INDIVIDUAL HEALTH INSURANCE "PLATINUM CARE"
GENERAL TERMS AND CONDITIONS NO. 1/2024

List of the information included in General Terms and Conditions of Insurance, as referred to in Art. 17(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 SECTIONING LEVEL OF CONTRACT TEMPLATE
1.	Preconditions for the payment of compensation and other benefits or surrender value of insurance	- § 3 - § 5, clauses 1–3 and 6 - § 8, clause 1
2.	Limitations and exclusions of liability of the insurance company that authorise to reduce compensation or other benefits, or to refuse to pay them	- § 4 - § 5, clauses 5, 6, 9 and 10 - § 7 - § 8, clauses 2-3

§ 1
GENERAL PROVISIONS

1. Medicover Försäkrings AB (publ.), operating through its Branch in Poland, with its registered office in Warsaw (hereinafter the "Insurer") concludes Insurance Contracts with natural persons in accordance with these General Terms and Conditions of Individual Health Insurance "Platinum Care" (hereinafter: "GTC").
2. The Insurance Contract may be concluded on behalf of the third person being a natural person (hereinafter: 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. If the Insurance Contract is concluded for the benefit of the Insured, the provisions relating to the Insuring Party will be adequately applied also to the Insured on the terms specified in separate regulations. In this case, the Insured shall not be required to pay the Premium, but the Insurer shall be entitled to raise charges having impact on the Insurer's liability also against the Insured.
5. The Scope of Medical Care Abroad, arising from Appendix No. 3 to the GTC, may be excluded in relation to a particular Insured person as a result of a conducted risk assessment. Information about the exclusion shall be confirmed in the Policy.
6. By mutual consent of the parties, the Insurance Contract may include specific terms that are inconsistent with these GTC. Said terms shall prevail over the provisions of the GTC. In such a case, the Insurer shall provide the Insuring Party with a list of discrepancies between the provisions of the GTC and the Insurance Contract before concluding the Insurance Contract.
7. In all matters not regulated by the GTC or the specific terms, provisions of the Civil Code and other provisions of the common law in force in the territory of the Republic of Poland shall apply.

§ 2
DEFINITIONS

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

1. **Medicover Centre** – Medical Facility belonging to Medicover Sp. z o.o. and/or Medical Facility in the franchise network of Medicover Sp. z o.o., excluding Medicover Hospitals.
2. **Disease** – health condition of the Insured, which, according to present medical knowledge, requires diagnostics or treatment.
3. **Chronic Disease** – a medical condition giving symptoms, diagnosed, or treated in the period of 12 months prior to the Cover Start Date, that requires constant or periodic treatment and/or rehabilitation, characterised by slow development or long-term course and by acute periods as well as decrease or subsidence of symptoms, or causing hospitalisation during the period of 12 months prior to the Cover Start Date.
4. **Congenital Disease** – impaired structure and/or functioning of the body at every stage of foetal development, in particular diseases present at birth, birth defects detected at any stage of life, genetic diseases and health consequences resulting from all these states.
5. **Cover Start Date** – the date specified in the Policy, on which the insurance coverage becomes effective.
6. **Medicover HotLine**– a 24-hour hotline service enabling the Insured to obtain help in case of a Sudden Illness or an Accident, in accordance with the chosen Insurance Scope.
7. **Implant** – an element made of biomaterial, placed in the body in order to supplement or replace tissues of an organ (or a part thereof), or to fulfil (or support) their functions, or for the purposes of carrying out a given medical procedure. Joint prostheses, artificial ligaments, vessel prostheses, vessel filters, lenses, bare metal and coated stents, heart pacemakers, among others, are considered implants.
8. **Intraoperative Medical Materials/Instruments** – elements made of a tissue or biomaterial, placed in the body in order to supplement tissues of an organ or support their functions, provided that the introduction of such elements is a stage of a given procedure rather than its objective.
9. **Insurance Month** – full month between the Cover Start Date and the same day in the following month of the Insurance Year, and if there is no such day in the following month – the last day of that month.
10. **Sudden Illness** – an 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.
11. **Accident** – a sudden event, resulting solely from an external cause, that occurred in the period of Insurer's liability, due to which the Insured has experienced bodily injury, regardless of his/her 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.
12. **Services Provision Area** – the area in which Emergency Service and home visits are available. Information about the current services provision area is available at **www.medicover.pl**.
13. **Hospitalisation Period** – the period of the Insured's stay at the Hospital, stated in days, not longer than 60 days in every Insurance Year wherein each day started is considered as full day.
14. **Deductible Period** – a period when the Insurer's liability is excluded in relation to the specified Medical Services.
15. **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 doctors, nurses and midwives being sole medical practitioners or sole specialist medical practitioners, as well as persons with appropriate professional qualifications, authorising such persons 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.
16. **Medicover Medical Facility** – Medicover Centres and Medical Facilities with which Medicover Sp. z o.o. has concluded cooperation agreements, including Damian Medical Centre. The list of Medicover Medical Facilities and the scope of Medical Services provided in each of them is available at **www.medicover.pl**.
17. **Policy** – a document confirming the conclusion of an Insurance Contract.
18. **Prosthesis** – an element made of artificial material, replacing a part of the body or an organ.
19. **Transplant** – cells, tissues (e.g. skin, cornea, bones) or an organ (e.g. heart, kidney) obtained from a donor and subject to surgical transplantation into the recipient's body, including to the same person (auto transplant).
20. **Highly Specialised Procedures** – diagnostic and treatment Medical Services listed in the Insurance Scope, performed for medical reasons, under local or infiltration anaesthesia (around the treated area) or under short-term intravenous anaesthesia, in outpatient clinics or as part of one-day hospitalisation, i.e. the so-called one-day surgery (maximum hospital stay up to 24 hours), not requiring anaesthesia with endotracheal intubation, laryngeal mask airway or any other type of anaesthesia requiring provision of respiratory tract patency, performed on the basis of a referral issued by a Medicover Centre 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, a Highly Specialised Procedure requires anaesthesia with endotracheal intubation, laryngeal mask airway or any other type of anaesthesia requiring provision of respiratory tract patency, and/or hospitalisation exceeding 24 hours, such Procedure is not subject to the scope of Highly Specialised Procedures and shall not be provided within this scope.

21. **Insurance Year** – 12 successive months, starting from the Cover Start Date.
22. **Premium** – the amount due to the Insurer from the Insuring Party for the Insurance Contract.
23. **Hospital** – an in-patient healthcare entity licensed to operate in the Republic of Poland under mandatory provisions of the law, offering 24-hour health services performed by qualified medical staff and having adequate infrastructure to perform diagnostic and surgical treatment, where the Insured can receive Hospital Services. Social care facilities, addiction treatment centres, hospices, sanatoria, resorts, rehabilitation centres, hospital rehabilitation departments and spa facilities (including spa hospitals) shall not be considered Hospitals.
24. **Damian Hospital** – the Hospital owned by Centrum Medyczne Damiana Sp. z o.o.
25. **Medicover Hospital** – the Hospital owned by Medicover Sp. z o.o.
26. **Insuring Party** – a natural person concluding the Insurance Contract, obliged to make Premium payments within the deadlines and in line with the terms of the Insurance Contract.
27. **Insured** – a natural person for the benefit of whom the Insurance Contract has been concluded and who is under 75 years of age.
28. **Insurance Contract** – a contract concluded under these GTC.
29. **Family Insurance Contract** – an Insurance Contract concluded to the benefit of the Insured, his/her partner living in the same household (a spouse, cohabitee) and/or children – own or supported by the Insured or their partner and living in the same household, who on the day of signing the Application to conclude the Insurance Contract have not yet turned 18, where such a partner and/or children have been indicated by the Insured.
30. **Pre-existing Condition** – recurrent or chronic diseases or conditions for which the Insured was treated or in relation to which the Insured obtained medical advice or underwent a surgical procedure in the last 12 months before the Cover Start Date.
31. **Medical Service** – a doctor's test/examination, a medical or diagnostic test/examination, a consultation (incl. advice given remotely via ICT channels), an outpatient, rehabilitation or inpatient procedure, listed in the chosen Insurance Scope, aimed at maintaining, restoring or improving the health condition of the Insured, including preventive measures. A Medical Service shall be provided exclusively based on Medical Reasons. The Insurer reserves the right to verify whether it is justified to provide a given Medical Service and the right to make the performance of such a Service conditional on obtaining a referral from a doctor working at a Medicover Medical Facility. The Medical Services may be provided at Medicover Medical Facilities or, once a referral from a Medicover Centre has been obtained, also at another indicated Medical Facility.
32. **Hospital Service** – a Medical Service included in the relevant Insurance Scope, covering diagnosis and/or treatment process conducted in hospital environment, requiring permanent medical and nursing supervision as well as relevant treatment and diagnostic procedures. Hospital Services shall also include the services included within the scope of Highly Specialised Procedures or Outpatient Procedures that due to the age or health condition of the Insured and change of the standards of the provision of services and medical procedure guidelines will require anaesthesia with endotracheal intubation, laryngeal mask airway or any other type of anaesthesia requiring provision of respiratory tract patency, and/or hospitalisation exceeding 24 hours.
33. **Scheduled Hospital Service** – admission to the hospital on a pre-agreed date, to a pre-agreed Department/Clinic, preceded by diagnostic tests, justifying the diagnosis and visits qualifying for the particular method of treatment, not requiring assistance in the Emergency Room or Hospital Emergency Department and making the decision on emergency admission. Postponing the time of a Scheduled Hospital Service shall not result in a direct threat to life and health.
34. **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, in particular guidelines and treatment standards. Medical Reasons may pertain to performing tests, examinations and specialist consultations, prescribing drugs, hospitalisation, performing a treatment/procedure, issuing the certificate confirming inability to work, as well as preventive activities; Medical Reasons may also define the urgency of a given activity and conditions for the provision of a service. Medical Reasons shall be verified by Medicover.
35. **Highly Specialised Medical Materials** – elements made of a tissue or biomaterial, used during a medical procedure, provided that the use of such elements is not necessary to carry out the procedure and can be replaced by the use of other materials without a material impact on the effectiveness and safety of the performance of the particular medical procedure.
36. **Outpatient Procedures**– any diagnostic and treatment Medical Services specified in the Insurance Scope, performed for valid medical reasons under local or infiltration anaesthesia (around the treated area), in the treatment room of the outpatient facility (outpatient clinic), and 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, such Procedure shall not be provided as an Outpatient Procedure and shall not be performed within that scope of services.
37. **Insurance Scope** – Medical Services to which the Insured is entitled under the Insurance Contract.
38. **Scope of Foreign Travel Insurance** – the Insurance Scope applicable to the Insured during a trip abroad; the coverage and terms of such insurance are described in Appendix No. 2 to the GTC.
39. **Scope of Medical Care Abroad** – the Insurance Scope applicable to the Insured in the event of a Serious Illness, in accordance with Appendix No. 3 to the GTC.

§ 3
SUBJECT MATTER AND SCOPE OF THE INSURANCE

1. The subject matter of the insurance shall be the health of the Insured.
2. The insurance coverage consists in:
   a) providing the Insured with Medical Services due to medical reasons, at Medicover Medical Facilities, 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;
   b) coverage during a trip abroad, in accordance with Appendix No. 2 to the GTC;
   c) coverage related to a serious illness, in accordance with Appendix No. 3 to the GTC.
3. The provisions of the Special Terms and Conditions of Foreign Travel Insurance and the Special Terms and Conditions of Medical Care Abroad Insurance take precedence over the provisions of these GTC.
4. The Insurance Scope is described in the relevant Appendices.
5. All persons insured under one Family Insurance Contract are covered by the same Insurance Scope, with the exception of the situation described in § 1(5).
6. In the case of a Hospital Service, the cover shall be provided at a Hospital within the applicable Insurance Scope – for a period calculated in days, not exceeding 60 days in each 12-month period of the Insurance Contract, with the stipulation that each commenced day shall be regarded as a full day. After the expiry of this period, further hospitalisation shall take place at the expense of the Insured.
7. The Insurer reserves the right to introduce changes in relation to Medicover Medical Facilities during the term of the Insurance Contract, for the following material reasons:
   a) termination of the contract with a Medicover Medical Facility;
   b) temporary suspension of activity – entirely or in respect of certain bodies or organisational units of a given Medicover Medical Facility;
   c) deregistration of a Medicover Medical Facility from the relevant register (entirely or in part);
   d) announcing or ordering liquidation, reorganisation or bankruptcy 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.

§ 4
LIMITATION OF LIABILITY OF THE INSURER

1. The Insurer shall not be liable (and thus shall not provide insurance coverage) if a Medical Service for the Insured was aimed at, resulted from or was caused by:
   a) HIV or AIDS infection, use of antiretroviral drugs (pre-exposure prophylaxis, PrEP);
   b) diagnostics, treatment, procedure or surgery related to gender-affirming surgery;
   c) diagnostics, treatment, procedure or surgery in the area of dentistry, jaw surgery, plastic or reconstructive surgery (with the exception of

definite medical reasons, when non-performance of a given procedure may pose a threat to the physical health or life), aesthetic medicine or cosmetology, including also the case when the execution of the abovementioned procedures was related to the treatment of the consequences of an Accident, regardless of their date;

d) long-term dialysis treatment;
e) transplant of organs or tissues (natural or artificial), including auto transplant, excluding transplants performed intra-operatively under a single operation, as listed below:
   - auto transplants of tendon, cartilage, skin or own blood vessels;
   - allogenic transplants of: frozen bone, dura mater, which are carries out at the expense of the Insurer, or the use of cellular culture for immunosuppression treatment;
f) highly specialised treatment of tumours, in particular chemotherapy and radiotherapy or thermoablation/embolisation;
g) treatment considered experimental or of unproven efficacy from a medical point of view;
h) intended self-mutilation, suicide attempt or exposure to unnecessary risk, except for attempting to save another person's life;
i) remaining under the influence of alcohol, drugs or other intoxicating substances;
j) remaining under the influence of medicines that limit the ability to drive a motor vehicle or operate machines and appliances, provided that in accordance with the information given by the manufacturer of the drug, its consumption affects the ability to drive motor vehicles;
k) driving a mechanical vehicle or a different type of vehicle if the Insured is not licensed to drive the given type of vehicle, or if the Insured had his/her licence temporarily or permanently retained under the applicable law; also if the mechanical vehicle does not meet the operational requirements as provided for in separate provisions of the law, i.e. if the vehicle was not in legal condition for operation and, in the case of vehicles that are required to be registered, if the vehicle did not have a valid MOT test certificate;
l) accident, injury or disease caused in relation to military service, and/or service in paramilitary forces, war, peace or stabilisation missions, acts of terror, or active participation in riots, demonstrations or acts of violence or during martial law, state of emergency or natural disaster;
m) practising extreme sports as amateurs or professionally, i.e. sports the practising of which involves high probability of injury, requires extraordinary physical or psychical abilities and adequate preparation, related to:
   i. the use of aircraft (aeroplanes, balloons, gliders, paragliders);
   ii. the use of parachutes, hang-gliders or paragliders, also equipped with engines;
   iii. speleology and exploration of caves;
   iv. practising of any martial arts;
   v. scuba diving, rafting, surfing, windsurfing, kitesurfing;
   vi. motorcar and motorbike racing;
   vii. motor and motorboat sports, skiing and jet-skiing, quad riding;
   viii. mountain biking, bobsleigh;
   ix. rope jumping, bungee jumping, ski jumping;
   x. climbing (mountaineering, rock climbing, ice climbing, Himalayan mountaineering);
   xi. skiing and snowboarding, except as practised for recreational purposes on designated routes;
   xii. equestrianism, except as practised for recreational purposes;
   xiii. hunting;
   xiv. running at a distance exceeding 10 km;
   under the present GTC, practising extreme sports is also understood as one-time undertaking of such activity or participation in sports contests of the above-described nature;
n) treatment at resorts or sanatoria;
o) detoxification after using drugs or other intoxicating substances, tobacco, or alcohol;
p) epidemic announced or confirmed by the relevant state administration authorities;
q) diagnosis and treatment of infertility, in particular any forms of assisted reproduction;
r) surgical correction of sight defects;
s) highly specialised treatment and diagnosis of Congenital Diseases, excluding outpatient treatment available under the chosen Insurance Scope;
t) purchasing and implanting artificial organs and/or systems;
u) childbirth (with the exception of outpatient services related to pregnancy management) – if the patient has not been covered by the Insurance Contract for at least 12 months prior to the date of childbirth;
v) abortion (due to extra-medical reasons).

2. The Insurer does not cover the costs of:
   a) the purchase of medicines;
   b) prostheses, implants;
   c) stimulators, heart pacemakers, valves, lenses;
   d) corrective devices (including the purchase of corrective glasses and contact lenses);
   e) highly specialised medical materials, except for intraoperative medical materials and instruments, e.g. wires and bars for a fracture stabilisation, separating film, non-absorbable anchors and screws, bone fixation plates, hernia surgical mesh implant;
   f) the performance of the Medical Services ordered to be provided to the Insured if such performance is due after the termination of the Insurance Contract applicable to him/her.
3. The Insurer is not liable for Hospital Services and Highly Specialised Procedures during the Deductible Period.
4. The Deductible Period for Hospital Services and Highly Specialised Procedures is 90 days and commences on the Cover Start Date. The Deductible Period does not apply to children born at the Medicover Hospital and the Damian Hospital, subject to §4(6), for whom the application to obtain insurance was submitted before the child has turned 30 days old.
5. The Deductible Period for Hospital Services and Highly Specialised Procedures resulting from Pre-Existing Conditions is 12 months and commences on the Cover Start Date.
6. Due to the development of the medicine or a change in the standard of the provision of medical services (due to 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), the provision of which involves extension of the service scope, such services shall not be available as part of the Insurance Scope.
7. If the method of carrying out a given Medical Service is not directly indicated in the Insurance Scope, such a method shall in each case be indicated by the Insurer.

§ 5
CONCLUSION AND TERM OF THE INSURANCE CONTRACT

1. The Insurance Contract is concluded for the period of 12 months.
2. Insurance coverage starts on the date specified in the Policy as the Cover Start Date, with the exception of the coverage linked to the Scope of Medical Care Abroad. Such coverage shall always commence on the first calendar day of the month following a period of minimum 90 days from the Cover Start Date, subject to the payment of the first Premium.
3. Should the Insured be admitted to hospital during the 90-day period mentioned in Clause 2 above, the insurance coverage under the Scope of Medical Care Abroad shall not take effect until the Insured is discharged from hospital subject to § 6(2.1) and § 9(3) of Appendix No. 3 – Special Terms and Conditions of Additional Insurance (Medical Care Abroad).
4. The first Insurance Contract is concluded on the basis of the Insuring Party's Application for the conclusion of such a Contract, following the consideration of that Application by the Insurer.
5. As a result of the assessment of the insurance risk, the Insurer:
   a) shall determine the terms and conditions of the insurance, in particular the amount of the Premium;
   b) may refuse to conclude the Insurance Contract;
   c) may make a proposal to the Insuring Party to conclude the contract under special terms and conditions, differing from those applied for by the Insured.
6. In order to conclude and activate the Contract under the terms and conditions presented by the Insurer, the Insuring Party shall pay the amount due on account of the first Premium.
7. If an incomplete application is submitted to the Insurer or if the amount on account of the first Premium is not paid, the Insurance Contract will not be concluded. An incomplete or unpaid application will become void after 30 days from its submission.
8. It is deemed the Insurance Contract has been entered into upon serving the Policy to the Insuring Party.
9. Subsequent Insurance Contracts are concluded pursuant to offers submitted by the Insurer and accepted by the Insuring Party. The Insurer shall present an offer for the conclusion of a subsequent Insurance Contract 20 days prior to the expiration of the current Insurance Contract at the latest. When presenting the offer for the conclusion of a subsequent Insurance Contract, the Insurer may propose an amendment of the terms of the Insurance Contract. The Insuring Party is obliged to inform the Insurer about the former's decision 3 working days before the

end of the current Insurance Contract at the latest. If the Insuring Party accepts the terms specified in the offer, in order to inform the Insurer of this fact, it is sufficient to pay the Premium in the amount and within the deadline indicated in the offer.

10. If a subsequent Insurance Contract including Hospital Services and Highly Specialised Procedures is concluded, the Deductible Period shall not apply, provided that the continuity of the insurance coverage was maintained.
11. The Insuring Party and the Insured are obliged to provide the Insurer with information which the Insurer may request before the conclusion of the Insurance Contract and 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 allow the Insurer to amend the terms of the Insurance Contract.
12. The Insurer may refuse to conclude the new Insurance Contract within the period of 6 months from the termination of the previous Insurance Contract without giving a reason.

§ 6
RESCISSION OF THE INSURANCE CONTRACT AND AMENDMENTS THERETO

1. If the Insurance Contract is entered into for a period exceeding 6 months, the Insuring Party has the right to rescind the Insurance Contract within 30 days, by submitting a declaration of intent regarding the matter to the Insurer.
2. The rescission of the Contract shall not discharge the Insuring Party from the obligation to pay premiums for the period in which the Insurer has provided the cover.
3. In the case of withdrawing from the Insurance Contract, the Insurer shall refund to the Insuring Party, within 30 days, the amount paid on account of the first Premium, in the manner agreed with the Insuring Party. The Insurer shall 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 any changes to the terms and conditions of the Insurance Contract, the Insurer shall provide the Insured with the information in this respect, with the indication of the impact of these changes on the value of services available under the concluded Insurance Contract.

§ 7
TERMINATION OF THE INSURANCE CONTRACT

1. The Insurer's liability under the Insurance Contract expires:
   a) at the end of the last day of Insurance Year, if the Insuring Party does not 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 in accordance with § 9(5) hereof;
   d) in the case of death of the Insuring Party, on the next working day after the Insurer receives the information thereon;
   e) for a specified Insured person:
      i. on the last day of the Insurance Year following the day when the insured child turned 18;
      ii. on the last day of the Insurance Year following the day when the Insured covered with the Insurance Scope turned 75;
      iii. in the event of the death of the Insured, on the next working day after the Insurer is informed thereof.
2. If, in the case described in Clause 1, the Insured is provided with a Hospital Service, the liability of the Insurer expires on the day of ceasing to provide this service to the Insured but not later than within a month from the cessation of the Insurer's liability.
3. 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, a refund of the premium can be requested by the Insuring Party's heirs.
4. The Insurance Contract may be terminated by the Insuring Party subject to a 30-day termination notice, starting from the first day of Insurance Month following the date on which the Insurer receives the notice of termination.
5. Where the conclusion of an Insurance Contract involved a discount on the amount of the 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 Insurance Contract before the end of the period for which the Contract was concluded.
6. The Contract with the Insured may be terminated with immediate effect in cases of gross violation of the law, violation of the Regulations of the Medical Facility of the Organisational Healthcare Entity or violation of any generally applicable social norms.

§ 8
SERVICES

1. The Insured shall be entitled to Medical Services included in the selected Insurance Scope, on the condition that there are medical reasons to provide such Services.
2. The Insurer may refuse to provide a service if the Insured, according to the current medical knowledge, does not require a given Medical Service or if it could pose a threat to the health or life of the Insured.
3. In the event of disclosure of any circumstances that significantly increase the insurance risk and have not been indicated by the Insured in the medical questionnaire, the Insurer shall have the right to change the premium within a period of 60 days counted from the date of conclusion of the Contract.
4. Should the amount of the premium referred to in Clause 3 above be changed, the Insurer shall immediately inform the Insuring Party about this fact. In such a case, the Insuring Party shall have the right to terminate the Contract within 14 days – with immediate effect.
5. If the Premium for the Insurance Contract is not paid on time, the Insured shall be provided with Medical Services only in case of a Sudden Illness or an Accident. Those services will be provided unless the Insurance Contract has been terminated by the Insuring Party, in accordance with § 9(5).
6. In order to be provided with a Medical Service, the Insured shall:
   a) contact the Medicover Call Centre or the selected Medicover Medical Facility – personally, by telephone or using other means of communication made available by a given Medicover Medical Facility;
   b) schedule the date for the provision of the Medical Service, arrive at the Medicover Medical Facility on the agreed date or inform the Facility about cancellation of the medical service not later than 6 hours before the visit;
   c) show a photo ID at the Medicover Medical Facility to confirm his/her identity; the Insurer stipulates that the Medicover Medical Facility may refuse to provide the Medical Service if it is not possible to confirm the identity of the Insured, unless he/she has a life-threatening condition;
   d) observe the Medicover Medical Facility's Regulations and follow the instructions and guidelines of the staff.
7. Hospital Services and Highly Specialised Procedures are subject to authorisation by the Insurer for the purpose of verifying whether the Insured is entitled to receive them. The Insured shall receive confirmation from the Insurer as to whether a given Hospital Service or Highly Specialised Procedure is available under the Insurance Contract.

§ 9
PREMIUM AND OTHER PAYMENTS

1. The Premium is calculated according to the rates in effect on the date of concluding the Insurance Contract, following individual evaluation of risk for each Insured person. The Premium amount is conditional on:
   a) the Insurance Scope;
   b) the 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) the frequency of Premium payments;
   f) the form of Premium payment;
   g) an analysis of both the frequency of the provision of medical services over the last 5 years as well as the type of such services.
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, quarterly, semi-annual or annual basis.
4. The Premium may be paid by bank transfer, direct debit or payment card.
5. The Premium is considered paid on the date of crediting the bank account of the Insurer with the full amount due.
6. If the Premium is not paid by the deadline specified in the Insurance Contract or within the additional period of 7 days provided for by the received call for payment, the Insurance Contract shall be considered terminated by the Insuring Party. Through the call for payment, the Insurer shall inform the Insuring Party of the consequences of the failure to pay the Premium.
7. The Insured shall be obliged to pay the fees in the amounts indicated in the Insurance Contract.

§ 10
RIGHTS AND OBLIGATIONS OF THE PARTIES

1. The Insurer is obliged to:
   a) provide the Insuring Party with the GTC and the Insurance Scope before the conclusion of the Insurance Contract – to the Insuring Party's email address indicated in the application;
   b) provide, through the Insuring Party, all Insured persons with the GTC and the Insurance Scope before each Insured gives his/her consent to the insurance cover;
   c) provide the Insuring Party with the Policy – to the Insuring Party's email address indicated in the application;
   d) explain the differences between the provisions of the Insurance Contract and the GTC to the Insuring Party (if special terms and conditions have been introduced).
2. The Insurer reserves the right to verify the circumstances of an Accident, (where applicable). In such a case, the Insurer shall be authorised to obtain both documents and information concerning the Accident as well as medical documentation (from entities providing medical services to the Insured).
3. The Insuring Party shall be obliged to make timely payments in the amounts and within deadlines specified in the Policy.
4. The Insuring Party shall be obliged to inform the Insured about fees related to the use of Medical Services.
5. All correspondence shall be conducted in Polish.

§ 11
COMPLAINT PROCEDURE

1. The Insuring Party and/or the Insured shall be entitled to appeal to the Insurer's Management Board against the decision of the Insurer regarding the conclusion, execution or termination of the Insurance Contract.
2. Appeals may be submitted by letter or electronically – personally to the Insurer, by post, within the meaning of Art. 3(21) of the Postal Law dated 23 November 2012, to the address: Medicover Försäkrings AB (publ.) Spółka Akcyjna – Branch in Poland, Al. Jerozolimskie 96, 00-807 Warsaw, or using a dedicated electronic communication channel.
3. Appeals are handled within 30 days after their receipt. The Insurer's decision made as a result of the appeal is final. The Insurer shall notify the Insuring Party and/or the Insured about the Insurer's decision.
4. The Insuring Party and the Insured may submit complaints to the Insurer's Management Board also in regard to matters other than those specified in Clause 1 above.
5. The complaints shall be considered within 30 days of their receipt. The person who lodged the complaint shall be informed about the manner in which the complaint has been considered immediately after this process is completed.
6. The classification of the submitted letter as a complaint depends on the content of such a letter.
7. Legal actions concerning claims arising from the Insurance Contract may be initiated either pursuant to legal provisions on general jurisdiction or before the court having jurisdiction over the place of residence or seat of the Insuring Party or the Insured.

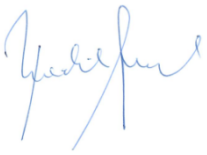
§ 12
FINAL PROVISIONS

1. All notices and declarations addressed to the Insurer shall be submitted electronically to ubezpieczenia@medicover.pl or in writing with confirmation of receipt or by registered mail sent to the Insurer's address specified in the Insurance Contract.
2. All notices and declarations addressed to the Insuring Party or the Insured persons shall be submitted electronically to the email addresses indicated in the application for the conclusion of the Insurance Contract.
3. The Insurer, the Insuring Party and the Insured are obliged to immediately inform each other of any change in address details.
4. The claims under the Insurance Contract may not be assigned within the meaning of Art. 509 and subsequent provisions of the Civil Code, nor pledged within the meaning of Art. 327 and subsequent provisions of the Civil Code.
5. A dispute between the Insuring Party and/or the Insured, and the Insurer may be settled in extra-judicial proceedings related to resolving disputes between clients and financial market entities in accordance with applicable legal provisions.
6. An action concerning claims under the Insurance Contract may be brought either in accordance with legal provisions on general jurisdiction, or before a court having jurisdiction over the place of residence of the heir of the Insured or the heir entitled under the Insurance Contract.

§ 13

List of appendices which constitute an integral part of the GTC:
   a) Appendix No. 1 to the GTC, containing the list of Medical Services to which the Insured persons are entitled;
   b) Appendix No. 2 – Special Terms and Conditions of Foreign Travel Insurance – Travel Healthcare 2010;
   c) Appendix No. 3 – Special Terms and Conditions of Additional Insurance – Medical Care Abroad.

These GTC were approved by the Resolution No. I of the Insurer's Management Board, dated 28 November 2023.
These GTC shall become effective as of 01 February 2024 and shall apply to Insurance Contracts concluded as of that date.

Fredrik Ragmark	Stephen Kennedy
	
President of the Management Board	Member of the Management Board