INDIVIDUAL HEALTH INSURANCE "CARE FOR THE BABY"
GENERAL TERMS AND CONDITIONS OF INSURANCE NO. 1/2025

List of the information included in General Terms and Conditions of Insurance referred to in Article 17 section 1 of the Act of 11 September 2015 on insurance and reinsurance business, including definitions from General Terms and Conditions of Insurance ("Index").

No.	Type of information	Number of paragraph/section in the contract template
1.	Preconditions for payment of compensation and other benefits or surrender value of insurance	- § 3 sections 2-4 - § 5 section 1-3, section 6, sections 11-12 - § 8 section 1
2.	Limitations and exclusions of liability of the insurance firm that authorise to refuse to pay or reduce compensation or other benefits	- § 4 - § 5 sections 5, 7, 9 and 10 - § 7 - § 8 sections 2-3

§ 1
GENERAL PROVISIONS

1. Medicover Försäkrings AB (publ.) operating through its Branch in Poland with its registered office in Warsaw (hereinafter referred to as the "Insurer") concludes Insurance Contracts with natural persons in accordance with these General Terms and Conditions of Individual Health Insurance "Care for the Baby" (hereinafter: "GTC").
2. The Insurance Contract shall be concluded on behalf of a third party being a natural person (hereinafter referred to as the "Insured"), on the terms specified in the Insurance Contract.
3. The Policy issued by the Insurer confirms the conclusion of the Insurance Contract.
4. By mutual consent of the parties, the Insurance Contract may include specific terms that are inconsistent with these GTC, which will prevail over the provisions of the GTC. In such a case, the Insurer will provide the Insuring Party with a list of differences between the provisions of the GTC and the Insurance Contract before concluding the Insurance Contract.
5. Matters not regulated in the GTC or the specific terms shall be governed by provisions of the Civil Code and other provisions of the law generally binding in the territory of the Republic of Poland.

§ 2
DEFINITIONS

The terms used in these GTC shall have the following meaning:

1. **Medicover Centre** – Medical Facility belonging to Medicover Sp. z o.o. and/or Medical Facility being a part of the franchise network of Medicover Sp. z o.o., excluding Medicover Hospitals, operating under the Medicover Medical Centre brand.
2. **Medicover Call Centre** – hotline enabling the Insured to fix the time and place of appointments for medical services or obtain information about the insurance.
3. **Disease** – health condition of the Insured which, according to present medical knowledge, requires diagnostics or treatment.
4. **Cover Start Date** – the date specified in the Policy on which the insurance coverage becomes effective.
5. **Medicover HotLine** – 24 h telephone service enabling the Insured to obtain help in case of a Sudden Illness or an Accident, in accordance with the Insurance Scope to which the Insured is entitled.
6. **Insurance Month** – full month between the Cover Start Date and the same day in the following month in the Insurance Year, and if there is no such day in the following month – the last day of that month.
7. **Sudden Illness** – illness arising suddenly and unintentionally in the period of the Insurer's liability, posing immediate threat to the health or life of the Insured, and urgently requiring doctor's advice and treatment.
8. **Accident** – a sudden event resulting from an external cause that occurred in the period of Insurer's liability, due to which the Insured has experienced bodily injury, regardless of their will. The Accident shall not include myocardial infraction, cerebral stroke or any other illness, including sudden cases thereof. The Insurance covers immediate consequences of Accidents, i.e. consequences of an Accident which occurred and were diagnosed and/or treated within 7 days of the date of the Accident.
9. **Services Provision Area** – the area in which Emergency Service and home visits are available. The information about the current area of benefits provision is available at: www.medicover.pl and at the Customer Service Centre phone number.
10. **Medical Operator** – an entity providing Medical Service to Insured in accordance with the Contract.
11. **Medical Facility** – an entity authorised to provide healthcare services, whose business activity is licensed under the applicable Polish legal regulations: a healthcare entity, natural persons practising a medical profession, i.e. a person who is authorised to provide healthcare services under separate provisions (including medical doctors, nurses and midwives being sole medical practitioners or sole specialist medical practitioners), as well as persons with appropriate professional qualifications, authorising them to provide healthcare services in the specific area or field of medicine, a group medical practice or a group nursing or midwife practice, where the Insured may receive Medical Services.
12. **Medicover Medical Facility** – Medicover Centres and Medical Facilities with which Medicover Sp. z o.o. has concluded cooperation agreements. A list of Medicover Medical Facilities and the range of Medical Services provided at these facilities is available at **www.medicover.pl** and by calling the Medicover Call Centre.
13. **Policy** – document confirming conclusion of an Insurance Contract.
14. **Insurance Year** – 12 successive months, starting from the Cover Start Date.
15. **Premium** – amount due to the Insurer from the Insuring Party for the Insurance Contract.
16. **Insuring Party** – the natural person concluding the Insurance Contract, obliged to make Premium payments within the deadlines and in keeping with the terms of the Insurance Contract.
17. **Insured** – a child, who has not reached 2 years of age upon signing the application to conclude the Contract, for the benefit of whom the Insurance Contract has been concluded.
18. **Insurance Contract** – contract concluded under these GTC.
19. **Medical Service** – an examination by a doctor, medical or diagnostic test, consultation, including advice provided via tele-information channels, outpatient, rehabilitation or hospital procedure aimed at maintaining, restoring or improving the Insured's health, including preventive activities, listed in the Insurance Scope. The Medical Service shall be provided only for Medical Reasons. The Insurer reserves the right to verify the basis for the provision of the Medical Service, making it dependant on obtaining a referral from a doctor from a Medicover Medical Facility. Medical Services shall be provided by Medicover Medical Facilities or, after obtaining a referral from Medicover, also by other Medical Facilities indicated by the Insurer.
20. **Medical Reasons** – occurrence of the circumstances in which the procedure carried out for diagnostic and treatment purposes is justified from the medical point of view, i.e. based on the proven medical knowledge, including in particular guidelines and treatment standards. Medical Reasons may pertain to the performance of tests, specialist consultations, prescribing drugs, hospitalization, performance of a treatment/procedure, issuing the certificate confirming inability to work, preventive activities; they may also define the urgency of the particular activity and conditions for the provision of the service. Medical Reasons shall be verified by Medicover.
21. **Outpatient Procedures** – any diagnostics and medical services specified in the Scope of the Contract performed for valid medical reasons under local or infiltration anaesthesia (around the treated area), in the treatment room of the outpatient facility (outpatient clinic), performed on the basis of a referral issued by a Medicover Medical Facility doctor. If given the age or health condition of the Insured and change of the standards of the provision of services and medical procedure guidelines, the Outpatient Procedure requires anaesthesia with endotracheal intubation, laryngeal mask airway or any other type of anaesthesia requiring provision of respiratory tract patency and/or hospitalisation, then it will not be provided as an Outpatient Procedure and will not be provided within that scope of services.
22. **Insurance Scope** – Medical Services to which the Insured is entitled under the Insurance Contract.

§ 3
SUBJECT AND SCOPE OF INSURANCE

1. The subject matter of the insurance shall be the health of the Insured.
2. Insurance coverage involves providing the Insured with Medical Services for Medical Reasons, by Medicover Medical Facilities or, after obtaining a referral from a Medical Operator, at other Medical Facilities indicated by the Medical Operator, during the term of the Insurance Contract, according to the chosen Insurance Scope and subject to the terms of the GTC, where such services are required to be provided in the period of the Insurer's liability.
3. The Insurance Scope is described in relevant appendices.
4. All persons insured under one Insurance Contract are covered by the same Insurance Scope.
5. The Insurer reserves the right to verify the basis for the provision of the Medical Service, making it dependant on obtaining a referral from a doctor from a Medicover Medical Facility.
6. The Insurer reserves the right to introduce changes to Medicover Medical Facilities during the term of the Insurance Contract, for the following material reasons:
   a. termination of the contract with the Medicover Medical Facility;

b. temporary suspension of activity – entirely or in relation to certain facilities or organisational units of a Medicover Medical Facility;
c. deletion of a Medicover Medical Facility from the relevant register, in whole or in part;
d. announcing or taking a decision on liquidation, reorganisation or bankruptcy on the part of a Medicover Medical Facility;
e. obtaining the status of a Medicover Medical Facility by a new Medical Facility, within the meaning of the GTC.

The current list of Medicover Medical Facilities is available at www.medicover.pl or by calling the Medicover Call Centre.

§ 4
LIMITATION OF LIABILITY OF THE INSURER

1. The Insurer shall not be held liable (shall not provide insurance coverage) if the Medical Service for the Insured resulted from or was caused by:
   a. HIV infection or AIDS, antiretroviral therapy (PREP – pre-exposure prophylaxis);
   b. treatment considered experimental or of unproven efficacy from a medical point of view;
   c. where, as a result of an epidemic, a natural disaster or a natural catastrophe announced or confirmed by the competent state administration authorities, Medicover Medical Facilities are unable to provide services.
2. The Insurer does not cover the costs of purchase of medicines.
3. Due to the development of the medicine or a change in the standard of the provision of medical services (resulting from the assessment of the patient's safety and mitigation of the risk of complications) or the medical procedure guidelines and the method of carrying out laboratory tests, the name or method of the performance of services available within the Insurance Scope may change. In the case of new medical services (including vaccines) occurring, the provision of which involves extension of the service scope, these services shall not be available as a part of the Insurance Scope.

§ 5
CONCLUSION AND DURATION OF THE INSURANCE CONTRACT

1. The Insurance Contract shall be concluded for the period of 12 months.
2. Insurance coverage starts on the date specified in the Policy as the Cover Start Date, but not earlier than on the day following the payment of the first Premium.
3. The first Insurance Contract shall be concluded based on the Application to conclude the Insurance Contract submitted by the Insuring Party, after its examination by the Insurer.
4. Based on an insurance risk evaluation, the Insurer:
   a. shall determine terms and conditions of insurance, in particular the amount of the Premium;
   b. may refuse to conclude the Insurance Contract; or
   c. may propose to the Insuring Party singing a contract on special terms, different from those applied for by the Insured.
5. In order to conclude and activate the Contract on terms presented by the Insurer, the Insuring Party shall be obliged to pay an amount in cash on account of the First Premium.
6. Submitting an incomplete Application to the Insurer or non-paying the amount on account of the First Premium shall hinder concluding the Insurance Contract. An incomplete Application or the Application not paid for shall expire after 30 days of its submission.
7. The Insurance Contract shall be considered concluded on terms specified in the application, upon the submission of the Policy to the Insuring Party.
8. The subsequent Insurance Contract shall be concluded based on an offer submitted by the Insurer and its acceptance by the Insuring Party. The Insurer will present the offer for the conclusion of a subsequent Insurance Contract 20 days prior to the expiration of the Insurance Contract at the latest. When presenting the offer for the conclusion of a subsequent Insurance Contract, the Insurer may propose an amendment to the terms of the Insurance Contract. The Insuring Party shall be obliged to inform the Insurer about their decision no later than 3 working days before the expiry of the Insurance Contract. Shall the Insuring Party accept terms and conditions included in the offer, in order to notify the Insurer, it shall be sufficient to pay the Premium in the amount and within the timeframe specified in the offer.
9. The Insuring Party shall be obliged to provide the Insurer with information the Insurer may request before conclusion of the Insurance Contract, which may affect the terms of the Insurance Contract. Failure to do so or misinforming the Insurer may prevent the Insured from receiving Medical Services and the Insurer will be entitled to amend the terms of the Insurance Contract.
10. The Insurer may refuse to conclude the new Insurance Contract within the period of 6 months from termination of the previous Insurance Contract without stating the reasons.

§ 6
WITHDRAWAL FROM AND AMENDMENTS TO THE INSURANCE CONTRACT

1. If the Insurance Contract is concluded for a period exceeding 6 months, the Insuring Party has the right to withdraw from the Insurance Contract within 30 days, by submitting a declaration of intent to the Insurer regarding the matter.
2. Withdrawing from the Contract shall not exempt the Insuring Party from the obligation to pay the Premium for the period of providing the cover by the Insurer.
3. In the case of withdrawing from the Insurance Contract, the Insurer will refund to the Insuring Party the amount paid on account of the first Premium, within 30 days, in the manner agreed with the Insuring Party. The Insurer will be entitled to deduct a part of the Premium for the period in which the insurance cover was provided.
4. Before the Insuring Party accepts amendments to terms and conditions of the Insurance Contract, the Insurer shall provide the Insured with the information in this respect together with the impact of these amendments on the value of benefits available under the insurance Contract made.

§ 7
TERMINATION OF THE INSURANCE CONTRACT

1. The Insurer's liability under the Insurance Contract shall expire:
   a. upon the expiry of the last day of the Insurance Year, if the Insuring Party fails to accept the terms of the subsequent Insurance Contract;
   b. in the case of termination of the Insurance Contract;
   c. if the Premium is not paid as provided for in § 9 section 5;
   d. in the case of death of the Insuring Party, on the next working day after the Insurer receives the information thereon;
   e. with respect to the particular Insured, on the last day of the Insurance Year following the day when the Insured turned 2, or in the case of death of the Insured, on the next working day after the Insurer receives the information thereon.
2. If the Insurer's liability expires before the end of the term of the Insurance Contract, the Insuring Party has the right to receive a refund of the premium for the period in which the insurance cover will not be provided. In the case of death of the Insuring Party, the Insuring Party's heirs can request a refund of the premium.
3. The Insurance Contract may be terminated by the Insuring Party with a 30-day notice period, starting from the first day of the Insurance Month following the date on which the Insurer has received a contract termination notice.
4. The Insuring Party shall be obliged to submit to the Insurer a notice of termination or withdrawal in one of the following forms:
   a. in electronic form – with a qualified signature;
   b. as a scan or photo of a document signed by hand, sent to the indicated e-mail address of the Insurer – ubezpieczenia@medicover.pl;
   c. in writing – with a handwritten signature;
   d. in person – by delivering the notice of termination document to the registered office of the Insurer.
5. If the termination is submitted electronically (via email), the message containing the termination statement must be sent from the email address assigned to the Insuring Party's account in the Insurer's system.
6. Terminations sent from an email address other than the one indicated in section 6 may be deemed ineffective unless the Insuring Party confirms their authenticity in a manner accepted by the Insurer.
7. When concluding an Insurance Contract involved a discount on the amount of premium (calculated by the Insurer for the Insuring Party), the Insurer may demand the return of the financial amount of the discounts on premiums if the Insuring Party terminates the Contract before the end of the period for which the Insurance Contract was concluded.

§ 8
BENEFITS

1. The Insured will be entitled to receive Medical Services, included in the selected Insurance Scope, provided that there are medical reasons to provide these Medical Services.
2. The Insurer shall have the right to refuse to provide the service if the Insured, according to the current medical knowledge, does not require the Medical Service or if the service could pose a threat to the health or life of the Insured.
3. If the Premium has not been paid on time, the Insured will be provided with Medical Services only in case of Sudden Illness or Accident. Those services will be provided unless the Insurance Contract has been terminated by the Insuring Party in accordance with § 9 section 5.
4. In order to obtain a Medical Service, the Insured should:
   a. contact a Medical Operator or the selected Medicover Medical Facility – personally, by telephone or using other means of communication made available by the given Medicover Medical Facility;
   b. agree the date for the provision of the Service;
   c. present an identification document with photo at the Medicover Medical Facility to confirm the Insured's identity; the Insurer stipulates that if it is impossible to identify the Insured, the Medicover Medical Facility may refuse to provide the Medical Service except for life threatening situations;
   d. observe the Medicover Medical Facility's Regulations and follow the instructions and guidelines of the staff.
5. Medical Services shall be authorised by the Insurer or the Medical Operator in order to verify whether the Insured is entitled to these Medical Services. The Insurer or the Medical Operator shall confirm to the Insured their entitlement to a given Medical Service under the Insurance Contract and the possibility to provide this Medical Service.
6. Prior to authorising a Medical Service, the Insurer may request additional information or documents (including a copy of a hospital referral, copy of medical

records), as well as may refer the Insured to additional medical examinations, at its own expense.
7. The place of performance of a given Medical Services, as well as the method and/or realisation technique (if not specified in the Insurance Scope) that will ensure security and intended treatment effects shall be specified by the Medical Operator or the Insurer.

§ 9
PREMIUM AND OTHER FEES

1. The Premium shall be calculated according to the rates in effect on the date of concluding the Insurance Contract, following individual evaluation of risk for each of the Insured. The Premium amount is conditional on:
   a. Insurance Scope;
   b. insurance risk related to the state of health of the Insured;
   c. the age of the Insured;
   d. the number of persons insured under one Family Insurance Contract;
   e. frequency of Premium payments;
   f. form of payment of the Premium;
   g. analysis of frequency and type of medical services provided during the last 5 years.
2. The Premium shall be paid by the Insuring Party in the amount and within the deadlines specified in the Policy.
3. The Premium may be paid on a monthly, semi-annual or annual basis. The Premium shall be paid by bank transfer.
4. The Premium shall be considered paid on the date of crediting the bank account of the Insurer with the full amount due.
5. If the Premium is not paid within the deadline specified in the Policy and in spite of calling for payment – within 7 days, the Insurance Contract shall be considered terminated by the Insuring Party. In the call for payment the Insurer will state the consequences of not paying the Premium for the Insuring Party.
6. The Insured shall be obliged to pay the fees in amounts specified in the Insurance Contract.

§ 10
RIGHTS AND DUTIES OF THE PARTIES

1. The Insurer shall be obliged to:
   a. make available the GTC and the Insurance Scope to the Insuring Party before entering into the Insurance Contract;
   b. make available the GTC together with the Insurance Scope to the Insured, through the Insuring Party, prior to the Insured granting their consent to the insurance coverage;
   c. submit the Policy to the Insuring Party to the e-mail address of the Insuring Party specified in the application, and if no e-mail address is specified – to the correspondence address specified in the application;
   d. present to the Insuring Party any difference between provisions of the Insurance Contract and the GTC (if special conditions are introduced).
2. The Insurer reserves the right to verify the circumstances of the Accident (if one has occurred). In such a case the Insurer will be authorised to obtain documents and information concerning the Accident and is authorised to obtain medical documentation from entities providing medical services to the Insured.
3. The Insuring Party shall be obliged to timely make payments in amounts and on dates set in the Policy.

§ 11
COMPLAINT PROCEDURE

1. The Insuring Party and/or the Insured shall be entitled to appeal against the decision of the Insurer regarding conclusion, execution and termination of the Insurance Contract.
2. Appeals may be submitted in the form of a letter or in electronic form – personally at the Insurer or in the form of a postal item within the meaning of Article 3 point 21 of the Act of 23 November 2012 – Postal Law, to the address: Medicover Försäkrings AB (publ.) Spółka Akcyjna – Branch in Poland, Al. Jerozolimskie 96, 00-807 Warszawa, or via a dedicated electronic communication channel.
3. Appeals shall be examined within 30 days of the day of their receipt. The decision of the Insurer taken as a result of the appeal shall be final. The Insurer shall notify the Insuring Party and/or Insured of its decision.
4. Claims and complaints shall be examined within 30 days of their receipt, and the person, who filed the claim or the complaint, shall be notified of the resolution immediately after the claim or complaint is examined.
5. The submitted letter will be qualified as an appeal or a claim or complaint on the basis of its text.
6. An action for a claim under the Insurance Contract may be brought in accordance with regulations on courts of last resort, or to the court competent for the place of residence of the Insuring Party or the Insured.

§ 12
FINAL PROVISIONS

1. All notices and declarations addressed to the Insurer shall be submitted in electronic form, to the address: ubezpieczenia@medicover.pl, or in writing with receipt confirmation, or shall be sent by registered post to the address of the Insurer indicated in the Insurance Contract.
2. Any correspondence shall be exchanged in Polish language.
3. All notices and declarations shall be sent to the Insuring Party and/or the Insured in electronic form, to the e-mail address indicated in the application, and if there is no e-mail address, shall be sent in written form. The Insurer, Insuring Party and the Insured shall be obliged to immediately notify one another of any changes of address details.
4. Claims under the Insurance Contract may not be assigned within the meaning of the provisions of Article 509 et seq. of the Civil Code, nor pledged within the meaning of provisions of Article 327 et seq. of the Civil Code.
5. A dispute between the Insuring Party and/or Insured and the Insurer may be resolved in extra-judicial proceedings for resolving disputes between customers and financial market entities in accordance with applicable legal provisions.
6. An action for a claim under the Insurance Contract may be brought in accordance with regulations on courts of last resort, or to the court competent for the place of residence of an heir of the Insured or an heir of the beneficiary under the Insurance Contract.

§ 13

List of appendices constituting an integral part of the GTC:
   a. Appendix no. I to the GTC – List of Medical Services to which the Insured are entitled under a given Insurance Scope.

These GTC were approved by the Resolution of the Management Board of the Insurer of 13 February 2025.

These GTC shall come into force as of 1 July 2025, and shall apply to Insurance Contracts concluded after that date.