General Terms and Conditions of Hospital Insurance LUX MED – Full Care for individual clients

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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 IUS/2/2022

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(2), §13, §14 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 With whom is the Agreement concluded?

You (hereinafter **the Insuring Party**) shall conclude the Insurance Agreement with us: LMG Försäkrings AB S.A., with its registered office in Stockholm (102 51), Box 27093, Sweden, acting in Poland through the branch of LMG Försäkrings AB S.A. Branch in Poland with its registered office in Warsaw (our full details as **the Insurer** can be found in §2(21)).

§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. **Minor Injury** – a trauma that requires surgical or orthopaedic assistance but does not require Hospitalisation or medical procedures performed in an operating room.
5. **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.
6. **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.
7. **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.
8. **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

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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).

9. **Insurance Policy Month** – monthly period starting on the first day of the Insurance Coverage Period, and each subsequent month starts on the same day of the subsequent month (e.g. for an Agreement effective as of 15 July, each Insurance Policy Month starts on the 15th day of the month). If in a given calendar month, there is no day on which the Insurance Policy Month should end, it lasts until the last day of the calendar month. (e.g., the Insurance Policy Month starting on 31 March ends on 30 April).

10. **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.

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

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

13. **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 indication of situations in which we cannot provide it, is described in Appendix 1 (Part I, §7) and Appendix 2 (Part I, §7) to the GTC. Emergency Care ends with recommendations for further treatment, depending on the health condition of the Insured Person.

14. **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.

15. **Insurance Policy** – a document confirming the conclusion of the Agreement.

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

17. **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.

18. **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 described in Appendix 1 (Part III) and Appendix 2 (Part II) to the GTC.

19. **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.

20. **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:
        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

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- **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 a 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.

21. **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.

22. **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.

23. **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.

24. **Insurance Application** (also **the Application**) – your proposal to conclude the Agreement submitted by you electronically, by telephone or in writing on a form prepared by us.

25. **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.

26. **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.

27. **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. If you conclude the Agreement and it concerns your health, you are both the Insuring Party and 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.

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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. When concluding the Agreement, you may choose one of the following coverage 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 in the Insurance Policy.

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 §13) and exceptional situations of the limitation of our liability (described in §14).

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 of a Minor Injury or Emergency Care, 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. You may conclude the Agreement with us after you and the Insured Person have provided all the information and circumstances known to you that are required in the Insurance Application and other information necessary to conclude the Agreement, which we shall ask for before concluding the Agreement.

2. 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.

3. We only accept Applications that are complete and correctly filled in.

4. You may submit an Application by means of remote communication.

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5. If the Insurance Application does not contain all the required information or documents, we shall immediately notify you about this and ask you to supplement it.
6. If the missing information or documents are not provided within the time limit indicated by us, the Agreement will not be concluded.
7. At the stage of verification of the Insured Person's health condition, we may ask you to provide additional documents or information.
8. Based on the risk assessment conducted, we can:
   a. conclude the Agreement, as evidenced by the issuance of the Insurance Policy;
   b. propose revised terms and conditions of the Agreement;
   c. refuse to conclude the Agreement.
9. The Agreement is concluded upon payment of the first Premium and upon acceptance of the Insurance Application by us. The date of conclusion of the Agreement and the date of its entry into force can be found in the Insurance Policy.

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

1. The Agreement is concluded for a period of 12 months.
2. The Insured Person shall be covered by insurance from the date on which the Insurance Coverage Period begins. The start date of the Insurance Coverage Period can be found in the Insurance Policy.
3. The Agreement shall be automatically renewed for subsequent 12 months, subject to sections 4-6.
4. 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 you a proposal to change the Premium at least 60 days before the end of the current annual period of the Agreement.
5. Your 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. If you do not agree to a change of the Premium and you inform us about this, the Agreement shall expire at the end of the current annual period of the Agreement.
6. The Agreement shall not be extended for another period of one year if, no later than 10 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.

§ 7 What terms and conditions can be changed during the term of the Agreement and how can this be done?

1. At any time during the term of the Agreement, you may add new Co-Insureds to the Agreement and exclude Co-Insureds from the Agreement, also if this changes the insurance cover option, provided that the exclusion of a given Co-Insured from the Agreement takes place once in each twelve-month period of the Agreement.
2. Yet another reporting of accession to the Agreement of a person who has previously been excluded from it is possible after 12 months from the date of his/her exclusion.
3. You can change the frequency of Premium payment on the anniversary of the Agreement.
4. Any amendment to the terms and conditions of the Agreement shall be made upon your request and shall require our acceptance. We shall confirm the amendment with an annex to the Insurance Policy, which shall be issued no later than 14 days after:
   a. the date of receipt of the request for adding or excluding the Co-Insured;
   b. the anniversary.
5. The amended terms and conditions of insurance shall apply from the date indicated in the annex to the Insurance Policy. At the same time, the date cannot be earlier than the day following the day on which we received the first Premium from you in the amount corresponding to the new scope.

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

1. You may withdraw from the Agreement within 30 days of the date of its conclusion. If the Agreement is concluded by means of remote communication, you may withdraw from it within 30 days from the date of receipt of confirmation of the terms and conditions of insurance coverage and information required by law when concluding remote agreements. You shall receive a refund of the Premium paid within 14 days of the date on which we receive 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, you shall have the right to terminate the Agreement at any time, with a 1-month notice period. You can do this by sending a relevant statement to the address of our registered office: 02-676 Warsaw, ul. Postępu 21C or to the email address: bok@luxmed.pl.

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3. Termination of the Agreement shall take place on the last day of the Insurance Policy Month, in which one month shall elapse from the date we receive your statement, referred to in section 2. You may also indicate another later date.

4. We may terminate the Agreement if you fail to pay the Premium within the specified time limit, and an additional 7-day period resulting from our request for payment elapses. In the request, we shall include information that failure to pay shall result in termination of the Agreement.

§9 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 in accordance with §8(1);
   b. on the date of termination of the Agreement in accordance with §8(3);
   c. on the expiry of the last day of the 7-day period for payment of the next Premium instalment referred to in §8(4);
   d. on the last day of the period of the Agreement, if it is not extended for another 12-month period;
   e. on the last day of the annual period of the Agreement in which the Insured Person reaches the age of 71;
   f. on the date of death of the Insured Person;
   g. on the date of death of the Insuring Party. In such a case, the Insured Person may enter into the rights and obligations of the Insuring Party under the Agreement, upon our consent.

2. The date of termination of the Agreement shall be at the same time the date of expiry of the Insurance Coverage Period.

3. With regard to the Co-Insured, the insurance coverage shall also expire on the date of his/her exclusion from the Agreement on the basis of the provisions of §7.

§10 What is the amount of the premium and how is it paid?

1. You may pay the insurance Premium on a monthly, quarterly, semi-annual or annual basis.

2. The amount of the Premium depends on:
   a. age;
   b. health condition;
   c. insurance option you choose;
   d. our risk assessment.

3. Please refer to the Insurance Policy for details regarding the amount of Premium and the method of payment.

4. The date of payment of the Premium shall be the date on which we receive the entire amount due on our bank account, indicated on the Insurance Policy.

§11 What obligations do we have towards the Insuring party?

1. Before we conclude an Agreement, we shall provide you with the GTC together with appendices. A detailed list of appendices can be found at the end of this document.

2. In order to confirm the conclusion of the Agreement, we shall issue and deliver the Insurance Policy. In the event of changes to the Agreement requiring changes to the Insurance Policy, we shall provide an annex to the Insurance Policy.

3. We shall inform you about a possible change of our mailing addresses, including a change of the Phone Line number under which the Insured Person can obtain information about the insurance.

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

§12 What obligations do the Insuring Party and the Insured Person have towards us?

1. You and the Insured Person are obliged to inform us of all known circumstances that we shall ask about in the Insurance Application, as well as to inform us if they change during the term of the Agreement.

2. You are obliged to:
   a. pay the Premium in the amount and within the deadlines specified in the Agreement;
   b. inform us about any change of your data and data of the Insured Person, provided in the Insurance Application;
   c. provide the Insured Person with the terms and conditions of the Agreement, in particular the GTC, before agreeing to be provided with insurance coverage. You are also obliged to deliver documents amending the Agreement and GTC during the term of this Agreement;
   d. inform us about the death of the Insured Person;
   e. inform the Insured Persons about the change of the Phone Line number under which the Insured Person may obtain information about the insurance and changes concerning the Operator.

3. 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;

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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.

§13 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. If you want to extend the Agreement by adding new Co-Insured, 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 prolonged for subsequent annual 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 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.

§14 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 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.

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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.

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);
   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. 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 you 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;

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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.

§15 How can a complaint be lodged?

1. Complaints related to the conclusion or performance of the Agreement may be lodged by you 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.

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, you 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/).

§16 Why do we process personal data?

1. We are the controller of your and the Insured Person's personal data within the meaning of Article 4(7) of Regulation (EU) No. 2016/679 of the European Parliament and of the Council of 27 April 2016 (hereinafter: 'Regulation'). The data shall be processed for the purposes of concluding the Agreement and providing insurance coverage. If you or the Insured Person have consented to the processing of personal data for marketing purposes or in order to receive marketing communication, the personal data controllers are entities from the LUX MED Group – their list can be found on the website www.luxmed.pl. In all matters related to the processing of personal data by us, you may contact our Data Protection Officer by writing to: daneosobowe@luxmed.pl.

2. Your personal data are provided to us at the time of conclusion of the Agreement. The Insured Persons' personal data are provided to us by submitting the Insurance Application (in the case of Co-Insured, their personal data are provided to us by the Main Insured Person). We process the Insured Persons' personal data listed in the Application, i.e. first and last name, Personal ID No. (PESEL), gender, date of birth, main place of care, address of residence. If the Insured Person is a foreign national, we also process information on the citizenship and the passport number. We may also receive the telephone number, but this information is not necessary for us to provide insurance coverage to the Insured Persons. In connection with making it possible for you to submit the Application via an electronic platform, as well as the Insured Persons reported by you to the insurance coverage accessing the insurance, we shall also process your email address and the email addresses of the Insured Persons. In order to assess the insurance risk, as part of the medical questionnaire filled in by the Insured Person, we also process personal data of the Insured Person, including age, weight, height, information about the profession or job position performed together with its characteristics, information about the Insured Person's employer, as well as information about the Insured Person's health condition within the scope resulting from the medical questionnaire. We may ask the Insured Person to provide additional information about his/her health condition or, on the basis of an authorisation granted by the Insured Person, ask the medical entities used in order to

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obtain the information necessary to make a decision on the provision of the Service, its correct coordination or performing a winding-up proceedings in connection with the submitted claim. If it is necessary to obtain medical records of the Insured Person for the purposes referred to in the preceding sentence, we will request him/her to provide us with a copy of his/her medical records to the extent necessary, or on the basis of the Insured Person's consent, we shall request the relevant medical entities to provide us with such records. The consent to the processing of data for marketing purposes shall include any information you or the Insured Person have given us. These may include, for example, identification data (name, surname, gender, date of birth, age, location). However, we assure you that under no circumstances will we access the Insured Person's medical records that he/she have provided to us or that we have obtained from a medical entity under the appropriate authorisation – only authorised persons have access to this information.

3. We process your and the Insured Person's personal data as the Insurer, and the purpose of this processing is to assess the insurance risk and to execute the Agreement. First of all, we need to accept the Application. This will enable us to establish the identity of the Insured Person before the Service is provided and execute the Agreement and contact the Insured Person. As the Insurer, we are required by law to perform an insurance risk assessment prior to entering the Agreement and to process personal data as part of its execution, including for the purpose of coordinating the Insured Person's use of Services (Article 6(1)(b) of the Regulation in conjunction with Article 41(1) of the Act on Insurance Activity). As part of the insurance risk assessment, we shall process the Insured Person's personal data (including data of a special category in terms of health condition) and this shall be done by automated means, including through profiling. The legal basis for such action on the part of LMG includes the regulations governing our business activity as an insurance entity. However, we inform that the Insured Person always has the right not to accept a decision based on automated processing of personal data, and to request human intervention, which we ensure. As a data controller who is an entrepreneur, we have the right to process personal data in order to pursue claims for our business activity (Article 6(1)(b) and (f) of the Regulation, as the so-called legitimate interests of the controller, which is pursuing our claims and defending our rights). If you or the Insured Person have shared with us your opinion on the processing of personal data, or you have made a complaint, we may process personal data in order to investigate and respond to the notification (Article 6(1)(f) of the Regulation, as the so-called legitimate interests of the controller, i.e. the processing of complaints and the defence of the Insurer's interests). As an entrepreneur, we keep accounting books and we are subject to tax obligations – e.g. we issue bills for the services we provide, which may involve the necessity to process personal data (Article 6(1)(c) of the Regulation in conjunction with Article 74(2) of the Accounting Act of 29 September 1994). If you or the Insured Person have agreed to the processing of personal data for marketing purposes, we may process personal data in order to send marketing communication regarding the LUX MED Group activities to you or the Insured Person. Such communication may include offers, information about services, events organised by the entities from the LUX MED Group, promotions and health-related articles. On the basis of the consent issued by you or the Insured Person, we may process personal data obtained in the course of our cooperation for marketing purposes, for example by analysing them and attaching them with other information about you in order to adapt communications addressed to you to your specific needs (Article 6(1)(a) of the Regulation).

4. Personal data may be transferred to the following categories of recipients in connection with our business activities:
   a. service providers supplying us with technical and organisational solutions that enable us to render services and manage our organisation (in particular, ICT service providers, courier and postal companies);
   b. providers of legal and advisory services and services supporting us in pursuing due claims (in particular law firms, debt collection companies);
   c. reinsurance undertakings which shall be engaged in the reinsurance of the risk assumed by us under the Agreement;
   d. Outpatient Clinics or Hospitals;
   e. the Operator.

As part of the process of coordinating the provision of services, the Insured Person's medical records provided to us or obtained, on the basis of his/her consent, from the relevant medical entities, may be made available by LMG to Outpatient Clinics or Hospitals through the coordinator assigned to the Insured Person to support the process of his/her hospitalisation and treatment.

5. On account of the fact that we use services of other providers, such as ICT structure services, personal data of the Insuring Party and the Insured Persons may be transferred outside the European Economic Area (which is composed of the Member States of the European Union, Iceland, Norway and Liechtenstein). We assure that in such an event, the data shall be transferred on the basis of a relevant legal basis, e.g., an agreement concluded between

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the Insurer and that entity, containing standard personal data protection clauses, adopted by the European Commission or on the basis of a decision of the European Commission stating the appropriate degree of personal data protection. The Insurer verifies whether personal data are being processed securely by the service provider to whom they are transferred.

6. One of the ways of processing personal data is through 'profiling'. This enables us to use the information we have about you or the Insured Person to create preference profiles and, on this basis, adapt our services and content you receive from us. We assure you that we do not process personal data in a fully automated manner, without human intervention.

7. We store personal data for the period of the Agreement and afterwards for 6 years after the expiry or termination of the Agreement. If we have processed data in order to pursue our claims (e.g., under debt collection proceedings), we shall process the data during the permitted period for claims in accordance with the provisions of the Civil Code. All data processed for accounting and tax purposes are processed for 5 years from the end of the calendar year in which the tax obligation arose. If you or the Insured Person consented to the processing of data for marketing purposes, we process data from the moment the consent was obtained to the moment it was withdrawn. After the expiry of these periods, the personal data are deleted or anonymised.

8. The conclusion of the Agreement with us is voluntary; however, as the Insurer we are obliged to identify the Insuring Party and the Insured Persons and carry out the insurance risk assessment with the use of personal data. Failure to provide data may result in refusal to conclude the Agreement or to provide the Services. Also for accounting and tax purposes, we have a legal obligation to process data. Failure to provide them may result, for example, in failure to issue an invoice or a personal invoice for you. Providing your or the Insured Person's telephone number to us is voluntary. The absence of such data does not affect the conclusion of the Agreement, but it will make it significantly more difficult for us to contact the eligible person in the performance of the Agreement. Granting of any of the marketing consents is also voluntary. This means that the refusal to provide them does not affect the use of our Services. You and the Insured Person have the right to revoke the granted consent at any time.

9. As the data controller, we grant you and the Insured Person the right to access your data. You can also rectify them, request their erasure or limit their processing. You may also object to the processing of your data and to the transfer of data to another controller. In order to exercise these rights, you should contact us via the Phone Line or website, or contact our Data Protection Officer. Please also note that you and the Insured Person have the right to lodge a complaint with the authority supervising the compliance with personal data protection regulations.

§17 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. your place of residence.

3. Applications, representations and notices addressed to us that relate to the performance of this Agreement must be made in writing to or via email.

4. Any amendments to the Agreement, as well as withdrawal from it or its termination, shall be made in writing.

5. Your 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).

6. The Insurer is subject to the supervision of the Polish Financial Supervision Authority (https://www.knf.gov.pl).

7. 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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