be prescribed by a doctor and are intended for the treatment of injuries resulting from clinical situations whose coverage is contractually guaranteed;

1. This coverage operates under the agreed network and the reimbursement benefits.
2. The original or copy of the medical prescription, signed by the supplying pharmacy and showing the stickers or bar codes or registration number of the prescribed medication, as well as the corresponding receipt, shall be sent to the Insurer, depending on the case, with express and legible mention of the medication supplied and the amounts that, after deduction of the coinsurance amount, if any, shall be payable by the Insured Person, under the terms set forth for the coordination of benefits. The Insurer will not reimburse expenses for which it does not have the necessary evidence.
3. The Coinsurance, Reimbursements, Insured Capital, Excesses and Copayments are set forth in the Specific Conditions.
4. Delivery of Medicines
	1. Object of the Service

Following a medical prescription and at the request of the Insured Person, the Assistance Service contracted by the Insurer, through a Protocol signed with the Insurer and the specialized service providers, will provide the necessary medication at the Insured Person's home, for the period, terms and limits set forth in the Specific Conditions.

This guarantee only applies in case of urgency and in the presence of a justified and proven need of physical or health impossibility to travel.

* 1. Territorial Scope

The guarantees provided for in this Special Condition are valid exclusively in Luanda and in other Provinces where there are material and human conditions to ensure it.

Single paragraph: This service will only be made available if there are material conditions for providers who can provide it, complying with all legal requirements and duly authorized and licensed for this purpose.

## SPECIAL CONDITION - VACCINES

1. Under the terms of this Special Condition, the Insurer, when the coverage is contracted, undertakes to reimburse the Insured Person, under the terms and limits set forth in the Specific Conditions, after the end of the Grace Period, for the expenses related to the medical act.
2. The costs with vaccines that are included in the National Vaccine Plan are excluded, being applicable, however, the foreseen in the previous number regarding the costs of the medical act.
3. The costs with other vaccines not included in the National Vaccine Plan are guaranteed as long as they are proven necessary and must be accompanied by a medical prescription.

**SPECIAL CONDITION -**

**HOME CARE**

**1.** ASSISTANCE SERVICE

Permanent service structure, through a Protocol signed with the Insurer and the service provider, after the end of the Grace Period, replacing it in the obligations arising from this Special Condition.

1. Scope of the Guarantee

By this contract, the Insurer, through the Assistance Service, guarantees coverage for the risks referred to in paragraph 3 of this Special Condition, within the limits set forth in the Specific Conditions, subject to the precepts and exclusions set forth in these paragraphs and in the General Conditions.

1. Main Guarantees
2. Medical appointments

Including Travel Fees

1. Home Nursing

If there is a medical prescription, the Assistance Service will arrange for a nursing professional to be sent to carry out the nursing acts described above.

The following nursing acts are covered by this guarantee:

* + Treatment of wounds, pressure ulcers and/or bedsores;
	+ Injections;
	+ Catheterization;
	+ Nasogastric intubation;
	+ IV fluids;
	+ Removal of stitches and staples;
	+ Travel Fees.

For each travel request made, the Insured Person will be liable for the value of the consumables used in the acts to be performed, under the terms and limits set out in the Specific Conditions.

1. Transport of the Insured Person to the Medical Services

I Should there be a proven need, the Assistance Service will arrange for the transport of the Insured Person in an ambulance or cab to the Health Care Units for Supplementary Diagnostic Examinations, Medical Appointments, Hospital Admissions and Discharges.

1. The Home Care coverage is subject to a 30-day grace period.
2. Territorial Scope

The guarantees provided for in this Special Condition are valid in Luanda and in the provinces where there are material and human conditions to guarantee this service.

## SPECIAL CONDITION - PROSTHESES AND ORTHOTICS

1. Under the terms of this Special Condition, when the coverage is subscribed to, the Insurer, under the terms and limits set forth in the Specific Conditions, after the end of the 90-day grace period, guarantees the payment of expenses incurred with the purchase or rental, according to medical prescription, of prostheses and orthotics, as long as they are prescribed by a specialized doctor or optometrist.
2. Reimbursable expenses in the context of compensation benefits are those incurred in payments (only guaranteed under the reimbursement benefit scheme) of:

**a.** Prostheses and orthotics.

1. For the purposes of this Special Condition, the following shall be deemed to be:

Prosthesis - any clinically designed or recommended instrument, which has the purpose of total or partial replacement of a limb or organ;

Orthosis - any clinically designed or recommended instrument which is intended to help a limb or organ to perform all or part of its function.

1. Under this Special Condition, coinsurance is granted for the purchase of:
2. hearing and non-ophthalmic prostheses;
3. rental or purchase of wheelchairs and crutches provided that the rental amount does not exceed the purchase amount.
4. The following documents must be submitted for the coinsurance of the expenses incurred with the acquisition of prostheses or orthotics:
5. photocopy of the physician's prescription in the case of hearing aids, orthopedic footwear, wheelchairs and crutches;
6. receipt from the entity that supplied the prosthesis or orthosis, naming and expressly indicating the quality, quantity and price of the materials purchased.
7. Apart from the exclusions set out in the General Policy Conditions, this coverage does not guarantee:
8. stomatological prostheses;
9. ophthalmic prostheses;
10. medical belts, elastic stockings, orthopedic mattresses, orthopedic pillows or orthopedic footwear;
11. other equipment classified as technical aids;
12. sunglasses, including frames and lenses, whether or not prescription;
13. Orthopedic footwear;
14. Isolated acquisition of frames;
15. Loss, theft, robbery or breakage
16. Coverage for Prostheses and Orthotics is subject to a 90-day grace period.
17. The Coinsurance, Reimbursements, Insured Capitals, Excesses and Copayments are set forth in the Specific Conditions.

## SPECIAL CONDITION - MEDICAL EMERGENCIES IN ANGOLA - EVACUATION AND REPATRIATION

The guarantees granted by this special condition are only actionable if there is a medical emergency in Angola.

For the purposes of this Coverage, MEDICAL EMERGENCIES are deemed to be those situations resulting from sudden illness or accident (trauma), which place the survival of the Insured Person at risk, or are likely to cause serious permanent disability, which require treatment within a short period of time and whose treatment

cannot be provided in a Hospital Unit in Angola.

The following guarantees are available under this Special Condition and can only be activated in the event of a medical emergency in Angola and the Company's intervention is requested to provide them.

1. Telephone Evaluation of the Nature and Gravity of the Occurrence

If the Insured Person is hospitalized, the Insurer guarantees, through its medical team and together with the Insured Person's Physician, the assessment of the nature and gravity of the clinical situation, as well as the monitoring of its evolution, making this information available to the family, if requested.

1. Emergency Medical Advice and Information

The Insurer guarantees the Insured Person the possibility, in case of emergency, to contact the medical advice and information telephone service, which will provide its support, aiming at the adoption of measures to improve the health of the Insured Person, being able to activate the available rescue means recommended for such situations.

The medical advice and support provided under this Special Condition is aimed at identifying the symptoms that the Insured Person communicates to the service by telephone, and it is the Insured Person's responsibility to suggest the use of the most appropriate means for the type of situation communicated, possibly indicating the need to resort to on-site medical care or other type of actions. The liability of this guarantee is therefore limited to the liability arising from this type of medical act in the circumstances where it is performed.

1. Emergency Transport of the Insured Person to the Appropriate Hospital Unit

The Insurer guarantees, whenever justified by the Insured Person's state of health, up to the limit mentioned in the Insurance Guarantee Guideline, the right to:

* 1. Emergency ambulance transport to the nearest hospital;
	2. Transportation from the hospital unit where the Insured Person is admitted to another hospital unit that is indicated to him/her;
	3. Transport back to his/her usual home, after medical discharge.
1. Sanitary transport

If the Insured Person requires treatment that cannot be provided in a Hospital Unit in Angola, the Insurer will arrange for their transfer, by the appropriate means, to a Hospital Unit in Portugal or another country in the region, where the necessary medical care can be provided. Each medical evacuation will be decided and supervised by the Insurer's medical team.

If the Insured Person is hospitalized and if their stay is expected to last more than 7 days or if they are a minor or a citizen with a congenital or acquired disability, the Insurer will also pay for the transport expenses of a relative (return trip) to accompany them, as well as the accommodation expenses in the hospital or elsewhere, if it is not possible to stay in the hospital itself, up to the limit mentioned in the Insurance Guarantee Guideline.

1. Inpatient Expenses

As a result of the activation of the Medical Transport guarantee, the Insurer guarantees, up to the limit mentioned in the Insurance Guarantee Guideline, the payment of hospitalization in a Hospital Unit abroad, where the medical care that the Insured Person requires can be provided.

1. Repatriation of the Sick Insured Person or of their Mortal Remains to Angola

If the Insured Person has been transported abroad, under the coverage of medical transport, the Insurer will guarantee, up to the limit mentioned in the Insurance Guarantee Guideline, his/her repatriation to Angola, when medically advisable or if he/she dies as a consequence of the Accident or Illness that originated the said transport

1. Exclusions

Any services not previously requested from the Company and thus performed without their prior and express agreement are expressly excluded.

## SPECIAL CONDITION - REPATRIATION ON DEATH TO THE COUNTRY OF ORIGIN

For this coverage, when contracted, in case of death of the Insured Person, the Insurer will guarantee

his/her repatriation to Angola or the country of his/her nationality, if he/she dies as a result of an accident or illness that led to the event.

The costs of payment and processing of formalities at the place of burial and the costs of transporting the body to the place of burial are guaranteed, up to the limit set forth in the Specific Conditions of the policy.

Repatriation expenses are expressly excluded, as well as any other services that have not been previously requested to the Insurer and that have been performed without its prior and express agreement.

Coverage under this Special Condition is provided on an In-Network Benefits basis and should be requested through Customer Service.

## SPECIAL CONDITION - FUNERAL EXPENSES

1. The Insurer guarantees, in the event of the death of the Insured Person as a result of an Accident or Sickness covered by the Policy, under the terms of these General and Special Conditions and the conditions described in this article, the payment of Funeral Expenses, under the terms of the following numbers.
2. The risks effectively covered and the sums insured in respect of the Insured Persons covered by this contract are set out in the Specific Conditions or in the Individual Certificates and may be adjusted annually.
3. In the event of death due to an accident covered by the policy, funeral expenses are guaranteed immediately in accordance with the General and Special Policy Conditions, without any Grace Period.
4. In the case of Death by Illness, Funeral Expenses are covered on the condition that the Insured Person dies after the first six months of the contract.
5. For the purposes of this contract, the capital sum is understood to mean the Funeral Expenses, which are those necessary for access to funeral services and other logistics related to the funeral day, such as preparation of the body, acquisition of the urn, hearse, funeral cortege, transport, burial scenario, hydration and similar, and the Transfer Expenses, when applicable, in accordance with the contracted amount (Capital).
6. Coverages:

By this contract, the Insurer, as a result of

accident or illness suffered by the Insured Person, as long as covered by the coverage and mentioned in the Individual Certificate, in the Specific Conditions, in the Special Conditions or in the Additional Addendum, guarantees the payment, up to the limits foreseen therein, of the corresponding compensation, for

* Funeral Costs, as a result of Death by Accident or Illness
1. Funeral Expenses
	1. In the case of Funeral expenses of the Insured Person, the Insurer will reimburse, up to the amount set forth for this purpose in the Individual Certificate, Specific Conditions, Special Conditions or Additional Addendum, the funeral expenses.
	2. Up to the limit of the coverage, transfer is also guaranteed, understood as the transport of the body from the site of death to the site of the funeral, exclusively in national territory (Angola).
	3. The reimbursement of expenses with the Funeral and Transfer of remains will be occur upon submission of the original supporting documentation to those who prove they have paid these expenses, up to the limit of the insured sum, for all expenses with the Funeral and Transfer of remains together with a single lump sum corresponding to the sum of all Funeral and Transfer expenses.
2. The coverage of Funeral Expenses does not work separately, so it only works as a direct consequence of Death by Accident or Illness, in accordance with the Policy Conditions.

# C - COVERAGE EXTENSION

## SPECIAL CONDITION - 2ND OPINION

1. Under the terms of this Special Condition, the Insurer undertakes to guarantee the Insured Person access, in accordance with the limits set forth in the Specific Conditions, to the 2nd medical opinion service provided by a specialized Entity treated by CUIDA, upon previous request through the CUIDA Line.
2. The agreed benefits provided for in this Special Condition are valid when performed by the Specialized Entity contracted by CUIDA.
3. What is guaranteed
	1. Within the scope of this Special Condition, the insurance contract

guarantees the Insured Person, in accordance with the limits set forth in the Specific Conditions and for the illnesses referred to in paragraph 3.2, access to a 2nd medical opinion service, which consists of a non-face-to-face analysis of the clinical situation, the respective diagnosis and indication of the most suitable medical care.

* 1. For the purpose of this Special Condition, illnesses or medical conditions are deemed to be those diagnosed by a physician but do not include diagnoses made by General Practitioners or Pediatricians.
1. Funding for any additional medical acts, even if resulting from a recommendation obtained under this Special Condition, is excluded.
2. The following are excluded from this coverage: acute outbreaks of illness of short duration, psychiatric illnesses, dentistry, second opinions on hospitalized patients and hospital admissions.
3. Only one service is guaranteed for the same pathology; however, a new medical appointment may be covered for the same illness if there is a new diagnosis that implies a significant worsening of the illness or a substantial modification in treatment, duly supported by a medical report.
4. The coverage of a 2nd medical opinion is subject to a 30-day grace period.
5. The Coinsurance, Reimbursements, Insured Capitals, Excesses and Copayments are set forth in the Specific Conditions.

**D - MEDICAL ASSISTANCE ABROAD**

**- TERRITORIAL EXTENSION**

## SPECIAL CONDITION - ACCESS TO MEDICAL SERVICES ABROAD

1. Under the terms of this Special Condition, the Insurer guarantees, in the terms and limits set forth in the Policy's Specific Conditions for each coverage and guarantee, the payment of health care expenses abroad, relative to the medical condition guaranteed by this Policy, up to the limit set forth in the Specific Conditions.
2. Unless otherwise agreed, subject to a special condition or authorization, this guarantee operates under the compensation benefit scheme provided for in the General and Special Conditions

of this policy (reimbursement benefits).

1. Expenses that are eligible as if they had been incurred in Angola shall be considered reimbursable, under the terms and limits set forth in the Specific Conditions of the policy for each contracted coverage.
2. The Coinsurance, Reimbursements, Insured Capitals, Excesses and Copayments are set forth in the Specific Conditions.

## SPECIAL CONDITION - EXTENSION TO THE MEDICAL NETWORK IN PORTUGAL

1. Under the terms of this Special Condition, the Insurer guarantees, in accordance with the terms and limits set forth in the Specific Conditions of the Policy for each coverage and guarantee, the payment of health care expenses in Portugal, relative to the medical condition guaranteed by this Policy, up to the limit set forth in the Specific Conditions;
2. This guarantee operates on an agreed network access basis.
	1. The Insurer guarantees access by the insured person to health care services, carried out at providers within the network agreed upon in Portugal, with the insured person bearing the costs indicated at the time of access to the network agreed upon, under the terms and limits set forth in the Special and Specific Conditions;
3. The Coinsurance, Reimbursements, Insured Capitals, Excesses and Copayments are set forth in the Specific Conditions;

Single paragraph: The information on the providers that make up the agreed network in Portugal is available and constantly updated at [www.FortalezaSeguros.ao.](http://www.FortalezaSeguros.ao/)

# E - OTHER SUPPLEMENTARY SERVICES

## CUIDA LINE- 24/7 SERVICE

Permanent telephone support to the Insured Person guaranteeing a service to register the information regarding the complaints presented, as well as the susceptibility of the situation requiring medical assistance and the degree of urgency of the situation, suggesting the most appropriate means for the situation and also alerting to the signs and symptoms that should imply other types of actions, this act, under no circumstances, constituting a medical act or a clinical diagnosis, through which the Insured Person may also be

referred to the most adequate care, with a view to improving his/her health and, if necessary, referral to Tele-consultation, and information of integrated preventive actions, within the scope of the contractual relationship existing between the Insured Person and FORTALEZA Seguros.

Permanent telephone support through which the Insured Person can be referred to the most appropriate care with a view to improving his/her health and, if necessary, phone call to a Physician.

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