MEDICOVER
UBEZPIECZENIA

INDIVIDUAL HEALTH INSURANCE "CARE FOR BABY"
GENERAL TERMS & CONDITIONS NO 2/2016

List of the information included in General Terms and Conditions of Insurance referred to in Article 17 Clause 1 of the Law on Insurance and Reinsurance Business dated 11 September 2015, including definitions from General Terms and Conditions of Insurance ("Index").

N.o.	Type of information	Number of sectioning level of contract template
1.	Preconditions for payment of compensation and other benefits or surrender value of insurance	- Section 3 Clauses 2-4 - Section 5 Clauses 1-3, Clause 6, Clauses 11-12 - Section 8 Clause 1
2.	Limitations and exclusions of liability of the insurance company that authorise to refuse to pay or reduce compensation or other benefits	- Section 4 - Section 5 Clauses 5, 7, 10, 13 and 14 - Section 7 - Section 8 Clauses 2 - 3

§ 1
GENERAL PROVISIONS

1. According to the General Terms & Conditions of Individual Health Insurance "Care for Baby" (hereunder GTC), Medicover Försäkrings AB (publ.) operating through its Branch in Poland seated in Warsaw (hereunder the Insurer) concludes Insurance contracts with natural persons.
2. The Insurance contract is concluded on behalf of the third person being the natural person (hereunder Insured), on terms defined in the Insurance contract.
3. The Policy issued by the Insurer proves conclusion of the Insurance contract.
4. By mutual consent of the parties, the Insurance contract may cover specific terms inconsistent with these GTC, which prevail over GTC provisions. In such case, the Insurer shall provide the Insuring Party with a written list of differences between provisions of GTC and the Insurance contract.
5. Any regulations inconsistent with provisions of these GTC require a written form for their validity.
6. In all matters not regulated by GTC or specific terms, Civil Code and common law obligatory on the territory of the Republic of Poland shall be applied.

§ 2
DEFINITIONS

The terms used in these GTC should be interpreted as follows:

1. **Medicover Centre** – Medicover Facility belonging to Medicover Sp. z o.o. and or Medical Facility in the franchise network of Medicover Sp. z o.o., excluding the Medicover Hospitals.
2. **Customer Care Centre** – infoline to enable the arrangement of medical services or getting information about one's insurance.
3. **Sickness** – health condition of the Insured which according to actual status of medical knowledge, requires diagnostics or treatment.
4. **Cover start date** – the date indicated in the Policy on which the coverage under the Insurance Contract becomes effective.
5. **Hot Line Medicover** – 24h telephone service in the framework of which one can receive help in case of accident or sudden illness, according to the chosen Insurance scope.
6. **Insurance month** – a month starting from the Cover start date and then in the same day of the next month and if there is no such day in a month – the last day of the month.
7. **Sudden sickness** – sickness arising suddenly and unintentionally in the period of the Insurer's liability, directly endangering health or life of the Insured, and requiring prompt doctor's advice and treatment.
8. **Accident** – sudden event solely caused by external cause in the period of Insurer's liability due to which the Insured experienced bodily injury, regardless from their will. The accident does not cover heart attack, stroke or any other diseases, including Sudden sickness. The insurance covers direct consequences of Accident which mean the ones that occurred and were subject to the diagnosis and/or treatment in 7 days from Accident.
9. **Area of benefits availability** – the area within which ambulance services and medical staff visits in the places where a patient got ill are provided. Information of the current area of benefits availability can be obtained at www.medicover.pl and at the Customer Care Centre number.
10. **Medical facility** – an entity operating in accordance with applicable Polish law, authorized to provide healthcare benefits; such as a healthcare entity company, a natural person practicing a medical profession, i.e. a person who under separate provisions is authorised to provide healthcare benefits (including MDs, nurses and midwives working as an individual practice or an individual specialist practice) as well as a person who has acquired expert qualifications to provide healthcare benefits in a specific area or field of medicine, a group practice of MDs, or a group practice of nurses or midwives, where the Insured may obtain Medical service.
11. **Medicover Medical Facility** – Medicover Centres and Medical Facilities with which Medicover Sp. z o. o. concluded cooperation Contracts, including Centrum Medyczne Damiana and Medi Partner. Information about the current list of Medicover Medical Facilities and the list of Medical services provided by each of them is available on **www.medicover.pl** and at the Customer Care Centre number.
12. **Policy** – document proving conclusion of the Insurance contract.
13. **Insurance year** – 12 sequential months, starting from the Cover start date specified in the Policy.
14. **Premium** – amount due to the Insurer from the Insuring Party for the Insurance contract.
15. **Insuring Party** – natural person concluding the Insurance contract and obliged to pay Premium pursuant to dates and under terms provided in the Insurance contract.
16. **Insured** – child which on the day of signing the application for concluding Insurance contract did not turn 2 years of age and for the benefit of whom the Insurance contract was concluded.
17. **Insurance contract** – contract concluded under these GTC.
18. **Medical service** – doctor's, medical or diagnostic examination, ambulatory, rehabilitation or hospital procedure, specified in the chosen Insurance scope, aimed at maintenance, restoration or improvement of health condition of the Insured, including also health prevention activities.
19. **Medical indications** – the incidence of circumstances in which some specific activity performed due to diagnostic and/or medical reasons is justified from the medical point of view, i.e. it is based on medical evidence, and especially on the guidelines and standards. The medical indications may be applicable to performance of tests/examinations, specialist consultations, issuing prescriptions, hospitalization, performance of a procedure/treatment, issuing a certificate of incapacity to work, preventive actions; the medical indications may also specify the urgency of an activity and the conditions for the delivery of the service. The medical indications are subject to verification by Medicover.
20. **Outpatient procedures** – medical services (diagnostics and/or treatment) listed in the Insurance scope, performed for medical reasons in local or infiltration anaesthesia (around the treated area) in treatment room of the outpatient clinic according to Medicover Medical Facility doctor's referral. If, due to age or health condition of the Insured or the change in standards of procedure delivery and medical guidelines, a medical procedure requires anesthesia with endotracheal intubation, laryngeal mask airway or some other kind of anaesthesia (that has to ensure the patency of respiratory passages) and/or hospitalization, is not subject to the scope of benefits within the Outpatient procedures, and will not be provided within this scope.
21. **Insurance scope** – the list of Medical services provided to the Insured according to the Insurance contract.

§ 3
INSURANCE SUBJECT AND SCOPE

1. The subject of the insurance is the Insured's health.
2. The insurance protection covers providing the Insured with Medical services at Medicover Medical Facilities due to medical indications in the period of the Insurance contract according to the chosen Insurance scope and on principles specified in GTC. The need of using those Medical services must appear during the period of Insurer's liability.
3. The Insurance scope is described in the attachment no 1 to GTC.
4. All people insured within one Family insurance contract are covered by the same Insurance scope.
5. The Insurer reserves the right to change, during the period of the Insurance contract, the list of Medicover Medical Facilities for the following important reasons:
   a) cancelling the contract with a Medicover Medical Facility,
   b) temporary withholding of full activities or in the scope of some Medicover Medical Facility's units or sections,
   c) removing the whole or a part of Medicover Medical Facility from the appropriate register,
   d) declaring or undergoing liquidation, transformation or bankruptcy of the Medicover Medical Facility,
   e) a new Medical facility acquires the Medicover Medical Facility status as understood in GTC.

   The updated list of Medicover Medical Facilities is available at **www.medicover.pl** and at the Customer Care Centre's number.

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§ 4
LIMITATION OF LIABILITY OF THE INSURER

1. The Insurer shall not be held liable (does not provide insurance protection) if a Medical service for the Insured was aimed at, resulted from or was caused by:
   a) HIV virus or AIDS disease,
   b) treatment which from medical standpoint is considered as experimental or treatment of unproven effectiveness,
   c) epidemic or pandemic announced or confirmed by appropriate administration bodies.

§ 5
INSURANCE CONTRACT CONCLUSION AND DURATION

1. The Insurance contract is concluded for the period of 12 months.
2. The insurance protection starts at the moment specified in the Policy as a Cover start date, but not earlier than on the day of the payment of the first Premium.
3. The first Insurance contract is concluded on the basis of the offer of its conclusion submitted by the Insuring Party and its acceptance by the Insurer. The Insuring Party submits the offer on the Insurer's application form.
4. When submitting the application form, the Insuring Party pays the amount on account of the first Premium.
5. Delivering to the Insurer incompletely filled application form or failure to pay the amount on account of the first Premium, makes it not possible to conclude the Insu-rance contract. Incomplete or unpaid application becomes invalid after 30 days from its submitting.
6. Subject to provisions of Clause 8, it is deemed the insurance Contract has been entered into on terms and conditions set out in the application upon serving the Policy to the Insurance Taker.
7. As a result of insurance risk evaluation, the Insurer may refuse to conclude a contract or offer the Insuring Party to sign an agreement on specific terms, different from those submitted in the offer.
8. If in a response to the submitted offer the Insurer delivers to the Insuring Party the Policy which contains the provisions which are inconsistent with the content of submitted offer to his detriment, the Insurer is obligated to communicate this fact in writing to the Insuring Party when delivering the Policy to him, and giving him 7 days for raising any objection. If the Insurer fails to do so, changes made to the detriment of the Insuring Party are not effective, and the Insurance contract is concluded in compliance with the terms of the offer. In case of the Insuring Party's lack of objections, the Insurance contract becomes effective according to the content of the Policy on the following day after the filing objection deadline.
9. If the Insuring Party raises objection against the content of the Insurance contract, the Insurer immediately reimburses the Insuring Party the full amount paid on account of the first Premium in a manner agreed with the Insuring Party. Reimbursement of the Premium shall take place within 45 days from the day of receiving objection, unless the Insuring Party e presses written consent for leaving the Premium with the Insurer for the time of investigating this objection.
10. In case of rejection of the contract conclusion, the Insurer reimburses the Insuring Party, within 30 days the full amount paid on account of the first Premium in the way agreed with the Insuring Party.
11. The next Insurance contract is concluded on the basis of the offer submitted by the Insurer and its acceptance by the Insuring Party. The Insurer will submit the offer of concluding the next Insurance contract at least 45 days before the end of the Insurance year. Submitting offer for the next Insurance contract, the Insurer may suggest changing conditions of the Insurance contract. The Insuring Party is obliged to inform the Insurer about their decision. If the Insuring Party accepts the conditions submitted in the offer, the sufficient way of informing the Insurer is paying the Premium in the amount and on date indicated in the offer.
12. The Insuring Party and the Insured are obliged to provide the Insurer with information the Insurer asked for before contract conclusion and which may affect the conditions of the Insurance contract. Failure to do so or if the Insurer was provided with false information may result in rejection of Medical service provision to the Insured and the Insurer has the right to change the terms and conditions of the Insurance contract.
13. The Insurer may refuse to conclude a new Insurance contract within the period of 6 months from the date of expiry of the previous Insurance contract.

§ 6
RESCISSION OF THE INSURANCE CONTRACT AND AMENDMENTS IN THE INSURANCE CONTRACT

1. If the insurance contract is entered into for a period exceeding 6 months, the Insurance Taker has the right to rescind the insurance contract within 30 days, by submitting a declaration of intent to the Insurer regarding the matter. If, at the latest upon entering into the insurance contract, the Insurer has not notified the Insurance Taker (being a consumer) of the right to rescind the contract, the period of 30 days starts on the date when the Insurance Taker (being a consumer) learns about this right. In this case, the cover is granted until the date on which the Insurer has received Insurance Taker's written declaration of intent to rescind the insurance Contract.
2. In case of cancellation of the Insurance contract, the Insurer reimburses the Insuring Party within 30 days the amount paid on account of the first Premium in the way agreed with the Insuring Party. The Insurer has the right to deduct part of the Premium for the period of cover provided.
3. The rescission of the Contract does not discharge the Insurance Taker from the obligation to pay premiums for the period in which the Insurer has provided the cover.
4 Before the Insurance Taker accepts changes to terms and conditions of the Contract or a change of the law applicable to the insurance Contract made, the Insurer provides the Insured, in writing or, if the Insured agrees, on another durable medium, with the information in this respect, including the impact of these changes on the value of benefits available under the insurance Contract made.
5 At the request of the Insured, the Insurer provides the Insured with the information referred to in Clauses 3 and 4.

§ 7
INSURANCE CONTRACT EXPIRATION

1. The Insurer's liability for the Insurance contract expires:
   a) on the last day of Insurance year, if the Insuring Party does not accept the conditions of the next Insurance contract,
   b) when the Insurance Contract was revoked,
   c) if Premium is not paid according to the rules specified in § 9, cl. 5,
   d) in the case of the death of the Insuring Party, on the next weekday upon the receipt of this information by the Insurer,
   e) in relation to the specific Insured: on the last day of the Insurance year following the day when the Insured has completed the second year of his life, or in the case of the death of the Insured, on the next weekday upon the receipt of this information by the Insurer.
2. If the Insurer's liability expires before the period for which the Insurance contract was concluded, the Insuring Party has the right to reimbursement of the premium for the period in which insurance protection shall not be provided. In the case of the death of the Insuring Party, the inheritors may apply for premium reimbursement.
3. The Insurance contract may be revoked in writing by the Insuring Party with a 30-day termination notice, counting from the first day of Insurance month following the date the Insurer received written notification about termination.

§ 8
BENEFITS

1. The Insured is entitled to Medical services covered by the chosen Insurance scope provided there will be medical indications to justify the provision of Medical services.
2. The Insurer may refuse granting of service if the Insured objectively does not require a Medical service, or supply of the Medical service would put the health or life of the Insured at risk.
3. If the Premium was not paid in time, the Insured will be provided with Medical services only in case of Sudden illness or Accident. Those benefits are provided unless the Insurance contract is terminated, according to § 9, cl.5.
4. In order to obtain a Medical service for the Insured, one must:
   a) Contact the Customer Care Centre or a chosen Medicover Medical Facility – in person, by phone or by means of other communication channels made available by the Medicover Medical Facility.
   b) Arrange a date of Medical service delivery and arrive on the arranged date to the Medicover Medical Facility as well as inform this Facility about resignation from the Medical service not later than 48 hours before the date,
   c) Show an ID with a photo in the Medicover Medical Facility to prove the Insured's identity; in the case of inability to verify the identity of the Insured, the Medicover Medical Facility may refuse to provide a Medical service, except in the case of life risk of the Insured.
   d) Observe the regulations of the Medicover Medical Facility and obey its personnel's instructions and advice.

§ 9
PREMIUM AND OTHER PAYMENTS

1. The Premium is calculated according to the rate obligatory as of the day of the Insurance Contract conclusion following individual evaluation of risk for each Insured, and the Premium amount is conditioned by:
   a) insurance scope,
   b) the age of the Insured,
   c) medical factors connected with health condition of the Insured,
   d) number of people insured under one Family Insurance Contract,
   e) frequency of Premium payments.
2. The Premium shall be paid by the Insuring Party in the amounts and on dates specified in the Policy.
3. The Premium may be paid monthly, quarterly, semi-annually or annually. The Premium may be paid by bank transfer, payment order or debiting the payment card account .
4. The Premium is considered as paid on the day of recording the Premium amount on bank account of the Insurer.
5. Failure to pay the Premium by the Insuring Party at the date specified in the Policy and despite the summons to pay within 7 days, authorises the Insurer to a

knowledge that the Insurance contract was revoked by the Insuring Party. In the summons the Insurer will provide to the Insuring Party the consequences of not paying the Premium.

§ 10
RIGHTS AND OBLIGATIONS OF THE PARTIES

1. The Insurer is obliged to:
   a) serve General Terms and Conditions of Insurance, including the Index, to the Insurance Taker before entering into the insurance Contract,"
   b) serve General Terms and Conditions of Insurance, including the Index, to the Insured, through the agency of the Insurance Taker, in writing or, if the Insured agrees, on another durable medium, before the Insured accepts the insurance cover and accepts to pay the cost of insurance premiums,
   c) serve the Policy to the Insurance Taker,
   d) present the Insurance Taker with differences between provisions of the Contract.
2. The Insuring Party shall make the payments described in the Policy according to the dates and amounts specified therein.

§ 11
CLAIMING PROCEDURE

1. The Insuring Party or Insured are entitled to appeal from decision of the Insurer regarding conclusion, execution and termination of the Insurance contract to the Insurer's Management.
2. Appeals may be submitted in writing – either personally to the Insurer, providing customer service, or by post within the meaning of Article 3 Item 21 of the Postal Law dated 23 November 2012 to the address: Medicover Forsakrings, Al. Jerozolimskie 96, 00-807 Warszawa
3. Appeals are handled within 30 days after their receipt. Insurer's decision made as a result of the appeal is final. The Insurer notifies the Insurance Taker and/or Insured about Insurer's decision in writing, by registered letter, unless the Insurer and/or the Insurance Taker has/have agreed to provide/receive notifications electronically.
4. Moreover, in matters different from specified under paragraph 1, the Insuring Party or Insured may submit claims to the Insurer's Management by means of the Polish branch.
5. The claims are considered within 30 days from their submission and the applicant is informed immediately after their consideration.
6. The content of statement is decisive for qualifying such statement as appeal or claim.
7. Complaints regarding claims resulting from the Insurance contract may be initiated according to general regulations or by the court relevant for the place of residence or seat of the Insuring Party or Insured.

§ 12
FINAL PROVISIONS

1. Any notification and statement communicated to the Insurer should be submitted in writing by receipt confirmation, or sent by registered mail to the address of the Polish branch specified in the Contract.
2. Excluding the case when the Insuring Party agreed to electronic delivery of the Policy, all notifications and statements to the Insuring Party will be made in writing and sent by post to correspondence address of the Insuring Party indicated in the application.
3. If the Insuring Party changed their correspondence address indicated in the application and failed to inform the Insurer, this fact shall be interpreted as if the Insurer complied their obligation for submission of notification or statement if the letter was sent to the last residence address or any other stated correspondence address of the Insuring Party or the Insured known to the Insurer and shall be effective after 7 days from the sending date.
4. The claims resulting from the Insurance contract may not be ceded as interpreted by provisions of article 509 and the remaining provisions of the Civil Code, nor pledge as interpreted by provisions of article 327 and other provisions of the Civil Code.
5. A dispute between the Insurance Taker and/or Insured, and the Insurer may be settled in extra-judicial proceedings related to resolving disputes between customers and financial market entities in accordance with applicable legal provisions.
6. An action for claims under the Contract may be brought either in accordance with legal provisions on general jurisdiction, or before a court having jurisdiction for the place of residence or seat of the Insurance Taker, Insured, beneficiary or another person entitled under the Contract.
7. An action for claims under the insurance contract may be brought either in accordance with legal provisions on general jurisdiction, or before a court having jurisdiction for the place of residence of the heir of the insured or the heir of the person entitled under the insurance contract.

§ 13
ATTACHMENTS

The attachment No 1 to GTC, constituting its integral part, is the list of Medical services within each Insurance scope.

These GTC were approved by the Resolution taken by the Insurer's Management no 1, date: 13.06.2016.

These GTC are enforced on 01.09.2016 and shall be applied to the Insurance contracts concluded from that date.

Fredrik Ragmark

President of the Management Board

Stephen Kennedy

Member of the Management Board, Executive Director