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Médis Dental Insurance

General and Special Conditions of the Policy

Customer Support: 707 502 424 / 918 272 424
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24 hours personalised service

www.millenniumbcp.pt

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GENERAL CONDITIONS

CLAUSE 1 - DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

ENDORSEMENT
Document which certifies an amendment of the Policy.

3. Relative to the health insurance subscription

MÉDIS DENTAL INSURANCE
Dental Medicine insurance contract concluded between the Insurer and Insurance Policyholder, certified by the issue of a Policy, by which the Insurer guarantees the Insured Persons access to the Médis Dental network of providers, under the terms and limits agreed with them.

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

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

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

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

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

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

5. Relative to the guarantees of the health insurance contract

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

AGREED PAYMENTS
Guaranteed funding of access, under the conditions established in the Policy,of the Insured Person to the network of Médis Dental providers, of free choice and access subject to the criteria for use stipulated in the Médis Dental Guide.

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

STOMATOLOGICAL DISEASE
All involuntary alteration of health condition exclusively related to stomatology, not caused by an accident and diagnosed by a physician.

PHYSICIAN
Graduate of a Higher Education Faculty of Dental Medicine, legally authorised to exercise the profession in Portugal and whose speciality and registration are recognised by the Portuguese Dentist Association or by corresponding entities of the countries where they perform their activity.

MEDICAL ACT
Act carried out by a dentist legally qualified by the respective Dentist Association, that includes the promotion of oral health, the prevention and treatment of disease, and stomatological interventions, which could determine supplementary procedures carried out by other Physicians.

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

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

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

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

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

6. Relative to the Médis Dental Healthcare System

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

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

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

MÉDIS DENTAL CARD
Personal and non-transferrable card which identifies its holder to the Insurer and Médis Dental Network, in order to enable the holder's access to the Dental Medicine healthcare system, recording, if it has a specific device for the effect, the appointments, medical acts and other means used.

CLAUSE 2 - OBJECT

By the present contract, the Insurer guarantees to the Insured Persons, in accordance with the provisions in the General, Special and Particular Conditions of the policy, the payment of dental medicine care carried out within the Médis Dental network of agreed providers, as a consequence of disease or accident occurred during the enforcement period of the contract, pursuant to the applicable tables of co-payments of the Special Conditions.

CLAUSE 3 - BASE OF THE CONTRACT

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

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

3. This coverage guarantees, under the terms and limits established for the effect in the Particular Conditions, the right of access to diagnostic or therapeutic acts that do not require means and services particular to hospital environments, even if carried out therein, with the Insured Person paying the entirety of the respective cost. This coverage includes the right of access to the acts referred to above that lead to expenses incurred due to:

a) Fees of medical appointments;
b) Materials and products associated to medical acts;
c) Auxiliary Diagnostic Tests;
d) Stomatological protheses.

4. Under the agreed payments, the Insured Person will directly pay the Provider the amount of the co-payment for which it is responsible, with the Insurer's contribution to these expenses being paid directly by the Insurer to the Provider.

CLAUSE 4 - DUTY TO MAKE AN INITIAL RISK STATEMENT

1. The Insurance Policyholder and Insured Person are obliged, before signing the contract, to accurately state all the circumstances they are aware of and should reasonably consider significant for the appraisal of the risk by the Insurer.

2. The provisions in the previous number are also applicable to circumstances whose mention is not requested.

3. Following acceptance of the contract, the Insurer cannot, except in the case of deliberate fraud by the Insurance Policyholder or Insured Person for the purpose of obtaining an advantage, avail itself of:

a) the fact that its representative, at the time of signing the contract, knew that it was inaccurate or, when having been omitted, knew this;

b) circumstances known to the Insurer, especially when public and manifest.

(1) Médis Line - 21 845 88 88 - Clinical triage: 24-hour personalised attendance - Administrative issues: Monday to Friday from 8h00 to 20h00

4. Before signing the contract, the Insurer should clearly inform the potential Insurance Policyholder or Insured Person about the duty referred to in number 1, as well as the arrangement in the event of its breach, under penalty of incurring civil liability, under the general terms.

CLAUSE 5 - DELIBERATELY FRAUDULENT BREACH OF THE DUTY TO MAKE AN INITIAL RISK STATEMENT

1. In the case of the deliberately fraudulent breach of the duty referred to in number 1 of the previous article, the contract shall be annullable by statement sent by the Insurer to the Insurance Policyholder.

2. If no incidences have occurred, the statement referred to in the previous number should be sent within the period of three months counted from the time that this breach is known.

3. The Insurer is not obliged to cover any Incident that occurs before becoming aware of the intentional breach referred to in number 1 or during the period established in the previous number, and should follow the general arrangement for annulment.

4. The Insurer is entitled to the premium payable up to the end of the period referred to in number 2, unless the Insurer or its representative has committed deliberate fraud or acted with gross negligence.

5. In the case of deliberate fraud by the Insurance Policyholder or Insured Person for the purpose of obtaining an advantage, the Premium is payable up to the end of the contract.

CLAUSE 6 - NEGLIGENT BREACH OF THE DUTY TO MAKE AN INITIAL RISK STATEMENT

1. In the case of the breach with negligence of the duty referred to in number 1 of Clause 4, the Insurer may, by statement sent to the Insurance Policyholder, within the period of three months counted as of its knowledge:

a) propose an amendment to the contract, establishing a deadline, of at least 14 days, for the sending of its acceptance or, if permissible, the submission of a counter-proposal;

b) terminate the contract, demonstrating that, under no circumstances whatsoever, will the Insurer conclude contracts covering risks related to the omitted or misrepresented fact.

2. The contract ceases its effectiveness 30 days after the sending of the notice of termination or 20 days after the Insurance Policyholder has received the proposed amendment, should the Insurance Policyholder neither respond nor reject this proposal.

3. In the case referred to in the previous number, the premium is returned pro rata temporis according to the coverage that has occurred.

4. If, before the termination or amendment of the contract, an incident occurs whose occurrence or consequences have been influenced by a fact relative to which there were negligent omissions or inaccuracies:

a) the Insurer shall cover the incident in the proportion of the difference between the premium paid and premium that would have been payable if, when the contract was signed, the Insurer had known the omitted or misrepresented fact;

b) the Insurer, demonstrating that in no case whatsoever would it have concluded the contract if it had known of the omitted or misrepresented fact, shall not cover the Incident and is solely bound to return the Premium.

CLAUSE 7 - TERRITORIAL SCOPE

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

CLAUSE 8 - INSURED PERSONS

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

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

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

CLAUSE 9 - AGREED PAYMENTS

1. The funding conditions entail maximum limits relative to specific medical acts, as well as Co-payments per visit payable by the Insured Person, whose scope is defined in the Special Conditions and Particular Conditions.

2. The Insurer provides the Insured Person, on the Médis Website, the Médis Dental Guide with list of providers that, at any given time, are included in the Médis Dental Network, where the Insured Person is free to choose the provider.

CLAUSE 10 - EXCLUSIONS

1. The present contract always excludes payments derived from:

a) treatments, surgery and other acts aimed at correcting congenital disorders or malformations, unless explicitly agreed otherwise under the terms stipulated in the Particular Conditions with respect to neonates covered by the Médis Policy since birth;

b) expenses incurred with physicians that are spouses, parents, offspring or siblings of the Insured Person;

c) expenses related to services that are not clinically necessary, as well as hospital care and treatment for reasons of social nature;

CLAUSE 11 - START AND DURATION OF THE CONTRACT

1. Once accepted, the contract or subscription is enforced from 0 hours of the 1st or 15th of the month after the proposal is received at the Insurer, according to whether it is received, respectively, up to the 15th or after the 15th of any given month, with the guarantees beign enforced for the Insured Persons from the start date indicated in the Particular Conditions.

2. The duration of the contract is as stipulated in the Particular Conditions of the Policy, and may be for a fixed and specific period of time or for one year to continue over the following years.

3. When the contract is signed for a specific period of time, the contract ceases to be effective at 24 hours on the last day of the established period.

4. When the contract is signed for a year to be continued for following years, it is considered automatically and successively renewed for annual periods, unless one of the parties denounces it by registered mail, or other means of which there is a written record with a minimum period previously of 30 days in relation to the end of the annuity.

5. The payments guaranteed by the Insurer refer exclusively to each contract enforcement period. There is no entitlement to any prolongation or extension of the guarantees beyond their due date, without prejudice to the provisions in relation to the non-renewal of the contract or subscription.

CLAUSE 12 - TERMINATION OF THE CONTRACT

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

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

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

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

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

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

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

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

5. The Médis Dental Card belongs to the Insurer, where its holder undertakes not to use it and return it immediately

upon the end of the enforcement of the insurance contract under which it was issued, under penalty of incurring the civil and criminal liability corresponding to the fact. In the event of misplacement, abusive appropriation, theft or robbery of the card, the holder undertaken to report the event to Médis, within the maximum period of 72 hours, under penalty of incurring civil liability for improper use.

CLAUSE 13 - FREE CANCELLATION

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

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

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

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

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

CLAUSE 14 - PAYMENT OF THE PREMIUM

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

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

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

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

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

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

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

CLAUSE 15 - NOTICE OF PAYMENT OF THE PREMIUM

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

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

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

CLAUSE 16 - NON-PAYMENT OF THE PREMIUM

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

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

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

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

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

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

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

CLAUSE 17 - TEMPORARY IMPOSSIBILITY OF NEW SUBSCRIPTION

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

CLAUSE 18 - DUTIES OF THE INSURANCE POLICYHOLDER AND/OR INSURED PERSON

1. The Insurance Policyholder should inform the Insurer of the inclusions of Insured Persons that occur during the enforcement of the Policy, taking effect on the first day of the month following the date of the notification made by the Insurance Policyholder.

2. The Insurance Policyholder should inform the Insurer of the exclusions of Insured Persons that occur during the enforcement of the Policy, taking effect on the due date of the annuity of the insurance in which the aforesaid amendment occurred.

3. In the event of any disease or accident covered by the guarantees of this contract, during the enforcement of the contract, the Insured Person is obliged to:

a) Select a provider of the Médis Dental Network;

b) Always present his/her Médis Dental card and a valid identity document with photograph to the Médis Dental Network to request the respective guaranteed services;

c) Pay the provider the value under his/her responsibility, in accordance with the Special Conditions of the Policy.

CLAUSE 19 - SUBROGATION

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

CLAUSE 20 - AMENDMENTS TO THE TERMS OF THE CONTRACT

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

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

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

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

CLAUSE 21 - ARBITRATION

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

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

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

CLAUSE 22 - COMMUNICATIONS AND NOTIFICATIONS

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

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

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

CLAUSE 23 - PERSONAL DATA

1. The processing of personal data is done by the Insurer and its subcontractors with the unequivocal consent of their owner. This data processing is necessary for the execution of the insurance contract and for purposes of management of the provision of care or medical treatments or management of health services, and is carried out by health professionals bound to secrecy or by persons likewise subject to professional secrecy.

2. The Insurer is responsible for the processing and assurance of appropriate data security measures, for the purpose foreseen in the previous number, with the Insured Persons being assured the right of access to and rectification of this data.

CLAUSE 24 - APPLICABLE LAW AND COMPETENT JURISDICTION

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

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

SPECIAL CONDITIONS

SPECIAL CONDITION - DENTAL COVERAGE

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

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

Funded acts in the Médis Dental Network:

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

SPECIAL CONDITION – ONLINE DOCTOR

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

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

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