General Terms and Conditions of Hospital Insurance LUX MED – Full Care for group customers

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LMG Försäkrings AB S.A. Branch in Poland
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District Court for the Capital City of Warsaw in Warsaw
13th Commercial Division of the National Court Register
KRS number: 0000395438
Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 4,800,000.00

Information contained in the General Terms and Conditions of Insurance G/002/2022/US

Type of information	Number of provision in the GTC
Prerequisites that oblige us to pay compensation and other services or the surrender value of the insurance	• §3, §4(1), (2), (4), (6)
Limitations and exclusions on our liability entitling us to refuse the payout of the claim and other services or to reduce them	• §4(3), §5(3), §15, §16 Appendix 1: • Part I §1(1)(b), (2)(b), (3)(b), (4)(b), (5)(b), (6)(b), (7)(b), (8)(b), (9)(b), (10)(b), (11)(b), §3(2), §4(2)-(3), §5(3), §6(2)-(4), §7(3)-(4) • Part II (2), (4)-(5) Appendix 2: • Part I §1(1)(b), (2)(b), (3)(b), (4)(b), (5)(b), §2(2)-(3), §3(3), §4(2)-(4), §5(3)-(4)

§1 Who are the parties to the Insurance Agreement?

Pursuant to these Terms and Conditions of LUX MED Hospital Insurance – Full Care for Group Clients (**GTC**), LMG Försäkrings AB S.A., with its registered office in Stockholm, acting through the branch LMG Försäkrings AB S.A. Branch in Poland (hereinafter referred to as **WE** or the **Insurer,** full data of the **Insurer** are in §2(22)), hereby concludes an Insurance Agreement with you (hereinafter referred to as the **Insuring Party**). The Insuring Party may be a natural or legal person or an organisational unit without legal personality.

§2 Definitions

In the GTC in Polish, we use the male gender (e.g. Insuring Party instead of Male Insuring Party/Female Insuring Party or the Male/Female Insuring Party) to ensure the legibility of the document. We always address the recipient, regardless of the recipient's gender.

1. **Illness** – an abnormal physical or mental state of the body according to generally recognised medical knowledge.
2. **Rare Disease** – illness which, according to Regulation (EC) No 141/2000 of the European Parliament and the Council of 16 December 1999 on orphan medicinal products, occurs with a frequency lower than 5 in 10,000 individuals of the population. It is most commonly determined genetically and it has a chronic and often serious course. It leads to premature death or causes disability. It usually manifests in childhood.
3. **High-Risk Pregnancy** – a pregnancy in which risk factors occur in the mother or in the foetus, increasing the frequency of complications of the pregnancy and childbirth, which constitute a hazard to the health or life of the mother or foetus, requiring, within the meaning of this Agreement, care or delivery at a level III perinatal care centre.
4. **Declaration of Accession** – a declaration of will of the Insured Person, in which the Insured Person wishes to be covered by insurance on the basis of these GTC.
5. **Minor Injury** – a trauma that requires surgical or orthopaedic assistance but does not require Hospitalisation or medical procedures performed in an operating room.
6. **Hospitalisation** – a stay in a hospital ward, aimed at performing diagnostics, delivery or treatment, including performance of surgeries due to an Accident or Illness. Hospitalisation covers:
   a. **Planned Hospitalisation** – a stay in a hospital ward which:
      I. takes place within the prescribed time limit;
      II. can be postponed for at least 24 hours from the time it becomes apparent that it is necessary, provided that the postponement shall not exceed the deadline which may be followed by a foreseeable serious deterioration in health condition or a significant reduction in the chances of recovery.
   b. **Emergency Hospitalisation** – a stay in a hospital ward which cannot be postponed.
7. **Admissions Ward** – a department in a Hospital which:
   a. qualifies patients for Hospitalisation;
   b. provides advice and emergency assistance to patients not eligible for Hospitalisation;
   c. prepares documents necessary for registration of Hospitalisation;
   d. transfers the patient over to the hospital ward's team.

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8. **Hospital Care Coordinator** (also: **HCC**) – our employee responsible for providing services to the Insured Person in the performance of the Agreement as part of the Coordination of Hospital Care.

9. **Physician** – a person who holds the required qualifications and licences, confirmed by relevant documents, to perform the medical profession in accordance with the generally applicable provisions of Polish law, including in particular the Act of 5 December 1996 on the professions of physicians and dentists (Journal of Laws of 2019, item 537, as amended).

10. **List of Insured Persons** (also: **List**) – a list of persons enrolled for insurance, excluded from insurance and changes in the insurance scope of a given Insured Person. The enrolled persons are those who submitted a Declaration of Accession and passed a positive risk assessment. The list shall be drawn up in accordance with the template provided by us.

11. **Accident** – a sudden event caused by a reason independent of the will or health condition of the Insured Person, in which the Insured Person suffered physical injury or damage to anatomical structures of the musculoskeletal system. A sudden Illness is not an Accident.

12. **Insurance Coverage Period** – a period during which we are liable towards the Insured Person for the events covered by the Agreement.

13. **Operator** – an entity coordinating the provision of Services on our behalf.

14. **Emergency Care** – a medical service for persons whose health condition has suddenly deteriorated, and if medical treatment is not provided immediately, could result in further deterioration. A detailed scope of Emergency Care, including an indication of situations in which we cannot provide it, is described in Appendix 1 (Part I, §7) and Appendix 2 (Part I, §5) to the GTC. Emergency Care ends with recommendations for further treatment, depending on the health condition of the Insured Person.

15. **Outpatient Clinic** – a healthcare entity providing outpatient services within the meaning of the Act of 15 April 2011 on healthcare activities, operating in the territory and in accordance with the laws of the Republic of Poland, providing Services on the basis of the GTC.

16. **Insurance Policy** – a document confirming the conclusion of the Agreement. The Insurance Policy recipient is the Insuring Party.

17. **Premium** – an amount due to us under the Agreement. Its amount and payment date shall be determined in the Insurance Policy.

18. **Hospital** – a healthcare entity providing hospital services within the meaning of the Act of 15 April 2011 on medical activity, operating in the territory and in accordance with the laws of the Republic of Poland, providing Services under the GTC. The definition of a Hospital, within the meaning of the GTC, shall also include outpatient clinics that are part of the Hospital.

19. **Service** – a service which is covered by the scope of this Agreement and comprises:
    a. **Hospital Service** – a medical service related to Hospitalisation or Emergency Care provided by a Hospital and, in some cases, also by an Outpatient Clinic. The detailed scope of the Hospital Service is described in Appendix 1 (Part I) and Appendix 2 (Part I) to the GTC.
    b. **Hospital Health Check** (also: **the Check**) – services in the area of diagnostic imaging, laboratory diagnostics and healthcare specialist consultations provided by the Hospital. Its aim is to promote good health. The detailed scope of the Hospital Health Check is described in Appendix 1 (Part II) to the GTC.
    c. **Hospital Care Coordination** – the scope of services performed by HCC, and described in Appendix 1 (Part III) and Appendix 2 (Part II) to the GTC.

20. **Medical Transport** – covers road transport:
    a. from the place of stay of the Insured Person to the Hospital, resulting from medical indications confirmed by us (inability to move independently due to medical reasons, the need for continuous care and medical supervision);
    b. interhospital transport in cases when we order medical transport to another unit as part of continuation of the treatment covered by the scope of the insurance, as well as to another nearby Hospital as part of continuation of the treatment, when further diagnostic and treatment are beyond our scope of responsibility;
    c. transport from the Hospital to the place of stay of the Insured Person, resulting from medical indications confirmed by us.

21. **Insured Person** – the Main Insured Person or the Co-Insured. Where the term 'the Insured Person' appears in the GTC, it shall mean both the Main Insured Person and the Co-Insured.
    a. **Main Insured Person** – a natural person for the account of whom the Agreement is concluded, who resides in the territory of the Republic of Poland and who, on the day of commencement of insurance cover, was at least 18 and was less than 70 years of age.
    b. **Co-Insured** – a natural person, indicated by the Insuring Party in the Insurance Application, whose health is covered under the Agreement. The Co-Insured may be:

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I. **Life Partner** – a spouse or a person who runs a joint household with the Main Insured Person, not related by blood, adoption or affinity, who on the date of commencement of the coverage was at least 18 and was less than 70 years of age.

II. **Child** – an Adult Child and Minor Child
   - **Minor Child** – an own or adopted child of the Main Insured Person or of the Partner, who is under 18 years of age. The person authorised to make statements on behalf of a Minor Child is the legal guardian.
   - **Adult Child –** an own or adopted child of the Main Insured Person or the Partner who is 18 or more years of age.

22. **Insurer** – LMG Försäkrings AB S.A., with its registered office in Stockholm (102 51), Box 27093, Sweden, registered with the Office for Registration of Companies under number 516406-0831, share capital: EUR 4,800,000 fully paid-up, operating in Poland through the branch of LMG Försäkrings AB S.A. Branch in Poland with its registered office in Warsaw, entered in the Register of Entrepreneurs of the National Court Register kept by the District Court for the Capital City of Warsaw, 13th Commercial Division of the National Court Register under KRS No 0000395438, Tax ID No (NIP): 1080011494, which is a large entrepreneur within the meaning of the Act of 8 March 2013 on counteracting excessive delays in commercial transactions.

23. **Insurance Agreement** (also: **the Agreement**) – an agreement concluded on the basis of these terms and conditions of insurance. The content of the Insurance Agreement shall be these GTC, together with Appendices 1 and 2, and the Insurance Policy.

24. **Multi-Organ Damage** (polytrauma) – an injury covering simultaneously multiple systems or organs, and causing damage to at least two body areas to a significant degree, constituting a possible disturbance in the circulatory and respiratory stability of the injured party. Any of these injuries can constitute an immediate life-threatening condition. In particular, such an injury covers conditions requiring immediate thoracosurgical or neurosurgical interventions, and a stay in the anaesthesiology and intensive care unit.

25. **Insurance Application** (also: **the Application**) – a proposal to conclude the Agreement submitted by the Insuring Party in writing, electronically or on a form prepared by us.

26. **Competitive Sports** – practising sports requiring physical activity, covering: participation in training sessions in a sports club, union or association, as well as practising sports for profit, participation in sports competitions (competitions, matches, tournaments, other sports events) and sports conditioning and training camps. This also refers to expeditions to places with extreme climatic or natural conditions. Recreational Sports are not Competitive Sports.

27. **Recreational Sports** – practising sports in spare time, requiring physical activity, but the purpose of which is only recreation and/or psychological and physical regeneration, and/or maintaining good health condition. It also covers, within the meaning of our Agreement, practising sports by children up to 18 years of age at a sports club, class or school.

28. **Highly Specialised Treatment and Diagnostic Methods** – the most technically advanced or extensive therapeutic methods, robotic surgery, surgical procedures concerning the intestines, pancreas and liver, arterial vessels, treatment of endometriosis, functional endoscopic sinus surgeries, procedures involving the use of implantable materials, implants or endoprostheses, intervertebral discs neurosurgical procedures, procedures with the use of vascular adhesive and PET-CT/PET-MRI diagnostics, scintigraphic examinations, MRI examinations of the heart. The diagnostic examinations referred to in this section refer to preparation for planned Hospitalisation or medical care following Hospitalisation. In medically justified cases, diagnostic examinations can be performed immediately during Hospitalisation covered by the insurance, provided that the diagnostics and treatment, the aim of which can be achieved in an outpatient clinic, are excluded in accordance with the provisions of Appendix 1§1(1)(b)(l) and Appendix 2§1(1)(b)(ll).

§3 What is the subject matter of the Agreement?

1. The subject matter of insurance coverage under the Agreement is the health of the Insured Person.

2. The Insured Person may take out an insurance for Hospital Service in the following cases:
   a. receiving a referral for hospital treatment (the date of the event is the date the referral is issued);
   b. pregnancy (the date of the event is the date of planned childbirth entered in the pregnancy card; if there are two dates, the date of the event is the earlier date);
   c. occurrence of a Minor Injury or health condition requiring Emergency Care (the date of the event is the day of occurrence of a Minor Injury or deterioration of health condition).

3. We are responsible for the events that occur during the Insurance Coverage Period.

4. If none of the events referred to in section 2 has occurred for at least 2 years of uninterrupted Insurance Coverage Period, the Insured Person may use Hospital Health Check.
5. Under the Agreement, we also ensure Hospital Care Coordination, aimed at assisting the Insured Person in the use of the insurance.
6. The detailed scope of Services referred to in sections 2-5 is included in the following appendices to the GTC:
   a. Appendix 1 – Scope of Services for the Main Insured Person, the Partner and the Adult Child;
   b. Appendix 2 – Scope of Services for a Minor Child.
7. The Insured Person may choose one of the following insurance cover options:
   a. Individual – for the Main Insured Person;
   b. Partner – for the Main Insured Person and one Co-Insured;
   c. Family – for the Main Insured Person and any number of Co-Insured.
8. Services are provided in the territory of the Republic of Poland in locations indicated by us, the full list of which can be found at www.opiekaszpitalna.luxmed.pl. The list of locations includes the scope of Hospital Services which a given facility performs.

§4 How can the insurance be used?

1. In order to benefit from the Services, the Insured Person shall notify the Hospital Care Coordinator of the event covered by the Agreement. The HCC contact details are provided to the Insuring Party by email immediately after the Agreement has been concluded.
2. In order to decide on the provision of the Service, we need the following documents:
   a. a complete and properly completed application for the provision of the Service;
   b. a copy of the referral to a hospital and a copy of the medical records held in the event of Planned Hospitalisation;
   c. a copy of the medical records held concerning pregnancy and a certificate, issued not earlier than at the beginning of the third trimester by the primary physician, that the pregnancy is not a High-Risk Pregnancy, if the application refers to the Obstetrics-Neonatology Service.
3. We shall provide the Hospital Service if the application for the provision of the Service is submitted to us no later than 30 days after the issue of the referral to the hospital.
4. In cases of a Minor Injury or Emergency Care, we treat the consent to receive treatment as submission of an application for the provision of the Service.
5. In certain situations, it may not be possible to benefit from the insurance. This is related to the grace period (described in §15) and exceptional situations of the limitation of our liability (described in §16).
6. If additional documents, information, additional examinations or medical consultations are required to determine whether the Insured Person is entitled to the Service, we shall inform the Insured Person submitting the application about this. We shall provide the information in writing or in any other way to which the person has consented.
7. We shall commence the provision of the Service no later than 30 days from the receipt of the application for the provision of the Service, within the time limit agreed with the Insured Person. The Insured Person may indicate another later date.
8. It may be impossible to determine whether the Insured Person is entitled to the Service within the time limit specified in section 7. In such a situation, we shall commence the provision of the Service within 14 days of the day on which it was possible to clarify these circumstances with due diligence.
9. When verifying the application for the provision of the Service and the enclosed medical records, we can establish that the Insured Person shall not be entitled to the Service. We shall inform the Insured Person submitting the application about this in writing and we shall indicate the circumstances and the legal basis that justify the refusal. We shall also communicate that if the Insured Person does not agree with this decision, it is possible to pursue claims in court.
10. In the event a Minor Injury or Emergency Care occurs, we shall verify the application for validity of the claim immediately after receiving it. We shall provide information on the recognition or refusal of a claim to the person reporting the event.
11. We provide the Emergency Care service immediately after our recognition of the claim.

§5 What do we require for the conclusion of the Agreement?

1. We conclude the Agreement on the basis of the Insurance Application, together with the documents enclosed thereto, indicated in the Application and referred to in §6(1).
2. The Insuring Party and the Insured Persons are obliged to inform us of all information and circumstances known to them, which are required in the Application, the Declarations of Accession and

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other information necessary for the conclusion of the Agreement, which we shall ask about before its conclusion.

3. We are not liable for the consequences of circumstances that may arise due to failure to inform us about important issues related to the Insured Person's health condition.
4. We only accept Applications that are complete and correctly filled in.
5. An Application may be submitted in paper or electronic format.
6. If the Insurance Application does not contain all the required information or documents, we shall immediately notify the Insuring Party thereof and ask for the missing information or documents.
7. If the missing information or documents are not provided within the time limit indicated by us, the Agreement will not be concluded.
8. At the stage of verification of the Insured Person's health condition, we may ask him/her to provide additional documents or information.
9. The Agreement shall be concluded upon our acceptance of the Insurance Application. The date of conclusion of the Agreement is confirmed on the Insurance Policy.

§ 6 How can the accession of the Insured Person to the Agreement be reported?

1. Persons enrolled in the Agreement shall be covered by our insurance coverage on the basis of:
   a. the List of Insured Persons provided to us by the Insuring Party;
   b. complete, correctly filled in Declarations of Accession;
   c. medical questionnaires provided, if required;
   d. other documents, if we have indicated that they are necessary for the conclusion of the Agreement.
2. During the term of the Agreement, the Insuring Party may enrol new persons for insurance on the basis of the documents described in section 1.
3. The first List of Insured Persons, together with all required documents, shall be provided to us no later than 5 business days prior to the start of the insurance period. Subsequent Lists of Insured Persons shall be provided to us on a monthly basis, no later than 5 business days before the end of the calendar month.
4. The Insurance Coverage Period starts with regard to the Insured Persons enrolled on the basis of the first List of Insured Persons on the date indicated in the Insurance Policy. The person's accession during the term of the Agreement shall take place on the first day of the calendar month following the date of receipt of the List of Insured Persons, provided that the deadline referred to in section 3 is met. If the list is submitted after that date, we shall assume that it relates to the following month. The date of a person's accession to the Agreement shall be the beginning of that person's Insurance Coverage Period.
5. At the stage of verification of the health condition of the person enrolled in the Agreement, we may ask for additional documents or information to be provided.
6. Based on the risk assessment of the enrolled person, we may:
   a. accept him/her in the Agreement;
   b. propose revised terms and conditions of the Agreement;
   c. refuse to accept him/her in the Agreement.

§ 7 How can the withdrawal of the Insured Person during the term of the Agreement be reported?

1. During the term of the Agreement, the Insuring Party may report persons excluded from the insurance on the basis of the List of Insured Persons.
2. The List of Insured Persons shall be provided to us on a monthly basis, no later than 5 business days before the end of the calendar month.
3. The person's withdrawal during the term of the Agreement shall take place on the first day of the calendar month following the date of receipt of the List of Insured Persons, provided that the deadline referred to in section 2 is met. If the list is submitted after that date, we shall assume that it relates to the following month.
4. A person's withdrawal during the term of the Agreement shall mean the end of the Insurance Coverage Period with regard to that person. Withdrawal of the Main Insured Person from the Agreement shall be tantamount to the end of the Insurance Coverage Period with regard to the enrolled Co-Insured.
5. Within 12 months from the date of withdrawal from the Agreement, the Insured Person may not re-access the Agreement, unless the re-accession is a result of re-employment of the Main Insured Person by the Insuring Party.

§8 For how long is the Agreement concluded and from when is the insurance valid?

1. The Agreement shall be concluded for a period of 12 months.

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2. The Agreement shall be automatically renewed for subsequent 12 months, subject to sections 3-5.
3. When renewing the Agreement for another annual period, we shall have the right to propose a change in the amount of the Premium. We shall send a proposal to change the Premium at least 60 days before the end of the insurance period.
4. The Insuring Party's failure to respond within 14 days before the start date of the next annual term of the Agreement shall be tantamount to expressing consent to the change of the amount of the Premium, and shall not require an amendment to the Agreement. In the absence of the Insuring Party's consent to change the amount of the Premium, the Agreement shall expire at the end of the period for which it was concluded.
5. The Agreement shall not be extended if, no later than 30 days before the end of its term, at least one of the Parties makes a statement to the other Party expressing its disagreement with the extension.

§9 When is it possible to withdraw from or terminate the Agreement?

1. The Insuring Party has the right to withdraw from the Agreement within 7 days of its conclusion. In such a case, we shall refund the Insuring Party with the Premium paid within 14 days from the date of receipt of the declaration of withdrawal. The Premium shall be reduced by the amount due for the period in which we granted the insurance coverage.
2. After the expiry of the time limit referred to in section 1, the Insuring Party shall have the right to terminate the Agreement at any time, with a 3-month notice period with effect at the end of the calendar month. For this purpose, the termination notice should be sent to the address of our registered office: 02-676 Warsaw, ul. Postępu 21C or in electronic format to: bok@luxmed.pl. The Insuring Party may also indicate another later date.
3. The Agreement shall also be deemed terminated if the Insuring Party fails to pay the Premium within the agreed deadline, despite our prior request for payment within an additional 7-day period. In the request, we shall include information that failure to pay shall result in termination of the Agreement.

§10 Until when is the Agreement valid?

1. The Agreement shall be terminated:
   a. on the business day following the date on which we received the notice of withdrawal from the Agreement;
   b. on the date of termination of the Agreement in accordance with § 9(2) and (3);
   c. on the expiry of the last day of the 7-day period for payment of the next Premium instalment referred to in § 9(4);
   d. on the last day of the term of the Agreement, if it is not extended for another 12-month period.

§11 Until when is the insurance for the Insured Person valid?

1. The Insured Person shall cease to be covered by insurance under the Agreement:
   a. on the date of termination of the Agreement, in accordance with §10;
   b. on the last day of the annual insurance period in which the Insured Person reaches the age of 71;
   c. on the date of death of the Insured Person;
   d. on the date of withdrawal of the Insured Person from the Agreement in accordance with §7(3).

§12 What is the amount of the Premium and how is it paid?

1. The insurance premium is paid on a monthly basis.
2. The amount of the Premium depends on:
   a. the gender and age structure of the group of persons enrolled in the Agreement;
   b. the insurance option chosen by the Insured Persons;
   c. our risk assessment.
3. The amount of the Premium due from the Insuring Party shall be determined as the product of the Premium per one Insured Person and the number of the Insured Persons in a given month, i.e. taking into account the persons acceding the insurance and excluded from the insurance.
4. The date of payment of the Premium shall be the date on which we receive the entire amount due in our bank account.
5. If the amount paid is lower than the amount of Premium due, the Premium shall be deemed unpaid.
6. If there are arrears in paying Premiums, subsequent payments shall first be transferred to cover the Premiums in arrears.

§13 What obligations do we have towards the Insuring Party?

1. We shall provide the Insuring Party with the GTC, together with appendices prior to the conclusion of the Agreement. A detailed list of appendices can be found at the end of this document.
2. As a confirmation of the conclusion of the Agreement, we shall issue and deliver the Insurance Policy, and in the event of amendments to the Agreement requiring changes in the Insurance

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Policy, we shall provide an Annex to the Insurance Policy.

3. We shall inform the Insuring Party, not later than within 14 days, about the change of our correspondence addresses and about the change of the Phone Line number under which the Insured Person may obtain information about the insurance.

4. We shall perform our obligations under the Agreement correctly and in a timely manner.

§14 What are the obligations of the Insuring Party and Insured Person towards us?

1. The Insuring Party and the Insured Person are obliged to inform us of all known circumstances that we shall ask about prior to the conclusion of the Agreement in the Insurance Application and in the Declarations of Accession. If we entered into the Agreement despite not having received the Insuring Party's or Insured Person's responses to particular queries, the omitted circumstances shall be considered irrelevant.

2. The Insuring Party is obliged to:
   a. pay the Premium in the amount and within the deadlines specified in the Agreement;
   b. provide us with complete Lists of Insured Persons in accordance with the template, together with all the required documents;
   c. notify us immediately, and not later than within 14 days, of a change of its registered office or postal address;
   d. inform us about any change to the information concerning the Insured Persons and the Insuring Party, specified in the Insurance Application;
   e. deliver to the Insured Persons the terms and conditions of the Agreement, including in particular the GTC, prior to the Insured Persons' consent to receive insurance coverage, if such consent is required by the Agreement or if the Insured Person agrees to pay the Insurance Premium cost before giving consent. This obligation shall also apply to the delivery of documents introducing any amendments to the Agreement during its term;
   f. inform us about the death of the Insured Person;
   g. inform the Insured Persons about the change of the Phone Line number under which the Insured Person may obtain information about the insurance and about the changes concerning the Operator.

3. The Insuring Party shall bear full liability for the actions
   and omissions under the Agreement, including, in particular, the violation of the provisions of section 2 above.

4. The obligations of the Insured Person shall include:
   a. complying with Physicians' recommendations;
   b. complying with the rules applicable in Outpatient Clinics and Hospitals;
   c. following the instructions of the staff of Outpatient Clinics and Hospitals;
   d. complying with the deadlines for the performance of Services agreed with us;
   e. arriving at the Hospital or Outpatient Clinic indicated by us within an agreed deadline or informing the Operator about the cancellation of the Service, no later than 12 hours before the agreed deadline for its provision. If the circumstances do not allow for this deadline to be met, the Insured Person shall inform the Operator about the cancellation immediately after the reason for the cancellation has arisen;
   f. refraining from any actions hindering or preventing the provision of the Service.

§15 What is the grace period and what is its length?

1. In the Agreement, we apply a grace period. This is a period that must elapse from the beginning of the Insurance Coverage Period before we provide a specific Service to the Insured Person.

2. The grace periods in the Agreement shall be as follows:
   a. 3 months – for Planned Hospitalisations;
   b. 10 months – for Highly Specialised Treatment and Diagnostic Methods as well as Obstetrics-Neonatology Services.

3. We do not apply the grace period to events resulting from an Accident, Hospital Care Coordination, Emergency Care and Emergency Hospitalisation.

4. In cases of adding new Co-Insured to the Agreement, they shall be subject to a grace period calculated from the beginning of their Insurance Cover Period.

5. We shall not apply the grace period in cases of continuation of the Insurance Coverage Period under the Agreement for subsequent periods in the same or narrower scope of insurance.

6. If the Insured Person was covered by an insurance in which we were the Insurer and which included Hospitalisation, the duration of the previous insurance is included in the grace periods for:
   a. Planned Hospitalisations, excluding oncology – if they were covered by the previous insurance,
   b. Obstetrics-Neonatology Services – if they were covered by the previous insurance.

   In order to benefit from this principle, the previous insurance must be completed and could not have ended earlier than 3 months before the beginning of

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the Insurance Coverage Period based on these terms and conditions. If the Insured Person was covered by several insurances, this rule applies only to the insurance agreement with the latest termination date.

§16 What are the exclusions from the insurance that will prevent us from providing the Services?

1. Our liability does not include insurance events, so we shall not provide a Service which results from:
   a. acts of war, military operations, martial law, civil war, revolution, state of emergency, civil coup d'état, acts of terrorism, military service, participation in military missions or stabilisation missions, active participation of the Insured Party in riots, unrest or strikes;
   b. use of scientifically unrecognised treatments and non-conventional medicine, the use of medicines not authorised for use in the European Union, the participation of the Insured Person in medical experiments, clinical trials or similar health-related studies;
   c. transplantation of organs or tissues, cells, cell cultures (cultivated naturally or artificially), including those involving an autograft or implants and insertion devices;
   d. Competitive Sports;
   e. state of emergency due to natural disaster, natural catastrophes, pandemic and epidemic announced
      and confirmed by the competent state administration authorities, if they cause disruption or inability to provide services on our side;
   f. the impact of nuclear energy, radioactive radiation, electromagnetic field and biological and chemical agents harmful to humans;
   g. driving a vehicle without a permit or driving a vehicle without a valid MOT certificate, according to the laws currently in force, or driving a vehicle under the influence of voluntarily consumed alcohol, drugs or other intoxicants, psychotropic drugs or substitute drugs within the meaning of the Act of 29 July 2005 on counteracting drug addiction (consolidated text, Journal of Laws [Dz.U.] of 2019, item 852, as amended);
   h. attempted suicide, self-harm, deliberate bodily harm;
   i. committing or attempting to commit a crime or an offence;
   j. independent treatment not recommended by the Physician, failure to follow the medical recommendations concerning the Services provided under the Agreement, modification of the recommended treatment or gross negligence;
   k. being under the influence of, abuse of or an intoxication with voluntarily consumed alcohol, drugs, other intoxicants or psychotropic drugs, drugs used contrary to the physician's recommendations and abuse or intoxication with tobacco;
   l. participation in a flight in the capacity of a pilot, crew member or a passenger of a military or private aircraft of an unlicensed airline.
2. Hospitalisation which due to medical safety reasons, determined on the day of admission to the hospital ward or during hospital stay, requires simultaneous highly specialised and multidisciplinary treatment in a medical facility outside the list referred to in §3(8), or its scope exceeds the scope specified in Appendix 1 and Appendix 2 to the GTC.
3. Taking into account medical safety standards, the Outpatient Clinic or Hospital may provide the Service to a particular patient with priority over other patients.
4. The Outpatient Clinic or Hospital shall have the right to refuse to provide the Service to the Insured Person if the person violates the principles of social coexistence or the organisational rules of the Hospital or Outpatient Clinic with the person's behaviour, and if the person hinders the work or functioning of the facility or its personnel. If the above action is persistent, we may exclude the Insured Person from Insurance Cover.
5. We shall not provide the Service if, as a result of a state of emergency due to natural disaster, natural catastrophe, pandemic or epidemic announced and confirmed by the competent state administration authorities, we are unable to provide services.
6. The Service does not include:
   a. immediate treatment of emergency conditions diagnosed on the day of admission to the hospital ward (including among others, stroke, myocardial infarction, pancreatitis, pulmonary embolism and others): in an intensive care unit (in particular: Anaesthesiology and Intensive Care Unit, Intensive Cardiology Supervision Ward, Stroke Treatment Ward, Intensive Neurology Care Ward, Asthmatic Conditions Treatment Ward) or with the provision of intensive renal replacement therapy, hepatic dialysis, ECMO, mechanical ventilation, counterpulsation.
   b. rehabilitation other than the one listed in Appendix 1 §6 And Appendix 2 §4;
   c. treatment of Multi-Organ Damage and its consequences;
   d. implantation of prostheses or implants other than those listed in Appendices 1 and 2 to the GTC, in particular replacing sensory organs (e.g. cochlear implant);

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e. robotic surgery procedures other than those listed in Appendices 1 and 2 to the GTC;
f. treatment in psychiatric wards;
g. diagnosis and treatment of fertility disorders and their consequences;
h. diagnosis and treatment of procedures related to sex change and its consequences;
i. diagnosis and treatment of congenital genetic defects associated with chromosomal aberrations and congenital defects causing the declared malfunction and their consequences;
j. diagnosis and treatment of Rare Diseases and their consequences;
k. performance of abortions and treatment of complications resulting from them;
l. prosthetic, orthodontic, periodontal and implant diagnoses and treatment and their consequences;
m. diagnosis and treatment, as well as procedures and surgeries in aesthetic medicine, plastic surgery resulting from non-medical indications, and cosmetology, as well as the treatment of their undesirable consequences, unless the scope of the Hospital Service provides otherwise;
n. diagnosis and treatment not provided at Hospitals or Outpatient Clinics designated by us and their consequences;
o. issuing medical certificates, declarations, statements and applications not related to the necessity to continue the diagnostic and therapeutic processes conducted at the Hospital or Outpatient Clinic designated by us (this exclusion does not apply to occupational medicine services as long as they are covered by the scope of insurance and certificates of incapacity to work or study);
p. sanatorium and health resort treatment and rehabilitation stays in a nursing home or other facility providing care and treatment or treatment and nursing care, in which the Insured Person is staying due to medical, family or social reasons;
q. treatment of infection with HIV (AIDS), SARS-CoV-2 or hepatitis (with the exception of hepatitis A) viruses, and diseases resulting from those infections;
r. home treatment as a continuation of hospital treatment, excluding treatment resulting from procedures covered by and performed under the insurance;
s. medical care after Hospitalisation within the scope described in Appendices 1 and 2 to the GTC related to Hospitalisation performed in facilities other than those indicated by us;
t. diagnosis and treatment without medical indications;
u. treatment resulting from psychological indications;
v. treatment of diseases or consequences of Accidents which were not disclosed to us in the documents required by us for the conclusion of the Agreement and which occurred or the reasons for their occurrence were known to the Insuring Party or the Insured Person within 12 months prior to the conclusion of the Agreement; also Illnesses or consequences of Accidents which you or the Insured Person could or could have become aware while exercising due diligence during that period;
w. detoxification, detox procedures and treatment and their consequences;
x. treatment of mental disorders, dementia, neurodegenerative diseases (including Alzheimer's disease) and their consequences;
y. services obtained through prohibited acts, extortion attempts or deliberate misinformation.

7. We shall not be held responsible for insurance events that result from:
   a. medical errors;
   b. errors resulting from medical records of the Insured Person not being maintained properly.

   The medical entity providing the Service shall be responsible for the errors listed in section 7(a) and (b).

8. We shall not provide the Hospital Service during the first 12 months from the beginning of uninterrupted Insurance Coverage Period with respect to the Insured Person, if it results from Illnesses that were diagnosed or treated, Accidents and injuries that occurred or were treated, symptoms that occurred or the reasons for their occurrence were known to the Insuring Party or the Insured Person, or of which they could have learned, using due diligence, during the 12 months preceding the beginning of the Insurance Coverage Period.

§17 How can a complaint be lodged?

1. Complaints related to the conclusion or performance of the Agreement may be lodged by the Insuring Party or the Insured Person:
   a. electronically – to the following email address: reklamacje.ubezpieczenia@luxmed.pl;
   b. in writing – by post to the address of our registered office: 02-676 Warsaw, ul. Postępu 21C.

2. The complaint should be addressed to us and contain a brief description of the irregularities, which shall enable us to identify the event covered by the complaint and to determine all the relevant circumstances.

3. We shall respond in writing or electronically, if the person lodging the complaint consents to it, within a maximum of 30 days of receiving the complaint.

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4. In particularly complex cases, you may receive a delayed response.In such situations, before the expiry of the deadline for response:
   a. we shall explain the reason for the delay;
   b. we shall indicate the circumstances which must be further determined in order to consider the case;
   c. we shall determine the expected deadline for handling the complaint and providing a reply, which shall not exceed 60 days from the date of receipt of the complaint.
5. Upon exhausting the complaint procedure, the Insuring Party and the Insured Person shall have the right to submit a request for examination of the case by an entity authorised to settle out-of-court disputes, i.e. the Financial Ombudsman (for details, please refer to the website of the Financial Ombudsman: https://rf.gov.pl/);

§18 Final provisions

1. In matters not regulated by this Agreement, the provisions of Polish law currently in force shall apply.
2. Any action for claims under the Insurance Agreement can be brought either under the general jurisdiction law or before a court:
   a. competent for our registered office, or
   b. for the place of residence or registered office of the Insuring Party, or
   c. for the place of residence of the Insured Person.
3. Applications, representations and notices addressed to us that relate to the performance of this Agreement must be made in writing to: 02-676 Warsaw, ul. Postępu 21C, or electronically to the address bok@luxmed.pl.
4. Any amendments to the Agreement must be made in writing, otherwise being null and void.
5. Claims for Services resulting from the Agreement may not be assigned within the meaning of Article 509 of the Polish Civil Code, and may not be the subject of a pledge within the meaning of Article 327 of the Polish Civil Code.
6. The claims are covered by the guarantee of the Insurance Guarantee Fund in the amount of 50% of amount due; however, not more than the PLN equivalent of EUR 30,000 converted at the average exchange rate announced by the National Bank of Poland in force on the date of declaration of bankruptcy, dismissal of the bankruptcy petition or discontinuance of bankruptcy proceedings or on the date of ordering compulsory liquidation (if any).
7. The Insurer is subject to the supervision of the Polish Financial Supervision Authority (https://www.knf.gov.pl).
8. Correspondence related to the Agreement shall be sent to the last known address of the Parties to the Agreement.

List of appendices:
- Appendix 1 – Scope of Services for the Main Insured Person, the Partner and the Adult Child
- Appendix 2 – Scope of Services for a Minor Child

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