INDIVIDUAL HEALTH INSURANCE "HOSPITAL CARE"
GENERAL TERMS AND CONDITIONS NO. 1/2026

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 - § 5 sections 1-3, 6 - § 8 section 1, 3-10
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, 6, 9 and 10 - § 7 - § 8 sections 2-4, 7, 10

§ 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 "Hospital Care" (hereinafter: "GTC").
2. The Insurance Contract may 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. If the Insurance Contract is concluded for the benefit of the Insured, the provisions relating to the Insuring Party will be applied also to the Insured respectively, on the terms specified in separate regulations. In this case the Insured will not be required to pay the Premium, but the Insurer will be entitled to raise charges having impact on the Insurer's liability also against the Insured.
   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. **One-Day Surgery** – medical services provided during a one-day hospital stay (up to 24 hours, including admission to and discharge from the hospital). These services may be performed with local or infiltration anaesthesia (around the treated area, short-term intravenous anaesthesia or other anaesthesia that does not require endotracheal intubation, laryngeal mask airway or using other technique for airway patency). The One-Day Surgery service included in the Insurance Scope shall be provided based on a referral issued by a Medicover Centre doctor. If, due to age or health condition of the Insured, or a change of standards of the provision of services and medical procedure guidelines, the provision of the service requires endotracheal intubation, laryngeal mask airway or any other type of anaesthesia requiring provision of respiratory tract patency and/or a hospital stay for more than 24 hours, the services shall not be included in the One-Day Surgery scope and shall not be provided as part of this scope. Within the meaning of these definitions, such a service shall be a Hospital Service.
4. **Disease** – health condition of the Insured which, according to present medical knowledge, requires diagnostics or treatment.
5. **Chronic Disease** – a medical condition giving symptoms, diagnosed, or treated in the period of 12 months prior to the Cover Start Date, which is characterized by slow development or long-term course, that requires constant or periodic outpatient treatment and/or rehabilitation, characterised by acute periods as well as decrease or subsidence of symptoms, or causing hospitalization during the period of 12 months prior to the Cover Start Date.
6. **Rare Disease** – a disease with a prevalence of no more than 5 per 10,000 individuals in the European Union population.
7. **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.
8. **Cover Start Date** – the date specified in the Policy on which the insurance coverage becomes effective and as of which the Contract year is counted for a given Insured Person.
9. **Medicover HotLine** – 24h hotline service enabling the Insured to obtain help in case of a Sudden Illness or an Accident, in accordance with the chosen Insurance Scope.
10. **Implant** – an element made of biomaterial put in the body in order to supplement or replace tissues of an organ (or a part thereof) in order to fulfil (or support) their functions, or for the purposes of carrying out the particular medical procedure. Implants include, among others, joint prostheses, artificial ligaments, vessel prostheses, vessel filters, lenses, and bare metal and coated stents.
11. **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, the introduction of which is a stage of the particular procedure rather than its objective.
12. **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.
13. **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.
14. **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.
15. **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 and by calling the Medicover Call Centre.
16. **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.
17. **Deductible Period** – a period when the Insurer's liability is excluded in relation to the specified Medical Services.
18. **Medical Operator** – an entity acting on behalf of the Insurer, responsible for the organisation, coordination, and provision of Medical services to the Insured in accordance with the Insurance Agreement.
19. **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.
20. **Medicover Medical Facility** – any of Medicover Centres and Medical Facilities with which Medicover Sp. z o.o. has concluded cooperation agreements, including Damian Medical Centre. 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.
21. **Policy** – document confirming conclusion of an Insurance Contract.
22. **Prosthesis** – an element made of artificial material, replacing a part of the body or an organ.
23. **Transplant** – cells, tissues (e.g. skin, cornea, bones) or an organ (e.g. heart, kidney) obtained from a donor, subject to surgical transplantation into the recipient's body, including to the same person (auto transplant).
24. **Insurance Year** – 12 successive months, starting from the Cover Start Date.
25. **Premium** – amount due to the Insurer from the Insuring Party for the Insurance Contract.
26. **Specialised Treatment Room** – a room for performing diagnostic and therapeutic procedures by qualified personnel, equipped with devices and tools necessary to perform these procedures and ensuring increased safety of service provision (e.g. the possibility of the administration of anaesthesia other than required for Outpatient Procedures).
27. **Emergency Health Condition** – a situation involving sudden deterioration of health, the direct consequence of which may be serious damage to bodily functions or bodily injury, or loss of life, requiring emergency medical assistance and treatment.
28. **Hospital** – a closed healthcare entity licensed to operate in the Republic of Poland under mandatory provisions of the law, providing 24-hour health services performed by qualified medical staff, having adequate infrastructure to perform dia-

gnostic 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.

29. **Cooperating Hospital** – a hospital with which a Medical Operator concluded a cooperation contract.
30. **Damian Hospital** – the hospital owned by Damian Holding Medical Centre Sp. z o.o.
31. **Medicover Hospital** – the hospital owned by Medicover Sp. z o.o.
32. **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.
33. **Insured** – natural person for the benefit of whom the Insurance Contract has been concluded. The Insured may be a natural person from 5 weeks of age who has not turned 75 years of age.
34. **Insurance Contract** – contract concluded under these GTC.
35. **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.
36. **Pre-existing Condition** – recurrent or chronic diseases or ailments 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.
37. **Injury** – damage to tissues, organs, or body parts caused by an external factor, requiring diagnosis, treatment, or rehabilitation
38. **Polytrauma** – an injury that simultaneously affects at least two systems or organs, causing significant damage to at least two body areas, which may cause circulatory or respiratory instability, requiring specialised treatment and potentially being a condition posing a direct threat to life. In particular, polytrauma includes conditions requiring urgent intervention or urgent procedures and a stay in an anaesthesiology and intensive care unit.
39. **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.
40. **Hospital Service** – Medical Service included in the relevant Insurance Scope, covering diagnosis and/or treatment process conducted in hospital environment, requiring permanent medical and nursing supervision, 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 hospitalization exceeding 24 hours.
41. **Scheduled Hospital Service** – admission to the hospital on a pre-agreed date, to a pre-agreed Department/Clinic, based on a referral issued by a doctor. Issuing the referral shall be preceded by diagnostic tests, justifying the diagnosis. The admission shall be preceded by visits qualifying for the particular method of treatment by the Hospital Doctor qualifying for the performance of the Hospital Service. The Scheduled Hospital Service shall not require assistance in the Emergency Room or Hospital Emergency Department and making the decision on emergency admission. Postponing the time of the scheduled hospital service shall not result in a direct threat to life and health.
42. **Urgent Hospital Service** – admission to the hospital based on a referral issued by a doctor that, due to the health condition of the Insured, shall take place within less than 7 days of the Hospital Doctor qualifying for the Hospital Service confirming such a need. The Urgent Hospital Service may require assistance in the Emergency Room or Hospital Emergency Department and making the decision on emergency admission.
43. **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.
44. **Highly Specialised Medical Materials** – elements made of a tissue or biomaterial used during a medical procedure, using which is not necessary to carry out the procedure, that can be replaced by other materials without a material impact on the effectiveness and safety of the performance of the particular medical procedure.
45. **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 out patient 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.
46. **Insurance Scope** – Medical Services to which the Insured is entitled under the Insurance Contract.
47. **Benefits Authorisation Team** – a unit designated by the Insurer or the Medical Operator responsible for assessing the validity of providing a Hospital service or One-day surgery, and for authorising Medical services.

§ 3
SUBJECT MATTER AND SCOPE OF THE 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 Hospitals, Cooperating Hospitals, Medicover Medical Facilities or, after obtaining a referral from a Medical Operator, at other Medical Facilities indicated by the 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 Family 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. In case of the Hospital Service, the coverage shall be provided in the Hospital, within the available Insurance Scope, for a period stated in days, not longer than 60 days in every 12 months of the term of the Insurance Contract, wherein each day started is considered as full day. After the expiry of this period, further hospitalisation shall be at the cost of the Insured.
7. 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, including the use of antiretroviral medications for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP);
   b. diagnostics, treatment, procedure or surgery related to the therapy of experienced gender incongruence;
   c. diagnostics, treatment, procedure or surgery in the area of dentistry, jaw surgery, plastic (including procedures of a corrective nature) or reconstructive surgery (with the exception of definite Medical Reasons, when non-performance of the given procedure may pose a threat to the physical health or life), aesthetic medicine or cosmetology, including also the case when execution of the above-mentioned procedures was related to treatment of Accident consequences regardless of their date;
   d. long-term dialysis treatment;
   e. transplant of organs or tissues (natural or artificial), including auto transplant (excluding single-operation following transplants:
      i. auto transplants of tendon, cartilage, skin or own blood vessels,
      ii. allogenic transplants of: frozen bone, dura mater which are covered by the Insurer) or the use of cellular culture for immunosuppression treatment;
   f. highly specialised treatment of malignant diseases, in particular involving chemotherapy and radiotherapy or thermoablation/ embolization;
   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 life;
   i. remaining under the influence of alcohol, drugs or other intoxicating substances;
   j. remaining under the influence of drugs that limit the ability to drive a motor vehicle or operate machines and appliances, provided that, in accordance with the information provided 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 by 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. undertaking amateur or professional extreme sport disciplines, i.e. sports involving a high probability of injury, requiring extraordinary physical and mental capacity as well as appropriate 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 cave exploration,
iv. practising any martial arts,
v. scuba diving using specialised equipment, rafting, sailing, surfing, windsurfing, kitesurfing,
vi. car and motorcycle races,
vii. motor and water motor 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 recreationally on marked ski runs,
xii. equestrianism except recreational horse riding,
xiii. hunting,
xiv. +10k running.

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. 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;
q. diagnostics and treatment of infertility, in particular using assisted reproduction methods;
r. vasectomy, vasectomy reversal;
s. sight defects surgeries;
t. diagnostics, treatment and consequences of Congenital Diseases and Rare Diseases;
u. purchasing and implanting artificial organs and/or systems;
v. abortion (for extramedical reasons);
w. the Insured's failure to comply with medical recommendations related to treatment, hospitalisation or the convalescence period.

2. The Insurer does not cover the costs of:
a. purchase of medicines intended for use by the Insured after the end of Hospitalisation or One-Day Surgery,
b. prostheses, implants;
c. corrective devices (including purchase of corrective glasses and contact lenses);
d. highly specialised medical materials, except 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;
e. performance of Medical Services required for the Insured if the date of their performance falls after termination of the Insurance Contract for this Insured;
f. diagnostics and treatment in Hospitals or Medical Facilities not indicated by the Insurer.
3. The Insurer shall not be held liable if the health condition of the Insured requires a treatment of Emergency Health Condition or a treatment of Polytrauma. In such the case, the Insurer or a Medical Operator shall indicate the nearest hospital, including a public one, where the patient may obtain help. If, as a result of the improvement of the condition of the Insured, a further treatment in one of Co-operating Hospitals is possible, the Insurer, at the request of the Insured, shall ensure medical transport and treatment continuation in such a hospital. If a Hospital Service or One-Day Surgery has been indicated in the Insurance Scope constituting Appendix No. I to the GTC, it shall be subject to insurance coverage in accordance with the provisions of the GTC.
4. The Insurer is not liable for Hospital Services and Surgical Procedures during the Deductible Period.
5. The Deductible Period for Hospital Services and One-Day Surgical Procedures is 90 days and begins on the Cover Start Date.
6. If the Hospital Service or the One-Day Surgery is related to Pre-Existing Condition or a Disease diagnosed during 90 days from the Cover Start Date, the Deductible Period referred to in § 4 section 4 shall be 12 months and shall begin on the Cover Start Date for the Insured.
7. If the Hospital service or One-day surgery is related to a Pre-existing medical condition, the Insurer shall not be held liable (shall not provide insurance cove rage).
8. 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 TERM 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 exa mination 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, including failure to answer questions contained in the application, medical questionnaire, or other documents required by the Insurer to carry out an assessment of insurance risk, 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 upon the delivery of the Policy to the Insured.
8. No later than 20 days before the end of the Insurance Contract, the Insurer shall present the Insuring Party with the GTC of the next Insurance Contract. If the In surer fails to present the Insuring Party with the GTC of the next Insurance Contract within the period specified in the first sentence, it shall be obliged to submit to the Insuring Party a statement of non-consent to concluding the next Insurance Contract. Such a statement should be submitted no later than 10 days before the end of the Insurance Contract. If the Insuring Party does not accept the GTC provided by the Insurer, it is obliged to inform the Insurer of this no later than 3 business days before the end of the Insurance Contract. If the Insuring Party accepts the GTC provided by the Insurer, a sufficient way of informing the Insurer is paying the Premium in the amount and within the deadline indicated by the Insurer.
9. If a subsequent Insurance Contract including Hospital Services and Highly Specialised Procedures is concluded, the Deductible Period will not apply, provided that continuity of the insurance coverage was maintained.
10. The Insuring Party and the Insured are obliged to provide the Insurer, truthfully and completely, with the information that the Insurer asked for in the application for concluding the Insurance Contract, the medical questionnaire, or other documents before concluding the Insurance Contract, and which may affect the GTC of the Insurance Contract. If the Insurer has reasonable grounds to assume that the information provided was incomplete or untrue, it may carry out an explanatory investigation. If the Insurer has reasonable grounds to assume that the information provided was incomplete or untrue, it may carry out an explanatory investigation in accordance with the rules set out in § 8. If these circumstances are confirmed, the Insurer may refuse to perform the Medical service, if the need for its performance arises from these circumstances, or may change the GTC of the Insurance Contract.
11. The Insurer may refuse to conclude the new Insurance Contract within the period of 6 months from termination of the previous Insurance Contract.

§ 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 the GTC 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

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1. The Insurer's liability under the Insurance Contract shall expire:
a. upon the expiry of the last day of the Insurance Year, if a subsequent Insurance Contract has not been concluded;
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. for a specified Insured:
i. on the last day of the Insurance Year following the day when the insured child has turned 18,
ii. on the last day of the Insurance Year following the day when the Insured turned 75,
iii. in the event of the death of the Insured, on the following working day after the Insurer is informed about the event.
2. If in the case described in section 1, the Insured receives 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 of the expiry 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, the Insuring Party's heirs can request a refund of the premium.
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 has received a request for termination of the Contract.
5. 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 email 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.

6. 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.
7. 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.
8. 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
SERVICES

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. In order to make use of a Hospital Service or One-day Surgery, the Insured is obliged to inform the Medical Operator of the need to provide the Medical Service and to provide the information and documents necessary to carry out the authorisation process for the Medical Service. The reported Medical service is subject to assessment by the Benefits Authorisation Team.
4. If the Insured has received a referral for a Hospital Service or One-day Surgery, they are obliged to inform the Medical Operator of the need to provide the Medical Service no later than within 60 days of the date the referral was issued.
5. Failure to meet the deadline referred to in point 4 shall not result in automatic loss of the right to the Medical Service; however, authorisation of the Medical Service may be refused if the delay made it impossible or significantly hindered the assessment of the Insurer's liability or the organisation of the Medical Service.
6. Before authorising the Medical Service, the Insurer, acting through the Benefits Authorisation Team, may request that additional information or documents be provided, including a copy of the hospital referral, a copy of any medical records held, or other documents necessary to assess the Insurer's liability, authorisation, or organisation of the Medical Service, and may also refer the Insured, at its own cost, for additional medical examinations. The Insured is obliged to provide the required information and documents and to undergo such examinations, if they are necessary for assessing the Insurer's liability, authorisation, or organisation of the Medical Service. If the Insurer has reasonable grounds to believe that the information provided before conclusion of the Insurance Contract may have been incomplete or untrue, it may carry out an explanatory investigation in order to determine the scope of its liability. Until the explanatory investigation is completed, authorisation of the Medical Service may be suspended, insofar as the Insurer's liability cannot be determined without establishing these circumstances. Failure to provide the information or documents, or to undergo the examinations referred to above, may result in refusal of authorisation of the Medical Service if it prevents assessment of the Insurer's liability. Once the explanatory investigation has been completed, the Benefits Authorisation Team shall make a decision to authorise or refuse authorisation of the Medical Service in accordance with the provisions of the GTC.
7. On the basis of the information provided, the medical records, and the results of any additional examinations, if required, the Benefits Authorisation Team shall decide to:
   a. authorise the Medical Service and allow it to be provided,
   b. refuse authorisation of the Medical Service if:
      i. the conditions for the Insurer's liability arising from the OWU have not been met, or
      ii. according to the current state of medical knowledge, there are no indications for performing the Medical Service, or its performance could pose a threat to the health or life of the Insured.
8. The Insured will receive information about the outcome of the authorisation. If authorisation of the Medical Service is refused, the Insured will receive information about the reasons for the refusal.
9. Once the Medical service has been authorised, the Medical Operator, or an entity acting on its behalf, shall organise the process of providing the Hospital Service or One-day Surgery, in particular by indicating the place where the Medical Service is to be provided, agreeing the date of hospitalisation, and coordinating activities related to preparation for the Medical Service and care following its provision. Hospitalisation directly related to a complication following a Hospital Service or One-day Surgery provided under the Insurance Contract shall be subject to assessment by the Medical Operator. The mere organisation or coordination of activities related to preparation for the Medical Service or care following its provision does not mean that Medical Services not listed in the Insurance Scope are covered by Insurance. The place where a given Medical Service is to be provided is designated by the Insurer, either directly or through the Medical Operator. The Insurer shall also indicate the method or technique for providing the Medical Service, if the Insurance Scope does not specify the manner in which the given Medical Service is to be performed, taking into account the safety of the Insured and the possibility of achieving the intended therapeutic effect.
10. In order to receive the Medical Service authorised by the Benefits Authorisation Team, the Insured should:
    a. cooperate with the Medical Operator in organising and providing the Medical Service,
    b. agree with the Medical Operator on matters relating to the provision of the Medical Service, in particular confirm the date and place where the Medical Service is to be performed and provide the information necessary for its provision,
    c. present a photo ID document at the Medicover Medical Facility to confirm the identity of the Insured; the Insurer reserves the right that, where it is not possible to confirm the identity of the Insured, the Medicover Medical Facility may refuse to provide the Medical Service, except where the Insured's life is in danger,
    d. comply with the internal regulations of the Medicover Medical Facility and follow the instructions and guidance received from its staff. Where the pro vision of healthcare services is obstructed or a threat is created to staff or other patients, the Medical Facility may refuse to provide the Medical Service.

§ 9
PREMIUM AND OTHER PAYMENTS

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 OBLIGATION 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 specified in the application of the Insuring Party, 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.
4. The Insuring Party shall be obliged to notify the Insured of the fees related to using the Medical Services.
5. The Insured shall be obliged to comply with scheduled dates of the provision of Medical Services and to notify the Facility of resigning from a Medical Service not later than 6 hours prior to its date. If serious circumstances occur preventing this deadline from being met, the Insured shall be obliged to inform about resignation immediately after these circumstances occur.

§ 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. The 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 re solved 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.

These GTC were approved by Resolution of the Management Board of the Insurer dated 23 July 2026.

These GTC shall come into force as of 01 September 2026, and shall apply to Insurance Contracts concluded after that date.