INSURANCE PRODUCT SHEET

LUX MED Group Insurance G/004/2024/C

Document containing information about an insurance product

Company: LMG Försäkrings AB S.A. Branch in Poland **Product**: LUX MED Group Insurance

Full details provided before the conclusion of the insurance contract and information concerning the contract itself are found in other documents forming an integral part of the contract, including the General Terms and Conditions of LUX MED Group Insurance.

What kind of insurance is it?

Group health and accident insurance.

What is the subject matter of the insurance?

- ✓ The subject matter of the insurance is the Insured Party's health and consequences of personal accidents.
- ✓ The Policyholder may select one or more Modules that will define the detailed scope of the Contract. The 9 available Modules are listed below:

Outpatient insurance

- ✓ Outpatient care
- ✓ Occupational medicine

Hospital insurance

- ✓ LUX MED Hospital Insurance – Full Care (also: Full care)
- ✓ LUX MED Hospital Insurance – Orthopaedic Care (also: Orthopaedic Care Plus)
- ✓ LUX MED Hospital Insurance – Orthopaedic Care Plus (also: Orthopaedic Care)
- ✓ Hospital Care – Coordination

Other personal insurance

- ✓ Treatment of Serious Illnesses Abroad – BEST HELP (also: BEST HELP)
- ✓ Serious Illness Insurance
- ✓ Accident Insurance

What is not covered by the insurance?

Our liability does not extend to incidents resulting from:

- x acts of war, hostilities, martial law, civil war, riots, state of emergency, civil coup d'état, acts of terrorism, military service, participation in military or stabilisation missions, the Insured Party's active participation in riots, commotions or strikes;
- x the use of scientifically unrecognised methods of treatment and/or unconventional, folk and oriental medicine, the use of medicines not authorised for use in Poland (or outside the territory of the Republic of Poland, but only in connection with the Treatment of Serious Illnesses Abroad – BEST HELP Module) and their consequences, as well as the Insured Party's participation in medical experiments, clinical trials or similar health-related research and their consequences;
- x transplantation of organs or tissues, cells, cell cultures (of natural or artificial origin), including by means of autologous transplantation, implantation of implants and devices; this exclusion does not apply to the Treatment of Serious Illnesses Abroad – BEST HELP Module;
- x competitive practising of sports or practising of high-risk sports; this exclusion does not apply to the Treatment of Serious Illnesses Abroad – BEST HELP Module;
- x states of emergency due to natural disasters, acts of God, states of pandemic and states of epidemic declared and confirmed by the competent government authorities, if they cause disruption or inability to provide services on our part;
- x the effects of nuclear energy, radioactivity and electromagnetic fields, as well as biological and chemical agents, to the extent that they are harmful to humans;
- x driving a vehicle without a licence, driving a vehicle without a valid MOT certificate (as required under the applicable regulations) or driving a vehicle under the influence of alcohol, drugs or other intoxicants, psychotropic drugs or substitutes within the meaning of the Act of 29 July 2005 on counteracting drug addiction;
- x suicide, self-mutilation or deliberate infliction of a health disorder attempted or committed by the Insured Party;
- x committing or attempting to commit a crime or offence;
- x wilful misconduct, self-diagnosis, treatment, modification of prescribed treatment or gross negligence by the Insured Party;
- x being under the influence, abusing or being poisoned as a result of the voluntary consumption of: alcohol, drugs, other intoxicants or psychotropic substances, medicines used contrary to a doctor's prescription, and tobacco abuse or poisoning;
- x detoxification, rehabilitation and drug treatment;
- x treatment of mental illnesses, disorders or other mental disturbances (including Alzheimer's disease) and their consequences;
- x obtaining medical services by means of prohibited acts, attempts at extortion or actions meant to deliberately mislead the Insurer.

A detailed list of exclusions applicable within individual Modules is provided in the General Terms and Conditions of Insurance.

What are the limitations of the insurance coverage?

We apply a grace period for selected Modules. A grace period means the time that must elapse from the beginning of the Coverage Period before the Insured Party becomes entitled to a Service. The grace periods for individual Modules are as follows:

- ! LUX MED Hospital Insurance – Full Care:
  - 3 months for Scheduled Hospitalisation and 10 months for Highly Specialised Methods of Treatment and Diagnosis and childbirth
- ! LUX MED Hospital Insurance – Orthopaedic Care Plus:
  - 3 months for Scheduled Hospitalisation and 10 months for Highly Specialised Methods of Treatment and Diagnosis
- ! Treatment of Serious Illnesses Abroad – BEST HELP insurance:
  - 3 months
- ! Serious Illness Insurance
  - 3 months

In addition to the grace periods, we also apply the following restrictions within the individual Modules:

! Outpatient Care:

If the Services to be provided to the Insured Party go beyond the scope of medically necessary Services, we may reduce the scope of Services to those that are medically necessary or provide a Service against payment upon the Insured Party's consent.

! LUX MED Hospital Insurance – Full Care and LUX MED Hospital Insurance – Orthopaedic Care Plus:

We will not provide a Hospital Service during the first 12 months from the beginning of an uninterrupted Coverage Period in respect of the Insured Party if the Service is necessitated by:

- illnesses that were present or were diagnosed or treated during the 12 months preceding the start of the Coverage Period;
- personal accidents and injuries which occurred or were treated or the effects of which existed during the 12 months preceding the start of the Coverage Period;
- disease symptoms that were present, occurred or the causes of which were known to the Policyholder or Insured Party during the 12 months preceding the start of the Coverage Period;
- disease symptoms of which the Policyholder or the Insured Party (had they exercised due diligence) could have become aware during the 12 months preceding the start of the Coverage Period.

! Treatment of Serious Illnesses Abroad – BEST HELP insurance:

- our liability does not cover medical conditions arising from Diseases that were diagnosed or treated or Diseases the symptoms of which were confirmed by appropriate medical records within 10 years preceding the commencement of the Insurance Coverage;
- if the Insurance Coverage under the Contract with respect to a given Insured Party expires and the Insured Party is in the course of treatment provided outside the Republic of Poland under the Contract, or where FURTHER has issued the Insured Party with a Treatment Promise prior to the expiry of the Insurance Coverage for that Insured Party, then the Insurer will guarantee the services under the Contract available to the Insured Party within the scope and subject to the limitations specified in the Contract and the Treatment Promise, with a stipulation that the maximum period for rendering the services shall be 6 months from the end of the Coverage Period with respect to a given Insured Party.

Where is the insurance valid?

✓ The insurance is valid in the territory of the Republic of Poland.

✓ For Treatment of Serious Illnesses Abroad – BEST HELP insurance, also outside the territory of the Republic of Poland.

What are the obligations of the Insured Party?

– Informing us of all circumstances known to the Insured Party that we will ask about before concluding the Contract.

– Following Doctors' recommendations and adhering to the rules in force at the Clinics and Hospitals;

– Compliance with the Service performance deadlines agreed with us;

– Production of an identity document with a photograph prior to the Service provision.

How and when are premiums paid?

The amount of premium and the details regarding the frequency and manner of its payment will be provided in the Policy. The premium must be paid by bank transfer to our bank account indicated in the Policy.

When does the insurance coverage start and end?

✓ The insurance coverage commences upon the Insured Party's enrolment in the insurance – always on the 1st day of a calendar month.

✓ Depending on which of the following events occurs first, the Insured Party is covered:

– until the date of termination of the Contract;

– until the date of the Insured Party's death;

– until the date of the Insured Party's withdrawal from the Contract;

– for individual Modules, until the last day of the Coverage Period in which the Insured Party has reached the age indicated in the GTCI as the maximum age up to which the insurance coverage is provided; the maximum age entitling the Insured Party to our coverage varies from Module to Module;

– for individual modules, until the date on which the sum insured or the quota limit (if defined for the Module) is exhausted.

How can the Contract be terminated?

The Policyholder has the right to withdraw from the Contract within 7 days of its conclusion – by submitting a declaration of withdrawal.

The Policyholder has the right to terminate the Contract at any time, by giving one month's notice, effective at the end of the calendar month. The notice of termination should be sent to our registered office address by letter or electronically.

The Contract will also be recognised as terminated by the Policyholder if the Policyholder fails to pay the premium by the agreed deadline, despite having received our prior request to make the payment within an additional period of 7 days.

General Terms and Conditions of LUX MED Group Insurance - GTC CODE G/004/2024/C

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13th Commercial Division of the National Court Register
KRS: 0000395438
Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

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4. Appendix no. 4: Policyholder's information clause;
5. Appendix no. 5: Information clause for the Insureds;
6. Appendix no. 6: Standard clauses applicable to insurance contracts concluded by LMG Försäkrings AB Spółka Akcyjna Branch in Poland.

Information contained in the General Terms and Conditions of Health Care Services of LUX MED Group Insurance – GTC CODE: G/004/2024/C, referred to in Article 17 section 1 of the Act of 11 September 2015 on insurance and reinsurance activity.

Type of information	Number of GTC provision
Prerequisites that oblige us to pay benefits	• General Part: §3, §4 sections 1, 2 • Outpatient Care Module: §1, §2 • Occupational medicine Module: § 2, § 4(1) • LUX MED Hospital Insurance Module Orthopaedic Care: §2, §3 sections 1, 3 • LUX MED Hospital Insurance Module Orthopaedic Care Plus: §2, §3 sections 1, 4 • LUX MED Hospital Insurance Full Care module: §2, §3 sections 1, 4 • Module for Coordination of Hospital care: §2, § 4, sections 1, 2 • Module for treatment of critical illnesses abroad – BEST HELP: §2 sections 1, 2, §3, §4 • Module for critical illness Insurance: §2, §3 sections 1, 2 • Accident Insurance module: §1, § 3, section 2
Limitations and exclusions on our liability entitling us to refuse the payout of benefits and other services or to reduce them	• General Part: §5 section 3, § 14 • Outpatient Care Module: §3 • LUX MED Hospital Insurance Module for Orthopaedic Care: §3 section 3, § 4 • LUX MED Hospital Insurance Module for Orthopaedic Care Plus: § 3 sections 3, 5, § 4 sections 2, 4, § 5 • LUX MED Hospital Insurance Full Care Module: §3 sections 3, 5, §4 sections 2, 4, §5 • Hospital Care Coordination Module: §5 • Module for treatment of critical illnesses abroad – BEST HELP: §2 sections 1, 2, §3, §5 • Module for Critical Illness Insurance: §2 section 4, §3 section 3, §4 sections 2, 3, §5 • Accident Insurance Module: §3 section 4, §4

General Part

§1 Who are the parties to the Insurance Agreement?

Pursuant to these Terms and Conditions of LUX MED Group Insurance (**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** can be found in §2 item 20 of the General Part of GTC), we hereby conclude an Insurance Agreement with you (hereinafter referred to as the **Policyholder**). The Policyholder may be a natural person running a business or a legal entity or an organisational unit without legal personality.

§2 Definitions

In order to ensure a better legibility of the document, we use the masculine in GTC regardless of the gender (e.g. Insured instead of Insured/Insured or Insured).

Below we introduce definitions which are common to most of the GTC Modules. You can find further definitions for a single Module in the description of the condition of that Module.

1. **Illness** – an abnormal physical or mental state of the body according to generally recognised medical knowledge.
2. **High-Risk Pregnancy –** a pregnancy in which risk factors occur in the mother or in the foetus, increasing the frequency of complications during 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.
3. **Declaration of Accession** – a declaration of the Insured Person, in which the Insured Person expresses his/her will to be covered by Insurance on the basis of these GTC.
4. **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).
5. **List of Insured persons** (also **List) –** list containing the data of persons reported to the Insurance Agreement, withdrawing from the Insurance Agreement and a list of changes in the scope of insurance coverage of a given Insured Person. Reported persons are persons who have submitted a Declaration of Accession (excluding the Occupational Medicine Module) and have passed a positive risk assessment, if necessary. The list will be prepared according to the template indicated by us.

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District Court for the Capital City of Warsaw in Warsaw
13th Commercial Division of the National Court Register
KRS: 0000395438
Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

The list of persons reported to insurance is provided to us by the Insured Person in the event that the Insured Person chooses the traditional form of paper Declarations of Accession as a method of reporting persons for insurance coverage. In the event that the Insured Person chooses e-declarations as a form of reporting persons for insurance coverage, the List of persons reported to insurance is not provided to us by the Insured Person. In the event that the e-declaration form is selected, however, we are still provided with a List containing a list of persons withdrawing from the Insurance Agreement and changes in the scope of insurance coverage of a given Insured Person.

6. **Module** – an integral part of GTC. We provide insurance coverage in respect of the events described in the Modules covered by the Insurance Agreement concluded with the Policyholder. We have indicated the Modules available under the GICs in §3 section 2 of the General Part of the GTC. The Main Insured may choose the modules to apply to him/her from among the Modules covered by the Insurance Agreement to which he/she subscribes. The Modules covered by a given Insurance Agreement are indicated in the Policy.

7. **Accident** – a sudden event caused by a reason that is independent of the will or health condition of the Insured, in which the Insured suffered physical injury or damage to anatomical structures of the musculoskeletal system. An accident does not include illnesses or conditions even if they are sudden.

8. **Coverage Period** – a period during which we are liable towards the Insured in respect of the events covered by the Agreement. It always commences on the 1st day of any calendar month. The coverage period shall not exceed the duration of the Insurance Agreement.

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

10. **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.

11. **Insurance Policy** – a document confirming the conclusion of the Agreement. The Insurance Policy recipient is the Policyholder.

12. **Employee** - a natural person remaining in a legal relation with the Policyholder on the basis of a civil-law Agreement, employment Agreement, appointment, selection or another Agreement, the subject matter of which is the provision of services; Also a natural person who is a Member of the governing body of the Policyholder's organisational unit.

13. **Anniversary –** a date in each year of the term of the Agreement, if it is extended for subsequent annual insurance periods, which corresponds to the date of conclusion of the Agreement.

14. **Premium** – an amount due to us under the Agreement.

15. **Sum Insured –** the amount specified in the Module constituting the upper limit of our liability under the Module towards the Insured. Its amount is specified directly in the Module, in an Appendix to the GTC or in the Policy.

16. **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 the outpatient clinics being part of the Hospital.

17. **Benefit –** a service to be provided or the amount to be paid to the Beneficiary in the case of an event falling within the scope of the Insurance Agreement.

18. **Medical Transport** – covers road transport:
    a. from the place of stay of the Insured 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, resulting from medical indications confirmed by us.

19. **Insured** (Party) – the main Insured Party or the co-insured Party who joined the Agreement and has been covered by Insurance. Where the term 'the Insured' appears in the GTC, it shall mean both the Main Insured as well as the Co-Insured Person.
    a. **Main Insured –** an Employee on whose account the Agreement has been concluded, residing in the territory of the Republic of Poland, who on the date of commencement of coverage was over 18 years of age;
    b. **Co-insured –** a natural person indicated by the Main Insured, to be covered under the Agreement. Depending on the module, 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.
        II. **Parent** – mother or father of the Main Insured or of the Partner;
        III. **Child** – an Adult Child and a Minor Child
            - **Minor Child** – an own or adopted child of the Main Insured 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. A Minor Child who turns 18 becomes an adult child on the anniversary of the conclusion of the Agreement.

    We provide cover to the Insured within the Module or Modules of his/her choice, specified in the List of Insureds, until the last day of the coverage period in which the Insured attained the age specified in the table below.

Table specifying the maximum age of insurance coverage:

	Modules:								
	Outpatient insurance		Hospital insurance				Other personal insurance		
	Outpatient Healthcare	Occupational medicine	Orthopaedic care	Orthopaedic care Plus	Full Care	Coordination Hospital care	Treatment for Serious Illnesses Abroad – BEST HELP	Critical Illness Insurance	Accident insurance
Main Insured	70 years	70 years	70 years	70 years	70 years	70 years	70 years	70 years	70 years
Partner	70 years	-	70 years	70 years	70 years	70 years	70 years	70 years	70 years
Minor child	18 years	-	18 years	18 years	18 years	18 years	18 years	N/a	18 years
Child of age	26 years	-	70 years	70 years	70 years	70 years	26 years	26 years	26 years
Parent	80 years	-	-	-	-	-	-	-	-

20. **Insurer** – LMG Försäkrings AB S.A. with its registered office in Stockholm (102 51), Box 27093, Sweden, registered with the Companies Registration Office under number 516406-0831, share capital: EUR 5,800,000 fully paid-up, operating in Poland through its branch LMG Försäkrings AB Branch in Poland with its registered office in 02-678 Warsaw, at. Szturmowa 2 street, entered into the Register of Entrepreneurs of the National Court Register, kept by the District Court for the capital city of Warsaw 13th Commercial Division under KRS number: 0000395438, Tax ID (NIP) 1080011494; Statistical ID No (REGON): 145156729 having the status of a large entrepreneur within the meaning of the Act of 8 March 2013 on counteracting excessive delays in commercial transactions;
21. **Insurance Agreement (also Contract)** — Insurance Agreement concluded by and between the Insurer and the Policyholder on the basis of the GTC set forth herein;
22. **Beneficiary** – a natural person, a legal person or an organisational unit without legal personality, entitled to receive a benefit from us;
23. **Availability Option** – a service which allows improving access to specialist doctors available under the Outpatient Module in accordance with the principle that the higher the option, the higher the availability Factor for the Insured, except for cases arising from medical safety standards;
24. **Insured's Age** – the age the Insured was on the date of beginning of the Period of Cover, and on the day of each Anniversary thereafter;
25. **Insurance Application** (also: **Application**) – a proposal to conclude the Agreement submitted by the Policyholder in writing, electronically or on a form prepared by us.
26. **Availability Factor** – a percentage determining the availability of visits to individual specialists in LUX MED family medicine facilities. We calculate it on the basis of 16 measurements per day taken in the last calendar year. These measurements concern specific specialties. The measurements check if the waiting time for a visit to a specific specialist does not exceed our internally determined requirements. We deduct the arithmetic mean from all measurements from the last calendar year, which constitutes the Availability Factor.
27. **Insured Event (**also: **Event) –** an event occurring during the coverage period which results in a claim being made against us.

§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 and the consequences of an Accident.
2. The Policyholder may choose one or more Modules that will define the scope of the Agreement:

Outpatient insurance
a. Outpatient Healthcare;
b. Occupational medicine.

Hospital insurance
a. LUX MED Hospital Insurance Orthopaedic Care (also: **Orthopaedic Care**);
b. LUX MED Hospital Insurance Orthopaedic Care (also: **Orthopaedic Care Plus**);
c. LUX MED Hospital Insurance – Full Care (also **Full Care**);
d. Hospital Care Coordination.

Other personal insurance
a. Treatment for Serious Illnesses Abroad – BEST HELP;
b. Critical Illness Insurance;
c. Accident insurance.

3. We are responsible for the events that occur during the Insurance Coverage Period and which, in accordance with the Agreement, are the basis for our provision of the Service.

4. The Main Insured may choose one of the types of insurance within the scope of individual Modules available under the Insurance Agreement which he/she joins. The type of Module shall determine who will be notified by the Main Insured for insurance:
   a. Individual — it covers only the Main Insured;
   b. Partner — shall include insurance coverage of the Main Insured and his/her Partner or child;
   c. Family cover – shall include the insurance cover of the Main Insured, his/her Partner and children;
   In addition, the Main Insured may choose the parent type — it provides coverage for the parents of the Main Insured and the parents of the Partner, in the number of not more than 4 per one Main Insured.

5. The Main Insured may choose different types for different Modules. The range of types available is specified in each of the Modules. The type of Insurance for individual modules under a given Insurance Agreement is indicated in the Policy.

6. Changing the type of Module indicated for individual insurances is possible at any time during the Protection Period and starts on the 1st day of the month following the submission of the List of Insured persons to us.

§4 How can the insurance be used?

1. In order to take out insurance, the Insured should notify us if the Event covered by the Agreement. Reporting method is different for particular Modules. Details of how to report an event are described in the Modules.

2. If additional documents, information, medical examinations or consultations are needed to determine whether the Insured or the Eligible Person is entitled to a Benefit, we will inform the person reporting the event. We shall provide the information in writing or in any other way to which the person has consented.

3. We shall commence the provision of the Service or Benefit no later than 30 days from the receipt of the application for the provision of the Service, within the time limit as agreed with the Insured.

4. It may be impossible to determine whether the Insured is entitled to the Benefit within the time limit specified in section 3. In such a situation, we shall commence the provision of the Benefit within 14 days of the day on which it was possible to clarify these circumstances with due diligence.

5. When verifying the application for the provision of the Benefit, we can establish that the Insured shall not be entitled to the Benefit. We will inform the applicant in writing and indicate the legal basis and circumstances that justify the refusal.

§5 What do we require for the conclusion of the Agreement or a change thereto?

1. We conclude the Agreement on the basis of the Insurance Application, together with the documents enclosed thereto, as indicated in the Application and referred to in §6 section 1 of the General Part of the GTC.

2. The Policyholder and the Insured are obliged to provide us with all the information and circumstances known to them which we ask about in the Application, the Declarations of Accession, and other information necessary for the conclusion of the Agreement which we ask about prior to its conclusion.

3. We shall not be liable for the consequences of circumstances of which we were not notified prior to the conclusion of the Agreement, if we asked about them prior to the conclusion of the Agreement.

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

5. An Application may be submitted in paper or in electronic format.

6. If the Insurance Application does not contain all the required information or documents, we shall immediately notify the Policyholder 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. 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.

9. The Policyholder may request at any time that a module be added or removal to the scope of the Agreement. On this basis, we will prepare an annex to the Application, which must be signed by the Policyholder in order to produce legal effects. A change to the Agreement aimed at extending the scope with a new Module occurs on the date indicated in the annex to the Application. A Module may only be removed on the Anniversary. We confirm the change in the form of an annex to the Policy.

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

1. The Insured, by way of a declaration submitted to the Insurer, selects one or two of the following two methods of registering persons for insurance coverage under the Agreement:

   a. traditional form of Declaration of Accession completed by the Insured in writing and the Insured providing us with a List of Insured. Persons registered for the Agreement are covered by us on the basis of:
      I. the List of Insured provided to us by the Insured;
      II. complete, correctly completed Declaration of Accession;
      III. other documents, if they were indicated by us as necessary for concluding the Agreement.
   b. independent completion by the Insured of an electronic e-declaration form. Persons registered for the Agreement are covered by us on the basis of:
      I. complete, correctly completed e-declarations;
      II. other documents, if they were indicated by us as necessary for concluding the Agreement.

2. During the term of the Agreement, new persons may be registered for insurance on the basis of the documents described in section 1.
3. The first List of Insured persons together with all required documents or the completion by the insured of the electronic e-declaration form together with all required documents referred to in par. 1 should be submitted to us no later than 10 business days before the first day of the Agreement. The submission of the List of insured persons or the completion by the insured of the electronic e-declaration form in each subsequent month should be submitted no later than 10 business days before the end of the calendar month.
4. The protection period begins in relation to the insured persons registered under the first List of insured persons or registered via the electronic e-declaration form on the day indicated on the Policy. The accession of a new person during the term of the Agreement shall take place on the first day of the calendar month following the date on which we receive the List of insured persons or the completion by the person registered for insurance of the electronic e-declaration form, provided that the deadline referred to in section 3. In the event of the submission of the List after this date, we shall consider it to apply to the following month. The date on which the person joins the Agreement shall be the beginning of their Protection Period.
5. For all Modules excluding: Outpatient Care, Occupational Medicine, Coordination of Hospital Care and Personal Accident Insurance, we may require verification of the health condition of the person to be enrolled in the Agreement.
6. At the stage of verifying the health status of the person enrolled in the Agreement, we may ask for additional documents or information, including, at our expense, referring enrollees for additional medical examinations. Based on the assessment of the health condition of the notified person, we may:
   a. accept him/her in the Agreement;
   b. propose revised terms and conditions of the Agreement;
   c. refuse to accept the Agreement.
7. During the term of coverage, the Insured may change the Module under the Hospital Insurance and the Variant in the Serious Illness Insurance Module, as long as they are covered by the respective Agreement with the Policyholder and such change means an increase in the existing scope of cover. Increasing the existing scope of insurance under the Hospital Insurance shall mean a change of:
   a. Module LUX MED Hospital Insurance Orthopaedic Care for the LUX MED Hospital Insurance Module Orthopaedic Care Plus, or
   b. Module LUX MED Hospital Insurance Orthopaedic Care Plus for Module LUX MED Hospital Insurance Full Care, or
   c. LUX MED Hospital Insurance Module Orthopaedic Care for the LUX MED Hospital Insurance Module Full Care.

   Increasing the existing scope of Insurance under the "Serious illness Insurance" Module means changing Option 1 to Option 2 within this Module.
8. A change in the scope of coverage to a lower one is possible on the Anniversary, provided you notify us in accordance with §6 section 3 of the General Part of the GTC. If the Policyholder chooses the form of the Policyholders completing the electronic e-declaration form themselves, the condition for changing the insurance scope of a given Policyholder is the additional acceptance by the Policyholder of the change for which the Policyholder has applied via the e-declaration.
9. The change of the insurance scope by the Insured, referred to in paragraph 7, is possible:
   a. in the event that the Insured chooses the traditional form of paper Declarations of Accession, provided that:
      I. the Insured provides a list of persons changing the insurance scope in the format specified by the Insurer;
      II. complete and correctly completed Declarations of Accession.
   b. in the event that the Insured chooses the form of the Insured completing the electronic e-declaration form independently, provided that:
      I. the Insured reports the intention to change the insurance scope by means of the e-declaration;
      II. the Insured accepts the change proposed by the Insured and submits the consent to the change to the Insurer.
10. Deferred periods caused by an increase in the scope of insurance under the Hospital Insurance or a change of the Variant under the "Serious Illness" Module are described in the individual Modules.

§7 How to report the withdrawal of the Insured from the Agreement during its term?

1. During the term of the Agreement, the Policyholder may report persons who withdraw from the Insurance through the List of Insureds.
2. Withdrawal of a person during the term of the Agreement shall occur on the first day of the calendar month following the date of receipt of the List of Insureds, provided that the deadline referred to in §6 section 3 of the General Part of the GTC is met. If the list is submitted after that date, we shall assume that it relates to the following month.
3. The Main Insured's withdrawal from the Agreement shall be considered to be the end of the Period of Coverage with respect to the enrolled Co-Insureds, effective at the end of the Main Insured's Period of Coverage.
4. 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 or the employment of the Co-insured Person by the Policyholder.

§8 For how long is the Agreement concluded and what are the conditions for its extension?

1. The Agreement shall be concluded for a period of 12 months.
2. The contract is renewed and the insurance cover is extended for another 12 months, subject to sections 3-9.
3. When renewing the Agreement for another annual period, we have the right to propose a change in the amounts constituting the premium in connection with indexation of the sums insured or an increase in the value of healthcare services. Indexation is intended to adjust the value of Sums Insured to the increase in consumer prices. The increase in the value of Health services reflects the increase in our costs associated with the Benefits we provide under the Agreement.
4. Indexation of Sums Insured shall consist in their increase by the indexation index. We set the indexation rate at a level higher by up to 3 percentage points than the consumer price index published by the Central Statistical Office (GUS) for 12 months, no later than 6 months before the date of submission of the proposal for a new amount of amounts constituting the premium.

5. The increase in the value of healthcare services is calculated based on the claims history of a given Agreement and changes in the costs of remuneration in the healthcare sector published by the Central Statistical Office (GUS).
6. In the proposal to change the amounts constituting the premium, we can indicate the indexed value of Sums Insured, the index of increase in the value of healthcare benefits, and the amounts constituting the premium resulting from the introduced changes.
7. We will send a proposal to change the amounts constituting the premium at least 60 days before the end of the term of the Agreement.
8. The Policyholder's failure to respond within 30 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 any change to the Agreement. If the Policyholder does not agree to change the amounts comprising the Premium, the Agreement will expire at the end of the period for which it was concluded.
9. The Agreement will not be renewed and the insurance cover will be extended if, at least 30 days before the end of its term, at least one of the Parties makes a statement to the other Party expressing disagreement with the extension.
10. The Agreement shall be terminated:
    a. on 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 section 2 of the General Part of the GTC;
    c. on the date of termination of the Agreement in accordance with §9 section 3 of the General Part of the GTC;
    d. upon the expiry of the notice period for termination of the Agreement in the case referred to in § 9 section 4;
    e. on the last day of the period of the Agreement, if it is not extended for another 12-month period according to section 9;

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

1. The Policyholder has the right to withdraw from the Agreement within 7 days of its conclusion. In such a case, we shall refund the Policyholder 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 Policyholder shall have the right to terminate the Agreement at any time, with a one month notice period with effect at the end of the calendar month. The Policyholder may also indicate another later date. The termination notice should be sent to the address of our registered office: 02-678 Warsaw, ul. Szturmowa 2 or in electronic format to: ubezpieczenia@luxmed.pl.
3. The Agreement shall be deemed terminated if the Policyholder 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.
4. The Policyholder may request that the Module be withdrawn from the scope of the Agreement no later than 30 days before the expiry of the 12-month term of the Agreement. On this basis, the Insurer shall prepare an annex to the Application. The Agreement consisting in the withdrawal of a Module from the scope of the Agreement shall be amended on the date indicated in the annex to the Application. We confirm the change in the form of an annex to the Policy.

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

1. Whichever occurs first, the Insured shall be covered by insurance under the Agreement:
    a. until the date of termination of the Agreement, in accordance with § 8 section 10 of the General Part of the GTC;
    b. on the date of death of the Insured;
    c. up to the date of withdrawal of the Insured from the Agreement in accordance with §7 section 3.
    d. for individual Modules, until the last day of the Coverage Period, in which the Insured has reached the age indicated in the table of §2 section 20, as the maximum age until which we provide Insurance coverage. The maximum age of the Insured entitling to our cover varies depending on the Module;
    e. for individual modules, until the date of exhausting the sum insured or the quota limit, if specified for the Module concerned.

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

1. The amount of prices of individual types of Insurance under the Insurance Agreement (comprising the amount of premium), frequency and dates of premium payment are specified in the Policy.
2. The amount of the Premium depends on:
    a. the Insurance option chosen by the Insureds;
    b. the gender and age structure of the group of persons enrolled in the Agreement;
    c. our risk assessment, if applicable;
    d. grace period
3. The amount of premium due from the Policyholder shall be calculated on the basis of the sum of premiums for the Insureds and on the basis of the sum of premiums for selected types of Insurance, taking into account the joining parties and the persons withdrawing from Insurance in a given month of coverage.
4. The date of payment of the Premium shall be the date on which we receive the entire amount due on our bank account specified in the Policy.
5. If the amount paid is lower than the amount of Premium due, the Premium shall be deemed unpaid.

§12 What obligations do we have towards the Policyholder and the Insureds?

1. We shall provide the Policyholder with the GTC, together with appendices prior to the conclusion of the Agreement. Please refer to the Table of Contents of this document for a detailed list of appendices. We will oblige the Policyholder to submit the GTC together with appendices to the Insured Persons before they submit a declaration of joining.

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

3. We shall inform the Policyholder, not later than within 14 days, about any 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, including the provision of Benefits, correctly and in a timely manner.

§13 What are the obligations of the Policyholder and the Insured towards us?

1. The Policyholder and the Insured 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 Policyholder's or Insured's responses to particular queries, the omitted circumstances shall be considered irrelevant.

2. The Policyholder is obliged to:
   a. pay a Premium in the amount and within deadlines specified in the Insurance Policy,
   b. provide us with complete Lists of Insureds 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 Insureds and the Policyholder, specified in the Insurance Application;
   e. deliver to the Insureds the terms and conditions of the Agreement, including in particular the GTC, prior to the Insureds' consent to receive insurance coverage, if such consent is required by the Agreement or if the Insured agrees to pay a part of the Insurance Premium cost before giving his/her consent. This obligation shall also apply to the delivery of documents introducing any changes to the Agreement during its term;
   f. inform us about the death of the Insured;
   g. inform the Insureds about the change of the Phone Line number under which the Insured may obtain information about the insurance and about the changes concerning the Operator.

3. The Insured is obliged to:
   a. comply with the Physicians' recommendations;
   b. comply with the rules applicable in Outpatient Clinics and Hospitals;
   c. follow the instructions of the staff of Outpatient Clinics and Hospitals;
   d. comply with the deadlines for the performance of Services agreed with us;
   e. arrive at the Hospital or Outpatient Clinic indicated by us within an agreed deadline or inform 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 shall inform the Operator about the cancellation immediately after the reason for the cancellation has arisen;
   f. refrain from any actions hindering or preventing the provision of the Service;
   g. present an identity document with a photograph before the performance of the Service. Where the beneficiary of the benefit is a minor child, an accompanying adult may also be asked to produce an identity document.

§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 in the cases) 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 methods of treatment or alternative, traditional and oriental medicine, use of drugs that have not been authorised for use in Poland (or outside of territory of Poland but, exclusively, in connection with the Module of Serious Illness Treatment abroad- BEST HELP)) and their consequences, as well as the Insured's participation in medical experiments, clinical trials or similar health-related research and their consequences;
   c. transplantation of organs or tissues, cells, cell cultures (cultivated naturally or artificially), including those involving an autograft or implants and insertion devices, whereby this exclusion shall not apply to the Module of Serious Illness Treatment abroad- BEST HELP;
   d. competitive practice of sports by the Insured Person, requiring physical activity, including participation in club, union or sports association training, practicing sports for profit, participation in sports competitions, as well as participation in fitness or training camps of a sports nature. In addition, it covers trips to places with extreme climatic or natural conditions, with this exclusion not applying to the Treatment of Serious Illnesses Abroad Module – BEST HELP. Competitive practice of sports does not include:
      I. recreational practice of sports disciplines in free time, the purpose of which is exclusively rest, regeneration of psychophysical strength or maintaining good health;
      II. participation in amateur sports competitions, i.e. sports events intended for individuals or teams not formally affiliated, organized outside clubs, leagues, unions or sports associations;
   e. practicing high-risk sports, i.e. those whose practice involves a particular risk to health. Under the GTC, we consider such sports to be:
      I. air sports and piloting any motor aircraft;
      II. ballooning,
      III. all types of parachuting,
      IV. bungee jumping,
      V. mountain biking,
      VI. motor sports and motor boating,
      VII. jet skiing,
      VIII. kite surfing,
      IX. mountaineering,
      X. high-mountain climbing, rock climbing, wall climbing,
      XI. caving,
      XII. mountain cave climbing,
      XIII. ski jumping,
      XIV. snowboarding and skiing except for recreational skiing/snowboarding on designated routes,
      XV. bobsleighing,
      XVI. rafting and other water sports undertaken on mountain rivers,
      XVII. diving with the use of specialist equipment,
      XVIII. martial arts,
      XIX. hunting,

XX. horse riding

The above exclusion does not apply to the Treatment of Serious Illnesses Abroad Module – BEST HELP.

f. state of emergency due to natural disaster, natural catastrophes, pandemic and epidemic announced and confirmed by the competent state administration authorities;
g. the impact of nuclear energy, radioactive radiation, electromagnetic field and biological and chemical agents harmful to a human;
h. 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);
i. the Insured attempting to commit suicide, self-harm, deliberately cause a health disturbance;
j. committing or attempting to commit a crime or an offence;
k. wilful misconduct, self-diagnosis, self-treatment or modification of the prescribed treatment or gross negligence of the Insured;
l. 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;
m. detoxification, detox procedures and treatment;
n. treatment of mental health illnesses, disorders and other forms of mental disturbances, including Alzheimer's disease, and their consequences;
o. obtaining medical services through prohibited acts, extortion attempts or deliberately misinforming the Insurer.

2. Taking into account medical safety standards, the Outpatient Clinic or Hospital may provide the Service to a particular patient with priority over other patients.

3. The Outpatient Clinic or Hospital shall have the right to deny the Insured a Service if he/she violates by his/her behaviour the rules of social intercourse or the organisational regulations of the Clinic or Hospital, as well as if he/she impedes the work or functioning of this facility or its staff. If the above action is persistent, we reserve the right to exclude the Insured from cover with effect at the end of a given calendar month.

4. We shall not provide the Service if, as a result of a state of emergency due to natural disaster, natural disaster, pandemic or epidemic announced and confirmed by the competent state administration authorities, we are unable to provide Services.

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

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

§15 Can the Insured continue the insurance when he/she ceases to be covered by the Agreement?

1. The Insured who ceases to be covered by the Agreement on the basis of these GTC in connection with:
   a. withdrawal of the Insured from the Agreement and, with respect to the Co-insured, withdrawal of the main Insured from the Agreement;
   b. termination of the Agreement

   may continue insurance cover for outpatient care or hospital insurance of LUX MED full care in the form of an individual Agreement entered into by the Insured directly with us.

2. In order to continue the insurance cover, you should contact us by phone: (22) 339 37 33 and apply for the conclusion of an agreement, no later than within 30 days of the end of the insurance coverage provided on the basis of these GTC.

3. The individual insurance agreement shall be concluded in accordance with the General Terms and Conditions of Insurance in force on the date of its conclusion. We will present it to the applicant before concluding an individual insurance Agreement. Concluding an agreement which constitutes continuation of insurance coverage does not require an individual risk assessment and we include the insurance period under the group agreement as insurance periods in the provisions limiting our liability under individual agreements. We will present detailed terms and conditions of providing insurance coverage under an individual agreement in the General Terms and Conditions of Insurance.

§16 Processing of personal data and entrusting data of the Insureds

1. Within the framework of cooperation between the Insurer and the Policyholder, data of the Insureds will be processed. Subsequently, in order to enable the Insureds to join the insurance coverage, including correct verification of their identity by the Insurer, the Policyholder, at the request of the Insurer, collects personal data of the Insureds and transfers it to the Insurer in a manner agreed by the Parties, i.e. by preparing a list of the Insureds or collecting the declarations of joining filled out by the Insureds. Therefore, in order to properly regulate the process described, it is necessary to conclude an additional agreement on entrusting the personal data to be processed. For the avoidance of doubt, the provisions of this paragraph in sections 1 to 34 shall be deemed the indicated agreement.

2. The processing of personal data is governed by the provisions of Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation) (hereinafter referred to as the '**Regulation**'). When processing the personal data of the Insureds for the purpose and to the extent referred to in section 1 above, the Policyholder shall act as a data processor within the meaning of Article 4(8) of the Regulation, at the request of the Insurer, in accordance with Article 28 of the Regulation..

3. LMG represents that, as an entity conducting insurance activity, it processes the personal data of the Insureds for the purpose and to the extent necessary for the performance of its obligations under the Insurance Agreement and acts in relation to such data as a controller within the meaning of the provisions of the Regulation.

4. LMG orders and the Policyholder accepts the processing of the Insured's data for the purpose, to the extent and on the terms and conditions of the Agreement.

5. For the avoidance of doubt, for the performance of the obligations under the Insurance Agreement, the Policyholder shall not be entitled to any additional remuneration within the scope of entrusting the processing of personal data, as specified in this clause.

6. The Policyholder shall not decide on the means or purposes of processing of the entrusted data.

7. The processing of personal data by the Policyholder shall consist in the collection of such data and their structuring in the form of a list, and transfer of the data to LMG on the list in the manner agreed by the Parties in the Insurance Agreement or in accordance with additional instructions provided by LMG, and in the event that the Policyholder, on an LMG's instruction, collects declarations on joining the insurance cover – also collection and transmission of such declarations to LMG. The Policyholder shall be obliged to transfer personal data in accordance with the security requirements resulting from the Regulation; in particular, when transferring personal data on lists, the Policyholder shall be obliged to encrypt them. The Policyholder shall be also obliged to enable persons entitled to join the insurance cover whose data are provided to LMG to read the LMG information clause constituting Appendix No. 5 hereto, subject to the principles of accountability, including among others, by making it available on the Insurer's intranet or providing the clause together with other information on the terms and conditions of insurance. The Policyholder declares to provide the Insurer with personal data of only such persons, i.e. Insureds who have been informed by the Policyholder about being covered by insurance coverage and who have fulfilled the information obligation on behalf of the Insurer (fulfilment of the obligation under Articles 13 and 14 of the Regulation by the Policyholder on behalf of the Insurer).

8. Depending on the Parties' arrangements concerning the rules of registration of Insureds for insurance cover purposes in accordance with the provisions of the Insurance Agreement and LMG's instructions, the personal data entrusted for processing shall include:
   a. details of the Main Insureds to the extent necessary for the Insurer to correctly establish their identity and thus verify their rights to access insurance coverage, i.e. name, surname, e-mail address or telephone number, Personal ID No. (PESEL), date of birth (in the case of persons without a Personal ID No. (PESEL)) – if the insurance application is made via the online platform made available – in such a case, the entrustment shall not include personal data of the Co-insured if the Policyholder does not have access to them (if this entrustment is also applicable to Co-insured);
   b. b) personal data of the Main Insureds and Co-insureds to the extent necessary to identify them and to include them in the insurance cover, i.e. first name, surname, personal ID No. (PESEL), date of birth, gender, and if the Insured is a foreign national – also the passport number and information about the nationality, address of residence, telephone number, e-mail address, and in the case of Co-insureds, also information about the relationship/kinship with the Main Insured. This applies to cases where the Policyholder acts as an intermediary in the collection of declarations on joining the insurance care and/or transfers personal data within the scope indicated in this provision on an LMG's instruction by means of the registration lists.

9. If this is required for the proper performance of the Policyholder's obligations resulting from the entrustment, the Policyholder may further entrust the processing of data. The Policyholder's right to entrust personal data for further processing shall not include the transfer of personal data to a third country within the meaning of the Regulation. The condition of further entrustment of personal data by the Policyholder within the European Economic Area is the prior communication of this fact to LMG and the Policyholder's representation that the entity to which the personal data are to be entrusted meets the requirements referred to in Article 28 of the Regulation and this is guaranteed in a data sub-processing agreement. The authorisation referred to in this section shall not preclude insurer's right to object to further sub-entrustment; the Insurer may express the objection within 5 business days of being informed of the intention to sub-entrust. Failure by LMG to respond within the time limit referred to in the preceding sentence shall mean no objection.

10. If the Processor intends to further entrust the processing of personal data as a result of which personal data are transferred to a third country, the Processor shall obtain the prior consent of LMG granted in written, electronic or documentary form via e-mail. To this end, the Policyholder is obliged to provide the Insurer with information on the basis of the data transfer, as required in Chapter V of the Regulation and, if applicable, information on supplementary measures which may be introduced to ensure an adequate level of protection of the entrusted data, and to provide any additional information that may be necessary for LMG to decide whether to grant the Policyholder consent to use the services of a processor from a third country or not.

11. The processing of personal data by the Processor is systematic and takes place in monthly cycles for the purposes of reporting groups of Insureds to be covered by insurance cover in particular insurance periods.

12. The Policyholder shall be entitled to process the Insureds' personal data entrusted to it for the period necessary for collecting the data and transferring them to LMG on individual lists and within the framework of the collected declarations (insofar as they are collected by the Policyholder), but for not longer than until the date of termination of the Parties' cooperation in this respect.

13. Upon sending a list containing the personal data of the Insureds registered for insurance purposes within a defined insurance period, the Processor shall be obliged to immediately erase the personal data of the Insureds whose data has been provided by it to LMG.

14. For the avoidance of doubt, on the date of termination or dissolution of the Insurance Agreement, the Policyholder shall also permanently delete all the entrusted personal data from all media available and used for the data processing. LMG shall have the right to request that the protocol of deletion of the entrusted personal data by the Policyholder be made available.

15. Access to the personal data entrusted to the Policyholder may be granted only to the employees or collaborators of the Policyholder who have been authorised by the Policyholder to process such data, preceded by the submission by those persons of a declaration of confidentiality of such data and of the ways of keeping them confidential.

16. The Policyholder is obliged to ensure personal data security by implementing relevant technical and organisational measures, appropriate to the category of the entrusted data and to the risk of infringing the rights of data subjects.

17. The Policyholder is obliged to cooperate with LMG in responding to data subjects' requests described in Chapter III of the Regulation (in particular information and transparent communication, access to data, information obligation, right of access, right to rectification of data, erasure of data, restriction of processing, right to data portability, right to object). To this end, the Policyholder is obliged to inform the Insurer of any request of the Insured within the exercise of his/her rights under the Regulation and to provide Insurer with all necessary information in this regard.

18. Taking into account the nature of the processing of the entrusted data and the information available to the Policyholder, the Policyholder is obliged to assist LMG in the latter's fulfilment of obligations as regards data security, management of personal data breaches and their reporting to the supervisory authority and the data subject, data protection impact assessment and consultation with the supervisory authority (Articles 32-36 of the Regulation).

19. The Policyholder shall immediately, not later than within 24 hours after becoming aware of a personal data security breach, inform LMG in electronic form, to the following email address: daneosobowe@luxmed.pl. The information provided shall include at least:

a. describing the nature of the personal data breach and, if possible, the categories and approximate number of data subjects concerned, as well as the categories and approximate number of personal data records concerned;
b. communicating the name and contact details of the data protection officer or other contact point or contact person as regards the personal data breach;
c. describing the likely consequences of the personal data breach;
d. describing the measures taken or proposed to be taken by the Policyholder to address the personal data breach, including measures aimed at mitigating its possible adverse effects.

20. The notification referred to in section 19 above should be sent in a manner that ensures the security of the personal data transferred, i.e. in an encrypted, password-secured file. The file password should be sent to the telephone number provided by LMG.

21. A change of email address referred to in section 5 above or a change of the manner of notifying LMG of personal data breaches may be made by email or letter and does not constitute any amendment to the Agreement.

22. The email address referred to in section 19 above is also the contact address of LMG to which the Policyholder may send any information and raise any issues related to the processing of personal data entrusted under the Agreement, including in particular the notifications referred to in § 16 section 10 of the GTC.

23. The Policyholder undertakes to regularly monitor changes in personal data regulations and to adapt the manner of data processing (in particular internal procedures and security measures) to the current legal requirements.

24. The Policyholder shall be liable for the acts or omissions of the persons used by him to process the entrusted personal data as for its own acts or omissions.

25. The Policyholder shall provide Policyholder with all the information necessary for Policyholder to demonstrate compliance with the obligations specified in the Agreement these GTC and in provisions of law, in particular the Regulation.

26. LMG shall be entitled to audit the compliance of the Policyholder's processing of the entrusted personal data with the provisions of the Regulation, acts, the Agreement; in particular the audits shall consist in the right to request written information or explanations and, where appropriate, the right to inspect locations where the Policyholder processes personal data. The Policyholder is entitled to refuse to provide written information or explanations or to grant access to the location of personal data processing, if the audit could result in the disclosure personal data other than those processed by the Policyholder under the Agreement. In such a case, the Policyholder is obliged to justify his position in writing in a clear and exhaustive manner.

27. The Policyholder shall be notified of a planned inspection at least 7 days in advance, with an indication of the scope of the inspection and the persons authorised by the Insurer to conduct the inspection. This does not preclude an inspection being commissioned by a third party authorised by LMG; however, each person acting on the third party's behalf may conduct the inspection only upon presenting to the Policyholder a named authorisation to conduct the inspection and solely to the extent provided for in the authorisation. If the scope of the inspection or inspection tools presented by Insurer constitute a breach of data protection legislation by the Policyholder, the Policyholder shall be entitled to oppose to Insurer carrying out the inspection and, at the same time, it shall be obliged to immediately communicate the fact to the Insurer in electronic or written form.

28. The right of audit referred to in sections 25-27 above shall be exercised by LMG not more frequently than once a year, with a stipulation that if there are circumstances raising reasonable doubts as to the compliance of the processing of the data entrusted to the Policyholder with the law and the provisions of the Insurance Agreement or in the event of a personal data security breach, LMG shall have the right to initiate an additional inspection, which will not be subject to the quantitative limit referred to in the first sentence.

29. LMG shall have the right to give the Policyholder instructions as to the manner in which the entrusted data are to be processed and as to the technical and organisational measures applied by the Policyholder to protect the entrusted personal data. The Insurer's recommendations are not binding for the Policyholder; however, an issued recommendation obliges the Policyholder to verify the possibility of implementing it into the internal procedures governing personal data processing. In the event of their implementation, recommendations issued by Insurer must not provide for any breach of law by the Policyholder.

30. The Policyholder is obliged to immediately inform the Insurer of any complaints, letters, inspections of a supervisory authority, court and administrative proceedings related to the entrusted personal data and to cooperate with Insurer in this regard, in particular by providing Insurer with any documentation related to this matter.

31. The Policyholder shall be liable for the acts or omissions of the persons used by it to process the entrusted personal data as for its own acts or omissions.

32. In the event that, due to the processing of the personal data entrusted to the Processor in breach of the Regulation for reasons attributable to the Processor (fault), the Insurer incurs any costs, in particular costs related to the payment of compensation or legal costs, the Processor shall be obliged to cover these costs in their full amount and, in the event that court proceedings are initiated, the Processor shall be obliged to provide the Insurer with all the support in these proceedings and to indemnify the Insurer in the event of granting a data subject compensation in such proceedings, in the amount equal to the compensation granted or to the costs of remedies, and to cover any necessary costs of defence against such claims incurred by the Insurer in such proceedings.

33. In addition, separately from the above provisions governing the Insurer's entrustment of the Policyholder with the processing of data of the Insured Persons, as part of the performance of the Agreement, the Parties shall also process the data of the persons appointed for current contact and representation, including the data of employees and collaborators. For the avoidance of doubt, each Party shall process data of the persons appointed by the other Party for the ongoing performance of the Agreement as a separate and independent administrator, in accordance with Article 6(1)(f) of Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC, i.e. on the basis of the administrator's legitimate interest in ensuring proper representation of the entity and contact in current matters related to cooperation between the Parties and performance of the Agreement. The scope of personal data that is exchanged between the Parties includes: first name, surname, business email address, business telephone number, position held in either Party's organisation.

34. Each Party shall be obliged to apply the provisions of the Regulation in respect of the data referred to in paragraph 33, including the fulfilment of the information obligation towards the persons designated to represent and contact the other Party whose data it processes. The Insurer's information obligation clause constitutes Appendix no. 5 to the GTC. The Policyholder undertakes to communicate the said clauses to the persons designated for representation and contact purposes, thus fulfilling the obligation under Articles 13 and 14 of the Regulation.

§17 How can a complaint be lodged?

1. Complaints related to the conclusion or performance of the Agreement may be lodged by the Policyholder or by the Insured:
   a. via the form available at: https://www.luxmed.pl/zgloszenie¬reklamacji¬ubezpieczenia;
   b. electronically – to the following email address: reklamacje.ubezpieczenia@luxmed.pl;
   c. in writing – by mail to the address of our registered office: LMG Försäkrings AB S.A. Branch in Poland, 02-676 Warsaw, ul. Szturmowa 2, or by submitting a written complaint at our registered office;
   d. orally – by telephone to the following telephone number: (22 501 81 60 or in person on a written record when visiting our premises.
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 will respond in writing or by email (if the complainant so requests), maximally within 30 days from the date of receipt of 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, the Policyholder and the Insured 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. Matters not regulated in the GTC shall be governed by generally applicable laws in force in the territory of the Republic of Poland.
2. Any action for claims under the Insurance Agreement can be brought either under the general jurisdiction law or before a court:
   a. for the place of residence or registered office of the Policyholder, or
   b. for the place of residence of the Policyholder, or
   c. the place of residence or registered office of the Eligible Party, or
   d. the place of residence of the Insured's heir or the Eligible Party's heir.
3. Requests, representations and notices to us that relate to the performance of this Agreement may be made at: 02-676 Warsaw, ul. Szturmowa 2 or in electronic format to: ubezpieczenia@luxmed.pl.
4. Any amendments to the Agreement must be made in writing or in documentary form, otherwise being null and void.
5. Claims regarding 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 Insurer is subject to supervision by the Polish Financial Supervision Authority as regards compliance of its activities with the provisions of Polish law. The sole supervision over the Insurer's financial management is exercised by the Swedish regulator.
7. Correspondence related to the Agreement shall be sent to the last known address of the Parties to the Agreement.
8. The clauses constituting Annex no. 6, which the Policyholder and the Insurer undertake to comply with, constitute an integral part of the General Terms and Conditions of Insurance.
9. These GTC have been adopted and approved by a resolution of the Management Board of the Insurer and shall apply to the insurance Agreements concluded as of **16.12.2024.**

Module: Outpatient Healthcare

The provisions of this Module shall apply to insurance agreements concluded on the basis of GTC, which cover the Outpatient Care Module. Inclusion of the Module in the Insurance Agreement shall be decided by the Policyholder.

§1 What is the subject matter of the Agreement?

1. Under the Module, we provide outpatient and cash benefits in the event of justified medical reasons.
2. Depending on the scope specified in the Agreement, the Insured may make use of:
   a. outpatient services – a full list of outpatient services available under the insurance agreements concluded under the GTC is set out in Appendix No 1 to the GTC.
   b. cash benefits – up to an appropriate percentage of the sum insured in accordance with sections 3 and 4.

   PLEASE NOTE! Appendix 1 to the GTC contains a list of all benefits that we can offer within the Module. The scope of benefits provided by us under a specific Insurance Agreement depends on the option selected by the Policyholder. The options and scopes of benefits available under a specific Insurance Agreement are specified in the appendix to the Policy.
3. Changing the Module variant from a higher to a lower one is only possible on the Anniversary. Changing the Module variant from a lower to a higher one is possible at any time during the Protection Period and starts on the 1st day of the month following the submission of the Insured List to us.
4. The sum insured in the Outpatient Care Module is equal to the cost of healthcare services arranged during the insurance coverage period and paid by the Insured. Health services whose partial or total reimbursement is covered by insurance are consistent with the scope of outpatient benefits made available to the Insured under the Insurance Agreement concluded on the basis of the GTC, subject to §3 paragraphs 4 and 5.
5. The amount of the Cash benefit we pay to the Insured is calculated as a percentage of the sum Insured in accordance with the Policy Schedule, provided that the total amount of Cash benefits we pay to one Insured may not exceed quarterly the limit stated in the Policy Schedule.
6. The Outpatient Care Module is available in the following types:
   a. Individual,
   b. Partner,
   c. Family,
   d. Parent.

   The Policyholder may choose all or selected types of Module which will be available to the Insureds under the Agreement.
7. The scope of services under the Outpatient Care Module does not include health services provided for life saving purposes in accordance with the Act of 8 September 2006 on State Medical Emergency.
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.luxmed.pl/placowki.

§2 How can the Outpatient Care be used?

1. In order to benefit from the Outpatient service, the Insured may report the event to the Operator and agree on the place and date of the Service in the following manner:
   a. electronically via the Patient Portal (online portal made available by the Operator);
   b. by phone via the hotline (telephone available at www.luxmed.pl);
   c. personally in one of the clinics indicated by us at www.luxmed.pl/ubezpieczenia;
2. The Insured chooses the service term and the Clinic where he/she wants to use Outpatient Service from the list of clinics indicated by us. The Clinics provide the Services with their opening hours and the scope of operation of a given Medical Facility.
3. We request that the Insured revoke the appointment for the provision of outpatient services agreed with the Operator, if the Insured cannot use it at the agreed time. This will enable other people to use the services of the Clinic. The revocation of the appointment may be made in any way, like in the case of notification of the Event.
4. In the event of doubts as to the medical justification or lack of medical safety of the medical procedure resulting from the referral submitted by the Insured Person, we have the right to verify the justification of the medical referral submitted by the Insured Person.
5. In the event of verification of the referral submitted by the Insured Person, we may request access to medical information related to the issued referral.
6. We will refuse to provide the Outpatient Service resulting from the referral in the event of:
   a. the medical referral is unjustified,
   b. the medical procedure resulting from the referral is unsafe, or
   c. failure to provide us with access to medical information and, as a result, the impossibility of verifying the referral.
7. In order to receive a Cash benefit the Insured may notify us in the following forms:
   a. electronically – to the following email address: roszczenia.ubezpieczenia@luxmed.pl;
   b. in writing – by sending documents to the following address: LMG Försäkrings AB S. A. Branch in Poland, 02-676 Warsaw, ul. Szturmowa 2, with the following note: LMG reimbursement.
8. In order to decide on the payment of the Benefit, we need the following documents:
   a. a complete and properly completed application for the Benefit payment;
   b. a copy of the bill or invoice for the healthcare service provided, which meets the requirements set out in section 9;

c. in the case of services which, in accordance with the Insurance Agreement require referral as an outpatient benefit, please attach a copy of the referral to a healthcare service. In the absence of such a copy, a copy of the Insured's medical records containing an appropriate annotation of the referral may also serve as proof of the referral;
d. In the case of rehabilitation – additionally, please attach a copy of medical documentation concerning the illness which is the reason for the rehabilitation order.

9. The invoice or receipt should include:
   a. details of the Insured to whom the healthcare services were provided (at least: full name, address). In the event that services are provided to a child, the invoice should be issued for the de facto carer or legal guardian of the child, and should include the data of the child for whom the services were performed;
   b. b)a list of services performed for the Insured (indicated in the invoice) or an attached specification issued by the Medical Facility providing these services, indicating description of the service, or a copy of the medical record related to the specific service provided;
   c. the number of a specific type of services provided;
   d. service performance date;
   e. service unit price.

10. If the value of invoices attached to the application exceeds the limit available in a given quarter, the payment of the pecuniary benefit shall be made up to the limit remaining in that quarter. The cost of the healthcare services provided cannot be counted towards future quarters and limits. The unused limit in a given quarter shall not be transferred to the following quarter.

11. If the health services covered by the Agreement are limited, e.g. as to the number of times they are performed, the limit is counted jointly for health services performed in the form of both an Outpatient Service and a Cash Benefit.

12. If health services are combined (e.g. psychotherapy for couples), the condition for payment of the Cash Benefit is that all Insureds using the service are eligible for such outpatient Benefit under the Agreement. In such a case, the amount of cash Benefit paid shall be calculated pro rata for each Insured and deducted from the quarterly limit.

13. We provide the benefit immediately upon receipt of the notification, at the latest within the time limits and in accordance with the principles described in §4 sections 2-5 of the General Part of the GTC.

§3 What are the additional exclusions from the coverage that will prevent us from implementing the Benefits within the Module?)

1. In addition to the exclusions set out in §14 of the General Part of the GTC, our liability for the Outpatient Care Module does not include:
   a. diagnosis and treatment of fertility disorders, including pregnancy resulting from the aforementioned proceedings, if it is a High-Risk Pregnancy;
   b. gender- adjusted diagnosis and treatment;
   c. performance of abortions and treatment of their consequences;
   d. High-Risk Pregnancy care;
   e. prosthetic, orthodontic, periodontal and implant diagnoses and treatment;
   f. diagnosis and treatment as well as procedures and surgeries in aesthetic medicine, plastic surgery and cosmetology, as well as treatment of adverse effects of the procedures specified in the previous sentence;
   g. diagnosis and treatment which is not ordered or not performed in the Facilities indicated by the Insurer;
   h. issuance of certificates, statements, applications not related to the necessity of continuation of the diagnostic and therapeutic process conducted in the facility indicated by the Insurer (exclusion does not apply to occupational medicine services – if covered by the Insurance, ZUS ZLA forms);
   i. 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 is staying;
   j. treatment of infection with HIV or hepatitis (with the exception of hepatitis A) and diseases resulting from those infections;
   k. events resulting from the Insured's 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. If the Services to be provided to the Insured exceed the scope of Medically Necessary Services, the Insurer may limit the medical Services to the Medically Necessary Service accordingly or to provide paid service after obtaining the consent from the Insured.

3. We are not responsible for the provision by the Clinic of Outpatient Services not covered by the Agreement and for services ordered or performed by a Clinic other than the one indicated by us.

4. We will not provide a cash Benefit in respect of services purchased by the Insured together with other services (in a medical package, card, medical subscription) and paid for jointly.

5. The Cash Benefit does not include occupational medicine, jurisprudence, sports medicine, driving licence examinations, aeronautical medicine, home visits, rehabilitation and dental services.

Module: Occupational medicine

The provisions of this Module shall apply to Insurance Agreements concluded on the basis of the GTC, which include the Occupational Medicine Module. Inclusion of the Module in the Insurance Agreement shall be decided by the Policyholder.

§ 1 Definitions used in the Module

1. **Preventive tests** – tests carried out on the basis of a referral issued by the employer. Preventive tests shall consist of:
   a. **Follow-up examinations** – are carried out in the case of each Employee who stayed on sick leave for longer than 30 days;
   b. **Periodic Examinations** – are carried out in the case of Employees working in a given position, whose previous medical certificate of fitness to work expired;
   c. **Preliminary examinations** – are carried out prior to commencing work, after changing positions at work, if new risks occur, or if a new risk occurs at a given position:
   d. **Sanitary and epidemiological examinations** – includes tests (smears) for the presence of Salmonella and Shigella pathogens;
   e. **Specialised and Diagnostic Examinations** – consultations with doctors and additional diagnostic tests performed in the occupational medicine process in accordance with methodological guidelines or at the request of an occupational medicine physician, closely related to the working conditions and hazards occurring at a specific job position.

2. **Occupational Health Service units** – medical facilities which meet the definition of entities referred to in Article 2 section 2 of the Act of 27 June 1997 on occupational health services, cooperating with us in the provision of Occupational Health Services.

3. **Occupational medicine** – protection of employees' health against the impact of adverse conditions related to the work environment, the manner of performing work and in the scope of preventive healthcare for employees.

§2 What is the subject matter of the Module?

1. The scope of the module covers the provision and coverage of costs of preventive healthcare services, as well as other occupational medicine services for employees, which the employer is obliged to provide under the provisions of the Act of 26 June 1974. Labour Code (hereinafter referred to as **Labour Code**).

2. The detailed scope of tests available within the module is indicated in §3 of the Occupational Medicine Module.

3. We will organise and cover the costs of Occupational Medicine services, which include:
   a. Preventive examinations for Employees;
   b. preventive healthcare for employees, necessary due to working conditions, including examinations outside the deadlines for Periodic Examinations and deciding on the possibility of performing the existing work; a referral for an examination shall be issued by the employer after the employee has reported inability to perform the previous work;
   c. issuing medical certificates for the purposes provided for in the Labour Code;
   d. preventive medical examinations for sanitary and epidemiological purposes;
   e. visiting the workplace in order to verify the proper safeguarding of the health conditions of workstations;
   f. participation of the occupational physician in the company's occupational health and safety committee established at the workplace in accordance with the procedure provided for in the Labour Code in cases provided for in the Labor Code.

§3 scope of occupational medicine

1. Basic legislation on preventive care for employees:
   a. the Act of 26 June 1974 Labour Code – Chapter X;
   b. the Act of 27 June 1997 on Occupational Medicine Service;
   c. Regulation of the Minister of Health and Social Welfare of 30 May 1996 on medical examinations of employees, the scope of preventive healthcare for employees and medical certificates issued for the purposes set forth in the Labour Code;
   d. the Act of 5 December 2008 on preventing and combating infections and infectious diseases in humans.

2. For medical purposes, the Operator offers access to:
   a. Centre for the Arranging of Occupational Medicine examinations – a special helpline for the arranging of occupational medicine examinations;
   b. Occupational Medicine Department – a separate premises and personnel team in a Medical Facility dealing exclusively with the provision of health services in the field of occupational medicine.

3. Tests for admission to professional activities:
   a. Preliminary Examinations**;**
   b. Periodic examination
   c. Medical check-ups:
   d. Sanitary and epidemiological examinations.

The purpose of the above tests is to establish that there are no contraindications to work at a particular work station. Medical certificates of the Employee's fitness for work shall be issued by physicians authorised to issue such certificates. The Employer may not admit an Employee to work without a valid medical certificate stating that there are no contraindications to work at a given work station. The responsibility for admitting the Employee to work without valid medical examinations lies with the Employer and not with the Employee.
As part of the Initial, Periodic and Follow-up Examinations, the occupational physician conducts or orders the examinations necessary to issue the Employee with a certificate of fitness to perform work in a given position, as required by the Labour Code, including Sanitary and Epidemiological Examinations.

4. For an additional fee in accordance with the price list applicable on the day of ordering the service, LUX MED provides:
   a. Review of workplaces – occupational medicine doctor, occupational health nurse;

b. Participation of an occupational medicine specialist in the company occupational health and safety commissions;
c. Preparing an opinion for the H&S committee;
d. Helping determine the composition of the first aid kit;
e. Arranging groups of employees reported directly by the employer.

5. Additional service: e-referral.
The service includes access to the Occupational Medicine e-Referral Portal, a system for electronic processing of occupational medicine examination referrals. The system allows:
a. to issue occupational medicine examination e-referrals, including their approval with electronic signature by persons authorised by the employer;
b. to notify Employees by means of a text message that their referral has been issued;
c. to send the original referral document by email to the Employee;
d. to notify persons authorised by the Employer of the occupational medicine examination status;
e. to monitor the expiry of medical certificates issued, including reminders to issue further periodic and follow-up examination referrals for Employees;
f. to create and manage job position templates.

§4 How can the occupational medicine be used?

1. In order to benefit from Occupational medicine benefits and cover their costs, the Policyholder shall issue personal referrals for examination in accordance with applicable laws. The referral shall include:
a. in the case of preventive tests — identification of the type of Preventive Test to be performed (Preliminary Test, Periodic Test or Follow-up test);
b. in the case of persons to be employed or transferred to other workplaces, identification of the workstation at which the examined person is or is to be employed. In this case, the Employer (the Policyholder) may indicate two or more workplaces in the order corresponding to the needs of the enterprise;
c. in the case of Employees – specification of the workstation at which the Employee is employed;
d. information on the presence at the workstation of factors harmful to health or arduous conditions, as well as current results of tests and measurements of factors harmful to health, performed at these workstations;
e. in the case of Sanitary and epidemiological Examinations – an indication of the work carried out by the Employee, where it is possible to transfer infections to other persons.
2. We provide the benefit immediately upon receipt of the notification, at the latest within the time limits and in accordance with the principles described in §4 sections 2–5 of the General Part of the GTC.

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District Court for the Capital City of Warsaw in Warsaw
13th Commercial Division of the National Court Register
KRS: 0000395438
Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

Module: LUX MED Hospital Insurance Orthopaedic Care

The provisions of this Module shall apply to Insurance Agreements concluded on the basis of the GTC, which include the LUX MED Module of Hospital Insurance Orthopaedic Care. Inclusion of the Module in the Insurance Agreement shall be decided by the Policyholder.

§1 Definitions used in the Module

1. **Hospitalisation** – a stay in a hospital ward, aimed at performing diagnostics or treatment, including performance of surgeries due to an Accident. Hospitalisation covers the following:
   a. **Scheduled Hospitalisation** – a stay in a hospital ward which:
      I. takes place within the prescribed time limit;
      II. may be postponed for at least 7 days from the time of confirmation of necessity by the Hospital Physician who qualifies for hospitalisation, provided that the postponement may not exceed the date after which there may be a foreseeable severe deterioration of health or a significant reduction in the chances of recovery.
   b. **Urgent Hospitalisation** - a stay in a hospital ward that should occur in less than 7 days from the time of confirmation of necessity by the Hospital Physician who qualifies for hospitalisation, with the proviso that the time of commencement of hospitalisation may not exceed the date after which there may be a foreseeable severe deterioration of health or a significant reduction in the chances of recovery.

2. **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.

3. **Hospital Care Coordinator (also KOS)** – a representative of the Operator responsible for attendance of the Insured in the performance of the LUX MED Hospital Insurance Orthopaedic Care as part of the Coordination of Hospital Care.

4. **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.

§2 What is the subject matter of the Module?

1. Under the LUX MED Hospital Insurance Module Orthopaedic Care we provide the following benefits:
   a. **Hospital benefit** – medical Benefit related to orthopaedic hospitalisation, provided in the Hospital. The detailed scope of the Hospital Service is described in Appendix no. 2 (Part I, II) and Appendix no. 3 (Part I, II) to the GTC.
   b. **Coordination of hospital care** – aimed at assisting the Insured in the use of the Module, the scope of benefits provided by KOS is described in Appendix no. 2 (Part IV) and Appendix no. 3 (Part II) to the GTC.

2. We provide insurance coverage in respect of events resulting from an accident which occurred during the Insurance period and for which the medical benefit related to hospitalisation in accordance with medical indications should be provided within a period not exceeding 30 days from the date of the Accident.

3. The Insured may use the Hospital Benefit within the Module in the event of receiving a referral for hospital treatment (the date of the Event is the date of issue of the referral).

4. The insured event, the occurrence of which gives rise to the obligation to provide the Benefit on the part of the Insurer, is the issuance of a referral for hospital treatment during the Period of Coverage as a result of an Accident that occurred during the Period of Coverage.

5. The detailed scope of Services referred to in sections 1-3 can be found in the following appendices to the GTC:
   a. Appendix no. 2 to the GTC – scope of Benefits under the LUX MED Hospital Insurance for the Main Insured, Partner and Adult Child;
   b. Appendix no. 3 to the GTC – scope of Benefits under the LUX MED Hospital Insurance for a minor child.

6. We provide the following types of Module: LUX MED Hospital Insurance Orthopaedic Care
   a. Individual,
   b. Partner,
   c. Family.
   The Policyholder may choose all or selected types of Module which will be available to be selected by the Insured under the Agreement.

7. 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.

§3 How to use the LUX MED Hospital Insurance Orthopaedic Care?

1. In order to benefit from the Services, the Insured shall notify the Hospital Care Coordinator [KOS] of the event covered by the Module. The KOS contact details are provided to the Policyholder 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;

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Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

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. Upon receipt of the event notification, we follow the steps described in §4 sections 2–5 of the General Part of the GTC.

§4 What are the additional exclusions from the coverage that will prevent us from implementing the Benefits within the Module?

1. Apart from the exclusions set out in § 14 of the General Part of the GTC, our liability within the LUX MED Hospital Insurance Module Orthopaedic Care 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: Anesthesiology and Intensive Care Unit, Cardiac Intensive Care Unit, Stroke Treatment Unit, Neurological Intensive Care Unit, Asthma Treatment Unit) or with the provision of intensive renal replacement therapy, hepatic dialysis, ECMO, mechanical ventilation, counterpulsation.
   b. rehabilitation other than in a facility indicated by us and listed in Appendix no 2 or 3 to the General Terms and Conditions;
   c. treatment of Multi-Organ Damage and its consequences;
   d. implantation of prostheses or implants other than those listed in Appendix no. 2 or 3 to the GTC;
   e. diagnosis and treatment of congenital genetic defects associated with chromosomal aberrations and congenital defects causing the declared malfunction and their consequences;
   f. diagnosis, treatment and procedures or surgeries also for medical reasons in the field of aesthetic medicine, plastic surgery resulting from non-medical indications and cosmetology, as well as treatment of their undesirable consequences, unless the scope of the Hospital Services provides otherwise;
   g. diagnosis and treatment not provided at Hospitals or Outpatient Clinics designated by us and their consequences;
   h. 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 Services and certificates of incapacity to work or to study);
   i. 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;
   j. home treatment as a continuation of hospital treatment, excluding treatment resulting from procedures covered by and performed under the insurance;
   k. medical care after Hospitalisation within the scope described in Appendices 2 and 3 to the GTC related to Hospitalisation performed in facilities other than those indicated by us;
   l. diagnosis and treatment without medical indications;
   m. treatment resulting from psychological indications;
   n. treatment of mental disorders, dementia, neurodegenerative diseases (including Alzheimer's disease) and their consequences;
   o. services obtained through prohibited acts, extortion attempts or deliberate misinformation.

2. Excluded from coverage is the Hospitalisation which, for medical safety reasons, established on the day of admission to the hospital ward or during the stay, requires simultaneous high and multi-specialty treatment in a medical facility outside the list referred to in §2 section 7 of this Module or its scope goes beyond that described in Appendices nos. 2 and 3 to the GTC.

3. We will not provide a Hospital Benefit to the Insured if it results from accidents and injuries that occurred or were treated in the period preceding the commencement of the coverage period.

4. We shall not provide services if, as a result of a state of emergency, natural disaster, state of pandemic or state of epidemic announced and confirmed by the competent state administration authorities, we are unable to provide services.

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Share capital: EURO 5,800,000.00

Module: LUX MED Hospital Insurance Orthopaedic Care Plus

The provisions of this Module shall apply to Insurance Agreements concluded on the basis of GTC, which include the Module of Orthopaedic Care Plus. Inclusion of the Module in the Insurance Agreement shall be decided by the Policyholder.

§1 Definitions used in the Module

1. **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 frequently determined genetically and it has a chronic and often serious course. It leads to premature death or causes disability. It usually manifests in childhood.

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

3. **Hospitalisation** – a stay in a hospital ward, aimed at performing diagnostics or treatment, including performance of surgeries due to an Accident or Illness. Hospitalisation covers:
   a. **Scheduled Hospitalisation** – a stay in a hospital ward which:
      I. takes place within the prescribed time limit;
      II. may be postponed for at least 7 days from the time of confirmation of necessity by the Hospital Physician who qualifies for hospitalisation, provided that the postponement may not exceed the date after which there may be a foreseeable severe deterioration of health or a significant reduction in the chances of recovery.
   b. **Emergency hospitalisation** – a stay at a hospital ward which should take place within less than 7 days from the date of confirmation of necessity by a physician of a Hospital who qualifies for hospitalisation, provided that the time of commencement of hospitalisation may not exceed the time limit after which a foreseeable serious deterioration of health or a significant reduction in the chances of recovery may take place.

4. **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.

5. **Hospital Care Coordinator (**also **KOS)** – a representative of the Operator responsible for attendance to the Insured in the performance of the LUX MED hospital insurance Orthopaedic Care Plus within the framework of the Coordination of Hospital Care.

6. **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. Emergency Care ends with recommendations for further treatment, depending on the health condition of the Insured.

7. **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.

8. **Highly Specialized Treatment and Diagnostic Methods** – the most technically advanced or extensive treatment methods, procedures requiring implantable materials, implants or endoprostheses, and diagnostic examinations using PET-CT / PET-MRI scanners, scintigraphic examinations, cardiac MRI examinations. The diagnostic examinations referred to in this definition refer to preparation for Scheduled Hospitalisation or medical care following Hospitalisation. In medically justified cases, diagnostic tests may be carried out on an ad hoc basis during a covered Hospitalisation, provided that diagnostics and treatment, the purpose of which can be achieved in an outpatient facility, are excluded in accordance with the provisions of Appendix no. 3 §1.1(b)(I) and Appendix no. 4 §1.1(b)(II) to the GTC.

§2 What is the subject matter of the Module?

1. Under the Hospital LUX MED Hospital Insurance Orthopaedic Care Plus Module, we provide the following benefits:
   a. **Hospital benefit** – medical service related to Orthopaedic Hospitalisation or Emergency Care, provided in a Hospital and, in some cases, also in a clinic. The detailed scope of the Hospital Services available under the Module has been described in Appendix no. 2 (Part I) and Appendix no. 3 (Part I, II) to the GTC.
   b. **Hospital Health Check** (also **Check**) – services in the scope of diagnostic imaging, laboratory diagnostics and healthcare specialist consultations provided by the Hospital. Its aim is to promote good health. The detailed scope of Services covered by the Hospital Health Check has been described in Appendix no. 2 (Part II) to the GTC.
   c. **Hospital Care Coordination -** the aim of which is to give support to the Insured regarding the use of the Module. The scope of services performed by KOS, has been described in Appendix no.2 (Part III) and Appendix no. 3 (Part II) to the GTC.

2. Events that entitle the Insured to use the Benefits available under the Module are:
   a. Receiving a referral for hospital treatment (the date of the Event is the date the referral is issued);
   b. Minor injury or deterioration of health requiring Emergency Care (the date of the Event is the day the Minor injury or the day of deterioration of health occurs)

3. If none of the events referred to in section 2 has occurred for at least 2 years of uninterrupted Insurance Coverage Period, the Insured may use Hospital Health Check.

4. The detailed scope of Services referred to in sections 1-3 can be found in the following appendices to the GTC:
   a. Appendix no. 2 to the GTC – scope of benefits under the LUX MED Hospital Insurance for the Main Insured, Partner and adult child;

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District Court for the Capital City of Warsaw in Warsaw
13th Commercial Division of the National Court Register
KRS: 0000395438
Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

b. Appendix no. 3 to the GTC – scope of Benefits under the LUX MED Hospital Insurance for a minor child.

5. We provide the following types of Module: LUX MED Hospital Insurance Orthopaedic Care module;
   a. Individual,
   b. Partner,
   c. Family.
   The Policyholder may choose all or selected types of Module which will be available to be selected by the Insured under the Agreement.

6. 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.

§3 How to use the LUX MED Hospital Insurance Orthopaedic Care Plus?

1. In order to benefit from the Services, the Insured shall notify the Hospital Care Coordinator of the event covered by the Module. 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 Scheduled Hospitalisation.

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 the case of a Minor Injury or Emergency Care, we treat your consent to treatment as an application for a Benefit.

5. Benefits under the Module will not be available in certain situations. This is related to the grace period (described in §4 of this Module) and exceptional situations of limitation of our liability (described in §14 of the General Part of the GTC and §5 of this Module).

6. Upon receipt of the event notification, we follow the steps described in §4 sections 2–5 of the General Part of the GTC.

7. If a Minor Injury occurs or Emergency Care is provided, we will verify if the request is reasonable as soon as it has been received. We provide information about recognition or refusal to recognise a claim to the person reporting the event and to the Insured if he/she is not the claimant.

8. We provide the Emergency Care Service immediately after our recognition of the claim.

§4 What is the grace period?

1. In the Agreement, we apply a grace period. This is the period that must elapse from the beginning of the coverage period before the Insured is entitled to the benefit. This means that during this period we are not liable for any Events.

2. The Module grace periods shall be as follows:
   a. 3 months – for Scheduled Hospitalisations;
   b. 10 months – for Highly Specialised Treatment Methods and Diagnostics. This deferred period shall also apply to the Scheduled Hospitalisation benefits and benefits resulting from an accident that we have accepted for provision. In such a case, during the grace period, the cost of highly specialised methods and diagnostics shall be borne by the Insured, while we shall provide other benefits in accordance with the GTC.

3. We do not apply a grace period to events resulting from an accident, as well as events justifying Benefits under: Coordination of hospital care, 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 Module for subsequent periods in the same or narrower scope of the Module.

6. If the Insured was covered by an insurance in which we were the Insurer and which included Hospitalisation in the scope of Orthopaedics, the duration of the previous insurance is included in the grace periods for the Scheduled Hospitalisations if they were covered within 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 in the range of this Module. If the Insured was covered by several insurances based on above- mentioned conditions, this rule applies only to the insurance agreement with the latest termination date.

§5 What are the additional exclusions from the coverage that will prevent us from implementing the Benefits within the Module?

1. Apart from the exclusions set out in §14 of the General Part of the GTC, our liability in the LUX MED Hospital Insurance Module Orthopaedic Care Plus 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: Anesthesiology and Intensive Care Unit, Cardiac Intensive Care Unit, Stroke Treatment Unit, Neurological Intensive Care Unit, Asthma Treatment Unit) or with the provision of intensive renal replacement therapy, hepatic dialysis, ECMO, mechanical ventilation, counterpulsation;
   b. rehabilitation other than in a facility indicated by us and listed in Appendix no 2 or 3 to the General Terms and Conditions;
   c. treatment of Multi-Organ Damage and its consequences;
   d. treatment in psychiatric wards;
   e. diagnosis and treatment of fertility disorders and their consequences;

f. diagnosis and treatment of gender adjustment and their consequences;
g. diagnosis and treatment of congenital genetic defects associated with chromosomal aberrations and congenital defects causing the declared malfunction and their consequences;
h. diagnosis and treatment of Rare Diseases and their consequences;
i. performance of abortions and treatment of complications resulting from them;
j. diagnosis, treatment and procedures or surgeries also for medical reasons in the field of aesthetic medicine, plastic surgery resulting from non-medical indications and cosmetology, as well as treatment of their undesirable consequences, unless the scope of the Hospital Services provides otherwise;
k. diagnosis and treatment not provided at Hospitals or Outpatient Clinics designated by us and their consequences;
l. removal of nodules, skin and/or subcutaneous lesions smaller than 2 cm;
m. 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 Services and certificates of incapacity to work or to study);
n. 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 is staying;
o. treatment of infection with HIV (AIDS), SARS-CoV-2 or hepatitis (with the exception of hepatitis A) viruses, and diseases resulting from those infections;
p. home treatment as a continuation of hospital treatment, excluding treatment resulting from procedures covered by and performed under the insurance;
q. medical care after Hospitalisation within the scope described in Appendices 2 and 3 to the GTC related to Hospitalisation performed in facilities other than those indicated by us;
r. diagnosis and treatment without medical indications;
s. treatment resulting from psychological indications;
t. diagnosis and treatment of diseases, disease symptoms 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 Policyholder or the Insured within 12 months prior to the conclusion of the Agreement; also Illnesses or consequences of Accidents that, with reasonable diligence, the Insured could have known about during this period;;
u. detoxification, detox procedures and treatment and their consequences;
v. treatment of mental disorders, dementia, neurodegenerative diseases (including Alzheimer's disease) and their consequences;
w. services obtained through prohibited acts, extortion attempts or deliberate misinformation.

2. Excluded from coverage is the Hospitalisation which, for medical safety reasons, established on the day of admission to the hospital ward or during the stay, requires simultaneous high and multi-specialty treatment in a medical facility outside the list referred to in §2 section 7 of this Module or its scope goes beyond that described in Appendices nos. 2 and 3 to the GTC.

3. We will not provide the Hospital Benefit during the first 12 months from the beginning of the uninterrupted Period of Cover for the Insured, if it results from:
   a. Illnesses that were present or were diagnosed or treated during the 12 months preceding the commencement of the protection period;
   b. Accidents and injuries that occurred or were treated or whose effects were present during the 12 months preceding the commencement of the Coverage Period;
   c. Disease symptoms that were present, had occurred, or the causes of their occurrence were known to the Policyholder or Insured during the 12 months preceding the beginning of the Coverage Period;
   d. Symptoms of which, with due diligence, the Policyholder or the Insured Party were able to learn during the 12 months preceding the beginning of the Coverage Period.

4. We will not provide the Hospital Benefit during the first 12 months from the beginning of the uninterrupted coverage period with respect to the Insured, if it results from the Insured's prior resignation from hospitalisation due to diagnostics or treatment based on referral to a hospital issued before the beginning of the Coverage Period.

5. We shall not provide services if, as a result of a state of emergency, natural disaster, state of pandemic or state of epidemic announced and confirmed by the competent state administration authorities, we are unable to provide services.

Module: LUX MED Hospital Insurance – Full Care.

The provisions of this Module shall apply to Insurance Agreements concluded on the basis of the GTC, which include the Full Care Module. Inclusion of the Module in the Insurance Agreement shall be decided by the Policyholder.

§1 Definitions used in the Module

1. **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 frequently determined genetically and it has a chronic and often serious course. It leads to premature death or causes disability. It usually manifests in childhood.

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

3. **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. **Scheduled Hospitalisation** – a stay in a hospital ward which:
      I. takes place within the prescribed time limit;
      II. may be postponed for at least 7 days from the time of confirmation of necessity by the Hospital Physician who qualifies for hospitalisation, provided that the postponement may not exceed the date after which there may be a foreseeable severe deterioration of health or a significant reduction in the chances of recovery.
   b. **Emergency Hospitalisation** – a stay at a hospital ward which should take place within less than 7 days from the date of confirmation of necessity by a physician of a Hospital who qualifies for hospitalisation, provided that the time of commencement of hospitalisation may not exceed the time limit after which a foreseeable serious deterioration of health or a significant reduction in the chances of recovery may take place.

4. **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.

5. **Hospital Care Coordinator (also KOS)** – a representative of the Operator responsible for attendance to the Insured in the performance of the LUX MED Full Care Hospital Insurance within the framework of the Coordination of Hospital Care.

6. **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. Emergency Care ends with recommendations for further treatment, depending on the health condition of the Insured Person.

7. **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.

8. **Highly specialized Treatment and Diagnostic Methods** – the most technically advanced or extensive treatment methods, robotic surgery, surgical procedures involving the intestines, pancreas and liver, arterial vessels, treatment of endometriosis, Functional Endoscopic Sinus Surgery, procedures requiring implantable materials, implants or endoprostheses, neurosurgical procedures involving intervertebral discs, vascular adhesive procedures, and diagnostic tests using PET-CT / PET-MRI scanners, scintigraphic tests, cardiac MRI examinations. The diagnostic examinations referred to in this definition refer to preparation for Scheduled Hospitalisation or medical care following Hospitalisation. In medically justified cases, diagnostic tests may be carried out on an ad hoc basis during a covered Hospitalisation, provided that diagnostics and treatment, the purpose of which can be achieved in an outpatient facility, are excluded in accordance with the provisions of Appendix no. 3 §1.1(b)(I) and Appendix no. 4 §1.1(b)(II) to the GTC.

§2 What is the subject matter of the Module?

1. Under the LUX MED Hospital Insurance Full Care Module we provide the following benefits:
   a. **Hospital benefit** – medical service related to Hospitalisation or Emergency Care, provided in a Hospital and, in some cases, also in a Clinic. The detailed scope of the Hospital Services available under the Module has been described in Appendix no. 2 (Part I) and Appendix no. 3 (Part I, II) to the GTC.
   b. **Hospital Health Check** (also **Check**) – services in the scope of diagnostic imaging, laboratory diagnostics and healthcare specialist consultations provided by the Hospital. Its aim is to promote good health. The detailed scope of Services covered by the Hospital Health Check has been described in Appendix no. 2 (Part II) to the GTC.
   c. **Hospital Care Coordination –** the aim of which is to give support to the Insured regarding the use of the Module. The scope of services performed by KOS and described in Appendix no. 2 (Part III) and Appendix no. 3 (Part II) to the GTC.

2. Events that entitle the Insured to use the Benefits available under the Module are:
   a. Receiving a referral for hospital treatment (the date of the Event is the date the referral is issued);
   b. Planned childbirth (the date of the Event is the date of entry in the medical documentation (pregnancy card) of the current pregnancy, the planned date of delivery of which falls within the Protection Period, and if the date of delivery entered in the pregnancy card falls within 14 days after the end of the Protection Period, then the insurer's liability for this risk expires on the day of delivery);
   c. Minor injury or deterioration of health requiring Emergency Care (the date of the Event is the day of occurrence of the Minor injury or the day of deterioration of health)

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13th Commercial Division of the National Court Register
KRS: 0000395438
Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

3. 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.

4. The detailed scope of Services referred to in sections 1–3 can be found in the following appendices to the GTC:
   a. Appendix no. 2 to the GTC – Scope of Benefits under the LUX MED Hospital Insurance for the main Insured, Partner and Adult Child;
   b. Appendix no. 3 to the GTC — Scope of Benefits under the LUX MED Hospital Insurance for a Minor Child.

5. We provide the following types of Module: LUX MED Hospital Insurance – Full Care:
   a. Individual,
   b. Partner,
   c. Family.

   The Policyholder may choose all or selected types of Module which will be available to be selected by the Insured under the Agreement.

6. 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.

§3 How to use the LUX MED Full Care Hospital Insurance?

1. In order to benefit from the Services, the Insured shall notify the Hospital Care Coordinator of the event covered by the Module. 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 Scheduled Hospitalisation (excluding pregnancy);
   c. in the case of pregnancy – 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 attending physician, that the pregnancy is not a High-Risk Pregnancy.

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. In the case of pregnancy, the application should be submitted at the beginning of the third trimester.

4. In the case 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. Benefits under the Module will not be available in certain situations. This is related to the grace period (described in §4 of this Module) and exceptional situations of limitation of our liability (described in §14 of the General Part of the GTC and §5 of this Module).

6. Upon receipt of the event notification, we follow the steps described in §4 sections 2–5 of the General Part of the GTC.

7. If a Minor Injury occurs or Emergency Care is provided, we will verify if the request is reasonable as soon as it has been received. We provide information about recognition or refusal to recognise a claim to the person reporting the event and to the Insured if he/she is not the claimant.

8. We provide the Emergency Care service immediately after our recognition of the claim.

§4 What is the grace period?

1. In the Agreement, we apply a grace period. This is the period that must elapse from the beginning of the coverage period before the Insured is entitled to the benefit. This means that during this period we are not liable for any Events.

2. The Module grace periods shall be as follows:
   a. 3 months – for Scheduled Hospitalisations;
   b. 10 months – for Highly Specialised Treatment and Diagnostic Methods as well as Obstetrics-Neonatology Services. This deferred period shall also apply if it becomes necessary to use Highly Specialised Treatment and Diagnostics Methods as part of Scheduled Hospitalisation and resulting from an Accident that we have accepted for performance. In such a case, during the grace period provided for Highly Specialised Treatments and Diagnostics, the cost of the Highly Specialised Treatments and Diagnostics used in the benefits provided by us shall be borne by the Insured, while we provide the remaining Benefits in accordance with the GTC.

3. We do not apply a grace period to events resulting from an accident, as well as events justifying Benefits under: Coordination of hospital care, 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 Module for subsequent periods in the same or narrower scope of the Module.

6. If the Insured was covered by insurance in which we were the Insurer and which covered benefits equivalent to Hospitalisation Benefits, then the duration of the previous insurance is included in the grace periods for:
   a. Scheduled 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 in the range of this Module. If the Insured was covered by several insurances based on above- mentioned conditions, this rule applies only to the insurance agreement with the latest termination date.

§5 What are the additional exclusions from the coverage that will prevent us from implementing the Benefits within the Module?

1. In addition to the exclusions set out in §14 of the General Part of the GTC, our liability in the LUX MED Hospital Insurance Module Full Care 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: Anesthesiology and Intensive Care Unit, Cardiac Intensive Care Unit, Stroke Treatment Unit, Neurological Intensive Care Unit, Asthma Treatment Unit) or with the provision of intensive renal replacement therapy, hepatic dialysis, ECMO, mechanical ventilation, counterpulsation;
   b. rehabilitation other than in a facility indicated by us and listed in Appendix no 2 or 3 to the General Terms and Conditions;
   c. treatment of Multi-Organ Damage and its consequences;
   d. robotic surgery procedures other than those listed in Appendices nos. 2 or 3 to the GTC;
   e. treatment in psychiatric wards;
   f. diagnosis and treatment of fertility disorders and their consequences;
   g. diagnosis and treatment of gender adjustment and their consequences;
   h. diagnosis and treatment of congenital genetic defects associated with chromosomal aberrations and congenital defects causing the declared malfunction and their consequences;
   i. diagnosis and treatment of Rare Diseases and their consequences;
   j. performance of abortions and treatment of complications resulting from them;
   k. prosthetic, orthodontic, periodontal and implant diagnoses and treatment and their consequences;
   l. diagnosis, treatment and procedures or surgeries also for medical reasons in the field of aesthetic medicine, plastic surgery resulting from non-medical indications and cosmetology, as well as treatment of their undesirable consequences, unless the scope of the Hospital Services provides otherwise;
   m. removal of nodules, skin and/or subcutaneous lesions smaller than 2 cm;
   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 Services and certificates of incapacity to work or to 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;
   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 2 and 3 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. diagnosis and treatment of diseases, disease symptoms 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 Policyholder or to the Insured within 12 months prior to the conclusion of the Agreement; also Illnesses or consequences of Accidents which the Insured 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.

2. Excluded from coverage is the Hospitalisation which, for medical safety reasons, established on the day of admission to the hospital ward or during the stay, requires simultaneous high and multi-specialty treatment in a medical facility outside the list referred to in §2 section 7 of this Module or its scope goes beyond that described in Appendices nos. 2 and 3 to the GTC.

3. We will not provide the Hospital Benefit during the first 12 months from the beginning of the uninterrupted Period of Cover for the Insured, if it results from:
   a. Illnesses that were present or were diagnosed or treated during the 12 months preceding the commencement of the protection period;
   b. Accidents and injuries that occurred or were treated or whose effects were present during the 12 months preceding the commencement of the Coverage Period;
   c. Disease symptoms that were present, had occurred, or the causes of their occurrence were known to the Policyholder or Insured during the 12 months preceding the beginning of the Coverage Period;

4. We will not provide the Hospital Benefit during the first 12 months from the beginning of the uninterrupted coverage period with respect to the Insured, if it results from the Insured's prior resignation from hospitalisation due to diagnostics or treatment based on referral to a hospital issued before the beginning of the Coverage Period.

5. We shall not provide services if, as a result of a state of emergency, natural disaster, state of pandemic or state of epidemic announced and confirmed by the competent state administration authorities, we are unable to provide services.

Module: Coordination of Hospital Care (self-insurance, not related to the hospital Insurances indicated in §3 section 2 of the General Part of the GTC)

The provisions of this Module shall apply to Insurance Agreements concluded on the basis of GTC, within the scope of which the Module of the Hospital Care Coordination falls. Inclusion of the Module in the Insurance Agreement shall be decided by the Policyholder.

§1 Definitions used in the Module

1. **Hospitalisation** – a stay in a hospital ward, aimed at performing diagnostics, delivery or treatment, including surgery. A stay shall take place on specified dates and may 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 the health condition or a significant reduction in the chances of recovery.

§2 What is the subject matter of the Module?

1. Under the Agreement, we ensure Coordination of Hospital Care, the aim of which is to support the Insured in using Hospitals specified by us. The scope of services provided under Coordination of Hospital Care is described in §3 of the Module.
2. The Insured Person may use the Coordination of Hospital Care insurance in the case of an Event which makes it necessary to use a Hospital's medical Services, in particular in cases of:
   a. the Insured being referred for hospital treatment;
   b. planned childbirth.
3. The costs of services not covered by the scope described in Appendix no. 3 and rendered by Hospitals shall be borne by the Insured.
4. We provide the following types of the Hospital Coordination Module:
   a. Individual,
   b. Partner,
   c. Family.

   The Policyholder may choose all or selected types of Module which will be available to be selected by the Insured under the Agreement.
5. 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 Services which a given facility performs.

§3 Scope of Coordination of Hospital Care

The scope of Services offered as part of Coordination of Hospital Care includes:

1. accepting a notification from the Insured;
2. coordination of care for the Insured Person before Hospitalisation:
   a. presenting a proposal for Hospitalisation – presenting a selection of available Hospitals and Physicians, as well as a midwife, if the Insured is planning for childbirth;
   b. arranging a stay according to the Insured's choice within the options presented by us;
   c. assistance in scheduling examinations and consultations eligible for Hospitalisation;
   d. monitoring the performance of examinations and consultations by the Insured;
   e. reminding the Insured about the date of admission to the Hospital and the required documents as well as confirmation of the presence of the Insured at the Hospital;
   f. coordination of the flow of medical documents between the Insured and the Hospital;
   g. providing information on Hospital stay.
3. coordination during Hospitalisation:
   a. handing over all documents necessary for the provision of the Benefit to the Insured;
   b. current contact with the Hospital;
   c. providing information on the current status of the performance of medical procedures to a person authorised to receive medical information about the Insured;
   d. arranging a follow-up visit after Hospital stay and presenting a post-Service care plan;
   e. organization of Medical Transport, if it results from medical indications, which includes:
      i. inter-hospital road transport in the event that we order medical transport to another facility as part of continuing treatment covered by the insurance, as well as to another nearest hospital as part of continuing treatment in a situation where further diagnostics and treatment exceed the scope of our responsibility;
      ii. transport from the hospital to the place of stay of the Insured, resulting from medical indications confirmed by us.
4. coordination of care after Hospitalisation, in accordance with the Physician's recommendations:
   a. arranging for examinations and rehabilitation recommended for the Insured;
   b. organization of Medical Transport, if it results from medical indications, which includes:
      i. inter-hospital road transport in the event that we order medical transport to another facility as part of continuing treatment covered by the insurance, as well as to another nearest hospital as part of continuing treatment in a situation where further diagnostics and treatment exceed the scope of our responsibility;
      ii. transport from the hospital to the place of stay of the Insured, resulting from medical indications confirmed by us.
   c. completion of the medical documentation of the Insured.

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§4 How to use Hospital Care Coordination?

1. Immediately after concluding the Agreement, we will provide the Policyholder with contact details of the team in charge of Coordination of Hospital Care. The details will be provided by email, text message or letter, depending on which contact information we have received.
2. The Insured shall use the insurance within the Module by contacting the Hospital Care Coordination Team in a manner of their choice.
3. The insured shall receive the Benefits within the framework of the Coordination of Hospital Care according to their needs. He/she may benefit from some or all of the Benefits offered under the Module.
4. Upon receipt of the Event notification, we follow the steps described in §4 sections 2–5 of the General Part of the GTC.

§5 What are the exclusions from the coverage that will prevent us from implementing the Benefits within the Module?

1. Apart from the exclusions set out in §14 of the General Part of the GTC, our responsibility for the Coordination of Hospital Care does not cover events resulting 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. the 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 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. the impact of nuclear energy, radioactive radiation, electromagnetic field and biological and chemical agents harmful to a human;
   e. 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;
   f. committing or attempting to commit a crime or an offence;
   g. detoxification, detox procedures and treatment;
   h. HIV and SARS-CoV-2 infections.
2. We shall not provide services if, as a result of a state of emergency, natural disaster, state of pandemic or state of epidemic announced and confirmed by the competent state administration authorities, we are unable to provide services.
3. We shall not render services in other hospitals than those specified by us.
4. We will not provide the Service if it is not medically indicated.

Module: Treatment for Serious Illnesses Abroad – BEST HELP

The provisions of this Module shall apply to Contracts concluded on the basis of the General Terms and Conditions, which include the Treatment for Serious Illnesses Abroad – BEST HELP Module. The Policyholder shall decide whether to include the Module in the Contract.

§1 General principles

1. The insurance covers the health of the Insured. The insurance event in Module for Treatment of Critical Illnesses abroad – BEST HELP is the occurrence of Critical illness in the Insured during the Coverage Period.
2. The terms used below shall have the following meanings in the Agreement:
   1) **Critical illness** – shall mean the following illnesses, medical procedures or operations:

A. ILLNESSES

MODULE 1. CANCER TREATMENT

a) The insurance Agreement covers the treatment and costs falling within the scope of the Agreement with regard to the following type of cancer:
   i. any malignant neoplasm, including leukaemia, sarcoma and lymphoma, characterized by uncontrolled growth and dissemination of neoplastic cells and infiltration of tissues,
   ii. any in situ cancer, not exceeding the basement membrane of the epithelium in which it was formed and not covering the substrate and the surrounding tissues;
   iii. any pre-neoplastic lesions in cells which, based on cytological or histopathological examination, have been classified as severe dysplasia or major dysplasia.

B. MEDICAL PROCEDURES

The Insurance Agreement covers the following (modules 2–4) medical procedures where the illness which caused the medical procedure is not related to the treatment of cancer (i.e. the basis for the procedure is not the treatment of the disease referred to in item A above – Module 1: Cancer treatment).

MODULE 2. CARDIAC SURGERY

a) **Coronary artery bypass grafting (by-pass), myocardial revascularisation** – a surgical procedure performed for cardiac indications to treat stenosis or obstruction of at least one coronary vessel of the heart, consisting in a vascular bypass graft; excluded diseases and medical procedures: any treatment of the coronary arteries using techniques other than coronary artery bypass grafting (by-pass), such as any type of angioplasty, stents;
b) **repair surgery** of the heart valve — surgery made according to cardiological indications, consisting in the replacement or plastic surgery of one or more heart valves.

MODULE 3. NEUROSURGERY

neurosurgery — any surgery of the brain or other intracranial structures; surgical treatment of benign tumours of the spinal cord;

MODULE 4. TRANSPLANTS

a) **transplantation from a living donor** — transplantation to the Insured of one of the following organs of human origin: kidney, liver lobe segment, lung lobe or pancreas part from another compatible living donor;
b) **bone marrow transplant -** autologous or allogeneic bone marrow or peripheral blood stem cell transplant from a live donor.

   2) **Further - FURTHER Underwriting International SLU ("FURTHER") with its registered office at Paseo Recoletos 12, 28001 Madrid, Spain, registered in the Commercial Register of Madrid under Page no. m-554734, volume 30823, sheet 126 and Tax Identification Number (CIF) B 86661857**, the entity through which the Insurer ensures the organisation and provision of the services and benefits covered by the Insurance Agreement in the Module for the treatment of critical illnesses abroad - BEST HELP, including the supervision over the organization of the Insured's treatment process.
   3) **Second medical Opinion –** Second medical Opinion on critical illness. Includes the preparation of a report containing a second medical opinion, drawn up by a medical expert, after collecting and analysing in detail the medical records of the Insured;
   4) **Medical care abroad (Medical Concierge service)** – a Service where FURTHER, on the basis of an approved claim, specifies all details of treatment of the Insured, takes over the supervision of a given case and the organisation of travel and accommodation for the Insured and any authorised accompanying person.
   5) **Medical Expert –** a doctor practising outside the Republic of Poland, appointed as part of the Second Medical Opinion Service to draw up a report on the health condition of the Insured and medical indications, whose specialty and experience correspond to the health needs of the Insured**.**
   6) **Hospitalisation –** treatment in respect of illnesses or medical procedures or operations covered by Insurance in a hospital outside of the Republic of Poland (except for health condition Control after returning to the Republic of Poland §3 section 4.1 item 2 – and force majeure – §3 section 4.2 item 3), lasting continuously for at least 24 hours;**.**
   7) **Medication —** any substance or combination of substances which may be used or administered to the Insured to restore, correct, correct or modify physiological functions of the organism by pharmacological, immunological or metabolic action, or to make a diagnosis; obtainable only on prescription by a doctor and dispensed by a licensed pharmacist; a medicinal product shall also be a medicinal product having the same qualitative and quantitative composition of active substances, the same pharmaceutical form, the same use, mode of action and dosage as the reference medicinal product indicated by the prescription doctor.
   8) **Prosthesis –** a device that replaces all or part of an organ or replaces all or part of its impaired functionality**.**

9) **Hospital –** a hospital operating, as a therapeutic entity in accordance with the laws of the state in which it is located, as an inpatient facility whose task is to treat patients and care for them around the clock in conditions specially adapted for these purposes, with adequate diagnostic and therapeutic facilities, under permanent medical management, employing qualified medical and nursing staff.

10) **Medically necessary –** medical services and medical supplies used in treatment which are:
   a) prescribed to the Insured to treat the illness covered by the Insurance or arrange a medical procedure covered by the insurance in order to improve the health condition of the Insured and;
   b) deemed effective for improving health on the basis of treatment plans that are consistent in type, frequency and duration with recognition, in accordance with published peer ¬ reviewed scientific medical literature (such as PubMed) or scientifically supported by U.S., U.K. and European guidelines (in particular, the NCN guidelines on clinical practice in oncology (module 1) and;
   c) more cost effective than similar treatments that yield similar results, including non-treatment, and are required for reasons other than the convenience of the Insured or his/her doctor.

   In itself, the fact that the Physician may recommend, prescribe, order or authorise a service or a means of medical supply does not necessarily mean that such service or means of medical supply is medically necessary in accordance with the Agreement**.**

11) **Medical promise** – a written referral issued by FURTHER on behalf of the Insurer, prior to receiving treatment abroad at the indicated Hospital, for medical services under the Agreement, which at the same time constitutes FURTHER's obligation to pay for the services indicated therein, in respect of each treatment, service, medical supply or claim prescription.

12) **Compensation period** – a period of thirty ¬ six (36) months, counted for each module, within the Serious Treatment Module Abroad – BEST HELP, separately starting from the date of the first journey arranged and paid for under the Agreement and a recognised claim.

   The compensation period is the period during which the benefits under the Agreement are provided in respect of all claims accepted within the same Module.

13) **Gene therapy products:** contain genes that lead to a therapeutic, prophylactic or diagnostic effect. They act by inserting recombinant genes into the organism, usually in the treatment of various diseases, including genetic diseases, cancers or chronic diseases. A recombinant gene is a DNA or RNA section which is created in a laboratory and which combines DNA or RNA from different sources.

14) **Somatic cell therapy products**: contain cells or tissues which have been manipulated to change their biological characteristics or cells or tissues not intended to be used in the same basic functions in the body. May be used for the treatment, diagnosis or prevention of diseases.

15) **Tissue engineered products**: contain cells or tissues which have been modified in such a way that they can be used for the repair, regeneration or exchange of human tissue.

16) **CAR-T cell therapy (CAR-T cell therapy with a chimeric antigen receptor**): the type of treatment in which the patient's T lymphocytes (cell type of the immune system) are modified in the laboratory in such a way as to be able to affect neoplastic cells. T Lymphocytes are taken from the patient's blood. A specific receptor gene is then added in the laboratory, which binds to a specific protein on cancer cells in the patient. This receptor is called a chimmer antigen receptor (CAR). A large number of CAR-T cells are grown in the laboratory and administered to the patient as droplets.

17) **Cognitive disorders**: disorders that impair a person's cognitive function to such an extent that its normal functioning in society is impossible without treatment, as defined in the most recent diagnostic and statistical version of the mental disorder Manual (DSM-V).

18) **Experimental treatment:** treatment, procedure, course of treatment, equipment, medicine or pharmaceutical product intended for medical or surgical use which:
   a) has not been generally recognised as safe, effective and appropriate for the treatment of diseases or injuries by various scientific organisations recognised in the international medical community, or
   b) which is under investigation, analysis, testing or at any stage of clinical experiments.

19) **Health surveillance:** any diagnostic examinations and/or monitoring/surveillance services (performed by a Physician with specialist knowledge of the critical illness being treated) after treatment abroad, used to determine whether the Insured suffers (or may suffer) from an aggravation or complication of the treated illness to prevent recurrence or relapse of the same critical illness condition.

   The Health Surveillance Plan should be prepared by the Physician treating abroad and provided to the Insured after the completed hospitalisation, upon completion of the treatment. The Plan shall indicate the time intervals and the type of diagnostic procedures to which the Insured should be subject.

20) **Injury**: physical injury to the Insured.

21) **Illness**: any disorder of an organism, system or structure or function of an organ with an identifiable and characteristic set of signs and symptoms or consistent anatomical changes, as diagnosed by a Physician.

   All injuries and effects resulting from the same diagnosis as well as all ailments caused by the same cause or related causes shall be considered an illness. If the ailment is due to the same cause as the previous Illness or a related cause, it should be treated as a continuation of the previous Illness and not as a separate Illness.

22) **Non-invasive or "in situ" cancer**: a malignant tumour not exceeding the basement membrane of the epithelium in which it occurred and not invading substrates and surrounding tissues.

23) **Reconstruction surgery:** procedures to rebuild a structure to correct a loss of its function.

24) **Operation:** all procedures carried out for diagnostic or therapeutic purposes at the Hospital by a Physician specialising in surgery, carried out with the interruption of tissue continuity, in the operating room.

25) **Treatment abroad**: **medically necessary treatment** arranged by FURTHER during the applicable compensation Period outside the territory of the Republic of Poland and paid for under the Agreement.

26) **Physician**: a person duly qualified and licensed to practise medicine in accordance with the generally applicable laws in the country in which the healthcare benefits are provided.

§2 Scope of the insurance

1. The scope of the Agreement covers the following services:
   1) The services and medical procedures specified in the Agreement during the compensation Period;
   2) The costs of any medical diagnostic procedures, treatment, services, medical supplies or prescriptions covered by the Agreement, referred to in §3;
   3) Treatment arranged by FURTHER in accordance with the claims procedure set out in §4;
   4) Medical expenses arising outside the territory of the Republic of Poland, except
      a) The costs of purchase of medicines incurred in the Republic of Poland, referred to in §3 section E, point 1,
      b) The costs of further care incurred in the Republic of Poland, referred to in §3 section E point 2, except for the scheme of further care which is covered by Insurance.

2. FURTHER covers only the costs of medically Necessary services covered by the Agreement..

3. The sums insured and the limits of the Insurer's liability are set out in the Policy or another document of the Insurance Agreement.

§3 Benefits due under the Agreement

The Insurance Agreement in the Module for Treatment of Critical Illnesses abroad – BEST HELP covers the following services, costs and monetary benefits (within the limits specified in the Policy or another document of the Insurance Agreement) arising in connection with a justified claim filed under the Insurance. The services must be organised and the expenses incurred within the applicable indemnity Period.

A SERVICES COVERED before starting treatment abroad:
Second Medical Opinion

The Insured shall have the right to ask FURTHER, at the time of reporting the claim, for a second medical opinion to confirm the critical illness diagnosis and to recommend an optimal treatment plan.

The second medical opinion may be requested only once for a single claim.

The second medical opinion consists of the following activities:
1) provision of information to the Insured on the necessary medical documentation for the preparation of the report by the medical expert;
2) in medically justified cases, reassessment of histopathological tissues of the Insured previously collected at the expense of the Insured, in order to make a diagnosis;
3) translate medical records concerning the health condition of the Insured, necessary for the preparation of the report by the medical Expert;
4) transmitting the translated medical records to a medical Expert;
5) preparation of a report by a medical Expert, including:
   a) the medical Expert's opinion on the diagnosis and treatment applied so far,
   b) a proposition concerning further action and treatment recommended by the medical Expert,
   c) answers to the Insured's questions regarding his/her medical case;
6) the issue of a report by a medical Expert;
7) translation of the medical Expert's report into Polish;
8) delivery of the medical expert report to the Insured.

B COVERED MEDICAL EXPENSES
during Treatment abroad:

Medical care abroad (Medical Service Concierge)

1. As part of the Medical Care Abroad benefit (Medical Concierge service), FURTHER will organise and pay the following costs arising in connection with a Critical Illness, the treatment of which requires Medically Necessary services, under the terms of the Agreement and up to the sum insured or limits specified in the Policy.

2. The scope of medical care abroad (Medical Concierge service) covers the organisation and:
   1) coverage of costs of medical treatment outside of the Republic of Poland:
      a) stay of the Insured in the Hospital, including the costs of:
         i. accommodation, meals and care services provided during hospitalisation of the Insured, costs of stay of the Insured in a room, ward or intensive care ward, as well as in an observation ward,
         ii. hospital services, including services provided by outpatient clinics,
         iii. an additional bed related to the stay at Hospital of a person accompanying the Insured (or two accompanying persons if the Insured is a minor person), if the Hospital makes such a service available,
         iv. the execution of operations in the operating hall, including the costs of anaesthesiological care;
      b) a stay of the Insured in a hospital or patient attendance centre, provided that the costs incurred there would be covered by Insurance in connection with the stay of the Insured in the Hospital;
      c) a stay at a daytime ward or help centre, if available to such a Hospital, but only if the treatment, operation or prescription are covered by the Agreement;
      d) medical care, in respect of examination, treatment or surgery;
      e) medical appointments during hospitalisation;
      f) anaesthesia and the administration of anaesthetics, provided they are carried out by a qualified anaesthesiologist;
      g) laboratory tests, histopathological examinations and, X-ray examinations, scintigraphy, electrocardiograms, echocardiograms, myelograms, electroencephalograms, vascular examinations, computed tomography, magnetic resonance imaging, and other diagnostic tests and procedures – which are necessary for the treatment of a covered Illness or the performance of a covered medical procedure, or Surgery, and for which a referral has been issued by the attending Physician abroad, and are performed by the Physician or under the supervision of the Physician;

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h) radiotherapy, procedures with the use of radioactive isotopes, chemotherapy and other therapeutic procedures which are necessary for the treatment of the covered disease or for the conduct of the covered medical procedure or surgery, and to which the attending Physician abroad has issued a referral, and are carried out by a Physician or under the supervision of a Physician;

i) blood, plasma and serum transfusion;

j) related to treatment with oxygen, use of intravenous fluids as well as injections;

k) reconstruction surgery consisting in the repair or reconstruction of a structure damaged or removed as a result of medical procedures organised and paid for under the Agreement;

l) treatment of complications or side effects directly related to medical procedures organised and paid for under the Agreement, which:

i. require immediate medical treatment in hospital, and

ii. require treatment before the Insured is considered fit for travel in order to return to the Republic of Poland after the end of the stage of treatment abroad;

m) medication prescribed by a doctor after hospitalisation related to Critical Illness treatment, incurred by the Insured outside of the Republic of Poland within 30 days from the date of completion of the treatment abroad, provided that the medication was purchased before returning to the territory of the Republic of Poland;

n) transfer and medical transport by ground or air ambulances, provided that it has been recommended by a doctor and has been previously accepted and arranged by FURTHER;

o) with respect to benefits for a living donor during the donation process for transplantation to the Insured resulting from:

i. the cost of tests, together with an analysis of the tests carried out to identify the appropriate donor in the Insured's family,

ii. Hospital services provided to the donor, including accommodation in a hospital room, ward or department, meals, general nursing services, standard services provided by Hospital personnel, laboratory tests, and use of Hospital equipment and other facilities (excluding personal items that are not required during the process of organ or tissue procurement for transplantation),

iii. the costs of medical operations and services related to the collection of the organ or tissue of the donor for transplantation to the Insured;

p) with respect to services and medical supplies necessary for bone marrow cultures in connection with a tissue transplant to be performed on the Insured, the Insurance will only cover expenses incurred from the date of issuance of the Treatment Promise.

3. If any force majeure or logistical or operational constraints imposed by national or international authorities impede the further organisation of treatment abroad, FURTHER arranges for the provision of the benefits referred to in §3 section B (1) in Poland, provided that the same logistical or operational constraints do not hinder the organisation of equivalent and medically feasible analogous treatment in Poland. The benefits specified in §3 Section B (1) will be available in Poland only until FURTHER is able to confirm the reinstatement of treatment abroad.

4. Benefits provided in Poland shall be paid in excess of any private health insurance possessed by the Insured.

C NON-MEDICAL COSTS COVERED during the Treatment abroad

1. The Agreement shall cover the below mentioned non-medical expenses incurred in connection with the travel and accommodation arranged by FURTHER in order to ensure that the Insured has access to treatment under the conditions specified in the treatment Promise.

2. The Insurance covers the travel and accommodation costs of the Insured, an accompanying person (or two accompanying persons if the Insured undergoing treatment is a minor person) for each trip involving travel from the Republic of Poland to the place of treatment and return, and the organisation of necessary accommodation for the total duration of each trip.

3. The dates and duration of the trip will be determined by THE FURTHER on the basis of the schedule of the treatment plan indicated by the attending Physician (Physicians) abroad.

4. The Insurance covers travel and accommodation expenses for each trip insured under the conditions set out below:

4.1. TRAVEL EXPENSES for treatment abroad:

covering travel expenses of the Insured together with an accompanying person (or two accompanying persons if the treated Insured is a minor person) and a donor (in the case of transplants) within the following scope:

a) FURTHER arranges and covers travel expenses of the Insured and the accompanying person (or two accompanying persons if the treated Insured is a minor person) and of the donor in the case of transplants to be performed abroad, in connection with the treatment of the Insured in a foreign medical facility confirmed in the medical Promise;

b) All travel arrangements must be made by any FURTHER person, whereby FURTHER shall not cover any costs of the travel arranged by the Insured or by any third party on behalf of the Insured.

FURTHER is responsible for determining the dates of travel for each insured trip based on the approved treatment schedule. These dates shall be communicated to the Insured in sufficient advance to enable him/her to make any necessary personal preparations;

c) travel or medical transport expenses, which include:

i. transport of the Insured from his/her place of permanent residence to an international airport or railway station from which, according to the travel plan, transport to the destination city will be arranged,

ii. economy class train or air ticket to the destination city of treatment and transport to the hotel indicated,

iii. transport from a hotel or Hospital to an airport or an international railway station,

iv. economy class train or air ticket and transport from the destination city to the place of permanent residence of the Insured;

d) Insured travel expenses do not include transfers from a hotel to a Hospital or to a Physician responsible for treatment abroad during treatment abroad.

4.2. ACCOMMODATION EXPENSES during treatment abroad:

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covering the costs of accommodation of the Insured and an accompanying person (or two accompanying persons if the treated Insured is a minor person) or a donor to the extent described in items a–f below

a) FURTHER arranges and covers the accommodation costs of the Insured and the accompanying person (or two accompanying persons if the treated Insured is a minor person) and the donor, in the case of transplants, related to their stay in the place of Operation;

b) All accommodation for any covered trip under the Agreement must be arranged by FURTHER and FURTHER will not pay for any accommodation arranged by the Insured or any third party on behalf of the Insured.

FURTHER is responsible for setting the booking dates for each insured trip based on the approved treatment schedule. These dates shall be communicated to the Insured in sufficient advance to enable him/her to make any necessary personal preparations;

c) FURTHER shall determine the period of accommodation for the persons referred to in letter a above on the basis of the Insured's agreed treatment plan, and in the event that the Insured, without medical justification and without agreement with FURTHER, changes the date of accommodation, the Insured shall be obliged to reimburse FURTHER for all costs associated with the changes in accommodation, if any;

The organisation of accommodation shall include:

d) staying in a two-person room in a three- or four-star hotel with breakfast. The choice of hotel will be determined by the distance from the Hospital or an attending Physician residing abroad, which should not exceed 10 kilometres;

e) all meals (except breakfast) and the costs related therewith are not covered by the Insurance;

f) an increase in the hotel standard is not possible and cannot be financed by the Insured.

4.3. REPATRIATION COSTS

covering the costs of repatriation of the body of the Insured or the donor to the extent specified in letters a–b below:

a) FURTHER shall organise and pay the costs of repatriation of the Insured's or donor's remains to a place of burial in the Republic of Poland if the Insured's or donor's death occurs during the treatment process organised by the Insurer outside the Republic of Poland;

b) the costs of repatriation of mortal remains include:
   i. services provided by a repatriation funeral, including embalming and any administrative formalities.
   ii. cost of purchasing a coffin meeting the minimum requirements
   iii. transportation of the deceased's body from the airport to the designated burial site in the territory of the Republic of Poland.

D CASH BENEFITS COVERED during treatment abroad

1) payment of a cash benefit for each day of hospitalisation within the scope specified in letters a–b below:

a) FURTHER shall pay the benefit to the Insured for each full day of hospitalisation during the hospital treatment of the Insured abroad as part of Medical Care abroad (Medical Concierge service), in the amount specified in the Policy or another document of the Insurance Agreement;

b) FURTHER shall pay a benefit to the Insured Person for each day of hospitalisation for a period not exceeding 60 days, which shall be calculated separately for each reasonable claim for Serious Illness.

E INSURED MEDICAL EXPENSES upon return from medical treatment abroad

1) **COSTS OF PURCHASE OF MEDICINES upon return from the Treatment abroad:**

reimbursement of costs incurred for the purchase of medicines, after returning to the territory of the Republic of Poland within the scope specified in letters a–d below:

After returning to the Republic of Poland from the treatment abroad, FURTHER will cover the costs of medicines prescribed and purchased in the Republic of Poland, subject to the following conditions and limitations:

i. The medicine is certified and approved by an authority authorised to register medical and therapeutic products in the Republic of Poland and its prescription and administration is subject to the regulations, and
ii. The medicine may be purchased in the Republic of Poland at the time and in the manner necessary for the continuation of the treatment, and
iii. The medicine is subject to prescription by a Physician in the Republic of Poland, and
iv. The medicine is recommended by FURTHER in accordance with the recommendations of the attending Physician of the Insured abroad as the necessary product for the treatment to be continued, and
v. The medicine is administered as a result of Hospitalisation outside the Republic of Poland lasting at least three days, approved by FURTHER in the treatment Promise, and
vi. No prescription is issued for consumption period exceeding 2 months, and
vii. all prescriptions shall be issued before the end of the compensation Period.

Purchase of a medicine under §3 section E (1), if made in the Republic of Poland, is arranged and paid for directly by the Insured. FURTHER reimburses the Insured for costs incurred upon receipt of the relevant prescription, original invoice and proof of payment.

If the cost of the medication has been partially or entirely reimbursed by the public Health Service of the Republic of Poland or any other insurance policy, FURTHER will reimburse only those costs which have not been reimbursed, i.e. were incurred directly by the Insured. The request for reimbursement should clearly distinguish the costs incurred directly by the Insured from the reimbursed parts.

If the recommended Medicine (or an exchangeable equivalent Medicine of similar efficacy), upon confirmation by FURTHER:

i. is not certified or approved for use in the Republic of Poland in accordance with the above condition of §3 section E point 1.a.i, or
ii. cannot be purchased or made available to the Insured in the Republic of Poland in accordance with the above condition of §3 section E point 1.a.ii, and

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iii. all other terms and conditions of § 3 section E points 1.a.i to VII are still met

also the costs of purchase of the Medicines outside Republic of Poland shall be reimbursed under the Agreement in Poland.

In such a case, FURTHER shall make the necessary arrangements for travel and accommodation in accordance with the principles described in §3 section C items 4.1. and 4.2. for the Insured and the named accompanying person (or two accompanying persons when the treated Insured is a minor person).

2) Health check after returning to the Republic of Poland within the scope specified in letters a–d below:

a) Upon return to the Republic of Poland after completion of the stage of Treatment abroad, the Agreement shall cover the expenses resulting from health inspection incurred in the Republic of Poland, subject to the following conditions and limitations:

i. The Health Check took place in one of the Hospitals selected by FURTHER, and

ii. The Health Check is available in the Republic of Poland at the time and in the manner necessary for regular medical examinations, and

iii. The Health Check is carried out in accordance with the recommendations of the attending Physician residing abroad (physicians) who treated the Insured, to the extent necessary for regular medical examinations and monitoring, and

IV. invoices relating to health Check shall be issued before the end of the compensation Period.

b) The Health Check within the framework of §3 section E pt. 2, if it takes place in the Republic of Poland, is arranged and paid for directly by the Insured in the Republic of Poland. FURTHER shall reimburse the Insured for the costs incurred upon receipt of the original invoice and the proof of payment.

c) If the Physicians responsible for organising a Health Check in the Republic of Poland indicate, in connection with a change in health condition of the Insured, the need to update the guidelines on the Health Check initially set by the attending Physician abroad, FURTHER shall inform the attending Physician abroad thereof in order to obtain the approval, and shall confirm, if appropriate, the reimbursement of such costs in accordance with the new approved guidelines.

d) If the cost of Health Check has been reimbursed in part or in full by the public Health Service of the Republic of Poland or any other insurance policy, FURTHER will reimburse only those costs which have not been reimbursed, i.e. were incurred directly by the Insured. The request for reimbursement should clearly distinguish the costs incurred directly by the Insured from the reimbursed parts.

e) At the request of the Insured and provided that the above conditions of §3 section E pt. 2 a. iii and §3 Section E pt. 2 a. iv are still met, FURTHER may also approve and organise the Health Check outside the Republic of Poland.
In this case:
i. The Health Check shall be carried out by the Physician attending the Insured abroad (Physicians) or by his/her medical team;
ii. The medical costs of such consultation and diagnostic tests shall be borne directly by FURTHER;
iii. FURTHER shall make the necessary arrangements for travel and accommodation in accordance with the principles described in §3 section C pts. 4.1. and 4.2. for the Insured and the indicated person (or two accompanying persons when the treated Insured is a minor person).

§4 Provision of Services

1. The critical illness Insurance benefit shall be provided upon reporting a claim to the Insurer, in writing, or via electronic means of communication, preferably on the Insurer's form with the appendices mentioned therein.

2. The coordination of the provision of services related to the Second medical opinion or medical Care abroad shall be carried out on behalf of the Insurer (FURTHER).

3. As a condition for receiving Medical Care abroad, the Critical Medical Condition must be confirmed by the Medical Expert's report (in the event the Insured elects to provide a Second medical opinion) or by complete medical documentation provided by the Insured and deemed necessary by FURTHER to assess the validity of the claim (in the event the Insured has elected to forgo a Second medical opinion).

4. Reimbursement of costs incurred for medicines referred to in §3 section E pt. 1 and health inspection referred to in §3 section E pt. 2 shall be made on the basis of a request for reimbursement of costs submitted by the Insured together with a copy of the prescription and the original invoice and proof of payment.

Procedure for the provision of benefits

Claim notification

5. Upon reporting a claim in accordance with section 1 above, the Insured Party shall be contacted immediately and informed of the actions required to provide FURTHER relevant diagnostic tests and medical documents necessary to assess the validity of the claim.

6. If the Insured requests the service of a Second medical opinion, the service shall be performed before confirming that the claim falls within the scope of coverage provided under the Agreement.

Confirmation of the legitimacy of the claim
and list of recommended hospitals

7. Upon receipt of all relevant diagnostic tests and medical history requested by FURTHER, the Insured shall be informed whether the claim is covered by the Agreement.

8. If the Insured wishes to receive Treatment abroad, FURTHER shall assess the availability of the compensation Period, resulting in one of the following scenarios:

(a) Scenario 1: Full availability
No claim was previously made under the relevant Module, as a result of which the treatment was arranged and paid for in accordance with the Agreement. Therefore, FURTHER will confirm the full availability of the 36 month compensation Period.

(b) Scenario 2: Partial availability
An earlier claim(s) has been made under the relevant Module, as a result of which treatment has been arranged and paid for in accordance with the Agreement. Therefore, FURTHER will confirm the availability of the number of remaining months in the compensation Period.

(c) Scenario 3: Compensation period expired
An earlier claim(s) has been made under the relevant Module, as a result of which treatment has been arranged and paid for in accordance with the Agreement until the indemnity Period expires. FURTHER confirms that the claim will not be admitted under the Agreement due to exhausting the compensation period.

9. In scenarios 1 (a) and 2 (b), the Insured will be provided with a list of recommended Hospitals

Promise of treatment

10. Upon receipt by FURTHER Party of the Insured's confirmation of the decision to receive treatment abroad at a Hospital selected from the list of recommended Hospitals, and provided that the treatment is to commence before the end of the compensation Period, FURTHER shall coordinate the necessary logistical and medical formalities for the proper admission of the Insured to the Hospital and issue a treatment Promise valid only for the Hospital concerned.

11. The list of recommended Hospitals and the treatment Promise shall be issued on the basis of the Insured's health condition at the time of issue of the treatment Promise by FURTHER. In connection with a possible change in health condition of the Insured after the issue of the treatment Promise, both documents, i.e. the list of recommended hospitals and the treatment Promise, shall remain valid for a period of three months from the date of issue.

12. If the Insured fails to select the Hospital from the list of recommended Hospitals or fails to commence the treatment in the approved Hospital referred to in the treatment Promise within three months from the issue of the document, FURTHER shall issue the aforementioned documents again on the basis of the current health condition of the Insured by that time.

Compensation period

13. The compensation Period under each module will start on the date of the first trip for treatment abroad. The Agreement shall cover services, expenses and monetary benefits (up to the limits specified in the Policy or another document of the Insurance Agreement) arising in connection with a justified claim made under the Agreement for the duration of the compensation Period.

14. If, at the end of the compensation Period, the Insured is hospitalised or is under the care of a Hospital under the conditions specified in the treatment Promise, the Agreement shall ensure that the costs of treatment specified in §3 section B pt. 1 until the next return to the Republic of Poland, planned on the basis of an agreed treatment plan.

Return from Treatment abroad

15. If the return to the Republic of Poland after the completion of the treatment plan takes place before the end of

the compensation Period, FURTHER shall provide the Insured with the guidelines on the insured costs of medical treatment after returning from medical treatment abroad. These guidelines will be based on the recommendations of a Physician practising abroad.

16. Under this scenario, the Insured shall be entitled to:
    a) Exercise the right to reimbursement of the costs of medicines referred to in § 3 section E pt. 1,) and
    b) Use the Health Check referred to in § 3 section E pt. 2

until the end of the compensation Period.

Analysis of claims after return from the Treatment abroad

17. Upon the return of the Insured to the Republic of Poland after the completion of the treatment plan, the Insured's health condition may change, which may result in a need to reassess it in terms of further medically necessary treatment. The Insured shall have the right to re- submit his/her claim to FURTHER for the purpose of such an assessment, provided that the relevant indemnity Period remains in force.

18. FURTHER shall then inform the Insured again of the necessary required diagnostic tests and medical documentation that should be provided to FURTHER for such assessment.

19. In the event that FURTHER's assessment confirms that further treatment is Medically Necessary, the Insured will receive confirmation in the form of a newly issued treatment Promise, together with a list of recommended Hospitals and a possible treatment Plan abroad.

20. In order to carry out the assessment, it may be necessary to re-perform the Second medical opinion service, if FURTHER deems it necessary from a medical point of view

21. The Agreement shall continue to cover all medical services and expenses (as further described in § 3) until the end of the indemnity Period in accordance with the terms of the last treatment Promise.

Co-operation

22. In order to confirm the Insured's cooperation with the treating Physician abroad, the Insured and the Insured's relatives are required to consent to visits by Physicians working for FURTHER and/or the Insurer and to any inquiries deemed necessary by FURTHER and/or the Insurer. To this end, Physicians who have provided benefits to the Insured Person shall be released from the obligation of professional secrecy. The consent will be given directly or indirectly for each visit or enquiry.

23. Failure to allow the above visits will be considered by the Insurer as an express waiver of the right to pay benefits with respect to the relevant claim covered by the Agreement.

Expenses

As long as the conditions of the treatment Promise are met, FURTHER shall cover directly, as part of the benefits under the Agreement, the expenses incurred by the Insured, subject to the limitations, exclusions and conditions specified in the Agreement.

§5 Exclusions and limitations of the Insurer's liability

1. Apart from the exclusions set out in §14 the General Part of the GTC, the Insurer's liability shall not include critical illnesses arising from:
   1) Illnesses that have been diagnosed or whose associated and medically documented symptoms or signs were first diagnosed within 3 months of the date of joining the Agreement in the scope of the Module of Critical Illnesses Treatment abroad – BEST HELP;
   2) Illnesses which have been diagnosed or treated or diseases the symptoms of which have been ascertained by relevant medical documents within 10 years preceding the date of commencement of insurance coverage under the Agreement in the scope of the Module for treatment of critical illnesses abroad – BEST HELP;
   3) Medical procedures required for AIDS, HIV or related diseases (including Kaposia's muscle), or for the treatment of AIDS or HIV;
   4) Experimental treatment as well as treatments or activities which have not been generally recognised by leading organisations in the United States of America and Europe recognised by the international medical community as safe, effective or appropriate for the treatment of a given Critical illness condition, or treatment
   at the stage of examination, testing or at any stage of medical experiments or clinical studies;
   5) A claim for which the Insured, before, during or after the process of assessment of the claim by FURTHER:
      a) has not complied with the advice, recommendations or agreed treatment plan of an attending Physician abroad; or
      b) refuses to undergo treatment or additional diagnostic analyses or tests necessary to make a final diagnosis or establish a treatment plan.

Expenses not covered

2. Apart from the exclusions set out in § 14 of the GTC General Part and referred to in section 1 above, the Insurer shall not be liable under the Agreement to the extent indicated in items 1–12 below, even if such benefits are justified or necessary as a result of a Serious Illness, i.e. within the scope of:
   1) expenses in connection with diagnosis, treatment, services, medical supplies or prescriptions of any kind incurred in the Republic of Poland), except
      a) medication expenses incurred in the Republic of Poland, referred to in §3 section E pt. 1,
      b) health Check expenses incurred in the Republic of Poland, referred to in §3 section 2;
   2) costs incurred before the date of issue of the treatment Promise;
   3) fees for other treatments, services, medical supplies or prescriptions in case of Illness or condition for which the best treatment according to the treatment plan confirmed by FURTHER is the organ transplantation covered by the Agreement (Module 4)
   4) costs incurred in another Hospital outside of the territory of the Republic of Poland than the one to which the Insured was referred in the treatment Promise;
   5) costs incurred for domestic care related to convalescence, staying in a healthcare home or services provided in an after-treatment centre or similar institution, health resorts, clinics and surgery of natural medicine, a hospice or the elderly home;
   6) costs incurred for the purchase or rental of any type of prosthesis or orthopedic devices, corsets, bandages, crutches, artificial members or organs, wigs (even if their use is deemed necessary during chemotherapy), orthopedic shoes, dental prostheses, hernia belts, wheelchairs, special beds, air-conditioning devices, air filters, appliances or items, except breast prostheses – after mastectomy, and artificial heart valves, necessary in connection with an Operation performed as part of the provision of Medical Care abroad (Medical Concierge service);
   7) organisation and coverage of alternative medicine and unconventional treatment (including acupuncture, aromatherapy, chiropractic, homeopathy, naturopathy, Ayurveda, traditional Chinese medicine and osteopathy), even if prescribed or recommended by a Physician during treatment of a Critical Illness;
   8) when, in addition to treatment under the Medical Care services abroad (Medical Concierge service), the need arises for treatment related to cognitive disorders, senile dementia or brain impairment, dementia, regardless of its severity, or in connection with childbirth or puerperium;
   9) the costs incurred for the translator, except for the translation organised by FURTHER, in relation to the treatment provided as part of the medical care abroad (Medical Concierge) service;
   10) costs incurred for telephone calls and charges in respect of items of personal use or which are not of a medical nature, or for services provided to an eligible accompanying person;
   11) costs incurred by the Insured or an authorised accompanying person, which are not covered by the scope of the Agreement;
   12) costs of accommodation or transport not arranged by FURTHER;
   13) treatment involving groups of therapies: gene therapy, somatic cell therapy, tissue engineering therapy and CAR-T cell therapy;
   14) any service or means of medical supply which is not medically necessary to treat the covered illness or to carry out the covered illness or operations;
   15) treatment of long-term side effects, alleviation of chronic symptoms or rehabilitation (including but not limited to physiotherapy, surgical rehabilitation, language and speech therapy);
   16) any expenses incurred in connection with any diagnosis, treatment, service, medical supply or prescription of any kind whatsoever, worldwide, where the Insured at the time of the claim cannot be regarded as a permanent/legal resident of the Republic of Poland;
   17) any expenses incurred outside of the compensation Period, except for those listed in § 4 pt. 14;
   18) Any medication that has not been dispensed by a licensed pharmacist or that is available without a prescription;
   19) Any medical expenses which are not a customary and reasonable charge;
   20) With regard to the costs of purchase of medicines referred to in §3 section E pt. 1, the following exclusions shall apply:
      a) Cost of medicine administration,
      b) Any purchases of Medicines made outside the Republic of Poland, unless expressly approved by FURTHER;
   21) With regard to the costs of a Health Check referred to in §3 section E pt. 2, the following exclusions shall apply:
      a) Any costs reimbursed by the National Health Fund (NFZ) of the Republic of Poland or covered by another insurance policy held by the Insured,
      b) Any costs incurred in breach of the guidelines established by FURTHER,
      c) Any costs incurred at a Hospital or medical facility other than those authorised by FURTHER.

3. Apart from the exclusions set out in §14 GTC General Part and referred to in sections 1 and 2 above, the Insurer's liability shall not include:
   1) in the case of cancer:
      a) any diagnosis of cancer within the meaning of §1 section A Module 1: Cancer treatment, in the course of acquired immune deficiency syndrome (AIDS);
      b) any skin cancer other than melanoma which has not been histologically classified as causing infiltration outside epidermis (external skin layer);
      c) any treatment involving CAR-T cell therapy.
   2) in the case of aortopulmonary bypass surgery:
      a) any coronary artery disease treated by techniques other than coronary artery bypass, such as, for example, any kind of angioplasty, stent.
   3) Organ transplant from a live donor (liver)
      a) any transplant carried out where there is a need to transplant as a result of hepatic disease caused by the consumption of alcohol;
      b) any transplant where transplantation is carried out as an self-transplant, with the exception of a bone marrow transplantation;
      c) any transplant where the Insured is a donor for a third party;
      d) any dead donor transplantation;
      e) any organ transplantation involving stem cell treatment;
      f) transplantation made possible by purchasing organs from donors.
   4. In the case of bone marrow transplantation:
      a) transplantation of haematopoietic stem cells (HCT) using cord blood.
   5. If the Insurance coverage under the Agreement with respect to a given Insured expires and:
      1) the Insured is in the course of treatment provided outside the Republic of Poland under the Agreement; or
      2) FURTHER issued a treatment Promise to the Insured prior to the expiry of the insurance coverage with respect to the Insured,

   The Insurer will guarantee the benefits under the Agreement available to the Insured to the extent and with the limitations indicated in the Agreement and the treatment Promise, but subject to a maximum period of up to 6 months from the date of termination of the Period of Coverage with respect to the Insured in question.

Module: Critical Illness Insurance

The provisions of this Module shall apply to insurance agreements concluded on the basis of GTC, within the scope of which the Module of critical illness Insurance falls. Inclusion of the Module in the Insurance Agreement shall be decided by the Policyholder.

§1 Definitions and exclusions used in the Module

1. **Critical illness** – the Illnesses or conditions specified below:
   a. **Malignant neoplasm (Cancer)** – Abnormal and excessive growth of body tissues, characterised by uncontrolled growth and spread of cancer cells, resulting in infiltration and destruction of normal tissue. The definition of a malignant neoplasm also includes leukemia, malignant lymphoma and Hodgkin's disease. Malignant neoplasms may be considered a Serious Illness on the following conditions:
      I. the results of histopathological examination, confirming cancer;
      II. confirmation of the diagnosis by the attending Physician specialising in oncology or hematology;
      III. the need for surgical, radiotherapeutic or chemotherapeutic treatment.

      The scope of insurance does not cover:
      I. any lesions described histopathologically as benign, precancerous, of low potential for malignancy and non-invasive; including carcinoma in situ (Tis) and Ta according to the classification of AJCC (American Journal of Critical Care, Seventh Edition TNM Classification);
      II. all skin cancers, except for malignant melanoma, grade higher than T1aN0M0 according to AJCC classification;
      III. prostate cancer, grade lower or equal to 6 by Gleason total score or described as T1N0M0 according to AJCC classification;
      IV. thyroid tumors with a diameter of less than 2 cm and described as T1N0M0 according to AJCC classification;
      V. all cancers coexisting with HIV infection, including (but not limited to) lymphoma and Kaposi's sarcoma.
   b. **Acute heart attack** – Clinical situation indicating an acute myocardial ischemia, with evidence of the presence of myocardial necrosis. The diagnosis of myocardial infarction must be made by the attending Physician based on the temporal relationship and meeting one of the following criteria:
      I. The detection of increase and/or decrease in the value of the cardiac biomarker [preferably cardiac troponin (cTn)], with at least one value above the 99th percentile of upper reference limit (URL) and at least one of the following:
         – symptoms of ischemia;
         – new or presumably new, significant changes in ST-segment T-wave (ST-T) or a new left bundle branch block (LBBB);
         – pathological Q waves in the ECG;
         – new loss of viable myocardium or new regional contractility abnormalities on imaging tests;
         – the presence of a blood clot in a coronary artery shown during angiography or autopsy.
      II. Increase (associated with Percutaneous Coronary Intervention - PCI) in cTn values (>5 × 99th percentile of URL) in patients with normal baseline results (<99th percentile of URL) or an increase in cTn >20% when the initial values were elevated and stable or were falling. Additional requirements:
         – symptoms suggestive of myocardial ischemia or
         – new ischemic lesions in ECG, or
         – angiographic image consistent with postoperative complications, or
         – visualisation by imaging of a new loss of viable myocardium or new segmental wall motion abnormalities;
      III. Detection (associated with stent thrombosis) of thrombosis by means of angiography or autopsy in the case of myocardial ischemia with an increase and/or decrease in the value of cardiac biomarkers, when at least one value exceeds 99th percentile of URL.
      IV. Increase (related to coronary artery bypass — CABG) in CTN value (>10 × 99th URL centile) in patients with correct cTN output values (£ 99th centile URL). Additionally, it is necessary to confirm:
         – new pathological Q waves or new LBBB, or
         – new graft or native coronary artery occlusion in the patient, documented by angiography, or
         – visualisation of new loss of viable myocardium or
         – new segmental contractility disorders .

      The coverage does not include episodes of angina chest pain (angina pectoris) or all other forms of acute coronary events.
   c. **Stroke** – Sudden, focal and irreversible brain tissue damage as a result of intracerebral circulatory disorders (embolism, blood clot or haemorrhage), resulting in permanent neurological deficits confirmed by physical examination and persisting for at least 3 months from the time of diagnosis of stroke. The diagnosis must be made by the attending Physician – a neurologist or neurosurgeon and be confirmed by the presence of fresh lesions in computed tomography (CT) or magnetic resonance imaging (MRI). The scope of insurance does not cover:
      I. episodes of transient ischemic attack (TIA);
      II. brain damage as a result of intracranial bleeding caused by an external trauma or an accident;
      III. pathology of the blood vessels causing labyrinth or visual disturbances, such as optic nerve or retina infarction;
      IV. a history of asymptomatic stroke, diagnosed on the basis of imaging studies.
   d. **Transplant of the main organs** – Transplant of the following to the Insured as the recipient: heart, lung, liver, pancreas, kidney or bone marrow. The transplant treatment had to be the result of irreversible, end-stage organ failure, and its performance had to be the only treatment for the Disease, confirmed by the treating Physician with a specialty in clinical transplantology or cardiology or general surgery or thoracic surgery or clinical oncology or hematology. The scope of cover does not include other grafts than those listed above, including, in particular, those using stem cells and pancreatic islets transplants.
   e. **Benign brain tumor** – Life-threatening brain tumor, resulting in permanent neurological deficits with evident movement or sensory disorders persisting continuously for a period of 6 months. The presence of the tumor must be confirmed by the treating Physician specialising in neurology or neurosurgery and visualized by CT or MRI. The scope of cover does not include cysts, granulomas, pathology of arterial and venous brain vessels, hematomas, abscesses, acoustic nerve neuromas, tumors (including adenomas) of the pituitary gland, lesions in the meninges and spinal cord.
   f. **Amputation of extremities** – Amputation of at least two limbs as a result of a Disease or an accident, at the level of the ankle or above for the lower limb or at the level of the wrist or above for the upper limb. The need for surgery must be confirmed by the treating Physician with a specialty in general surgery or orthopedics and traumatology of the musculoskeletal system.

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District Court for the Capital City of Warsaw in Warsaw
13th Commercial Division of the National Court Register
KRS: 0000395438
Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

g. **Heart valve surgery** – An open-heart procedure with the opening of the chest, replacement or repair of abnormal heart valves (one or more). The necessity of a surgery must be confirmed by the treating Physician specializing in cardiology or cardiac surgery and be confirmed by the results of medical examinations. Surgeries performed using endovascular techniques are excluded from the scope of cover.

h. **Coma** – State of unconsciousness with the lack of response to external stimuli and the natural needs, lasting for at least 96 hours, requiring intubation and mechanical ventilation to sustain life in the hospital. This state must result in permanent neurological deficits, persisting for at least 30 days from the onset of loss of consciousness, without prognosis for improvement. The diagnosis and scope of lesions must be confirmed by the treating Physician specialising in neurology or neurosurgery or anaesthesiology and intensive care. The insurance coverage does not include pharmacological coma or coma resulting from abuse of alcohol or drugs, self-harm or a suicide attempt.

i. **Multiple sclerosis** – A disease resulting from demyelination of nerve fibers in the central nervous system. The unambiguous diagnosis of the Disease (excluding other causes, including vascular ones), by the treating Physician specialising in neurology, must be confirmed by:
   I. the presence of permanent neurological deficits with evident movement or sensory disorders persisting continuously for a period of 6 months;
   II. the result of cerebrospinal fluid examination characteristic of multiple sclerosis, abnormal results of visual and auditory evoked potentials and magnetic resonance imaging (MRI), confirming the existence of scattered foci of demyelination in the central nervous system.

j. **Surgical treatment of coronary disease (by-pass)** – Surgical procedure involving opening of the chest, in order to eliminate stenosis or occlusion of one or more coronary arteries by by-pass graft implantation. The surgery must be preceded by an examination demonstrating the existence of coronary artery stenosis, and its performance must be the only way to treat the disease and be confirmed by the opinion of the treating Physician specialising in cardiac surgery. The coverage does not include coronary angioplasty (PTCA) or any other procedures performed on coronary arteries from the side of the coronary artery lumen and using coronary catheterisation techniques or laser techniques.

k. **Third degree burns** – Third-degree burns cover at least 20% of body surface. The diagnosis must be made by the treating Physician specialising in general surgery or thoracic surgery or plastic surgery and specify the degree and scope of burns, in accordance with the applicable clinical standards used for their determination.

l. **Loss of vision** – Total, permanent and irreversible loss of sight in both eyes due to an Illness or accident. The diagnosis must be confirmed by the treating Physician specialising in ophthalmology. The coverage does not include cases which may be corrected by therapeutic procedures, including surgical treatment.

m. **Loss of hearing** – Total, permanent, bilateral and irreversible loss of hearing in respect of all the sounds, caused by an Illness or accident. The diagnosis must be confirmed by the treating Physician specialising in otolaryngology and additionally by the result of tonal audiometric examination and impedance audiometry. The coverage does not include cases which may be corrected by therapeutic procedures, including a hearing aid and surgical treatment.

n. **Renal failure** – End-stage renal disease, characterized by a complete, irreversible bilateral renal impairment without prognosis for improvement, representing an absolute indication to start chronic dialysis therapy. The fact of starting dialysis therapy and the necessity to use it must be confirmed by the treating Physician specialising in nephrology. Acute renal failure requiring periodic dialysis is not covered by the Insurance.

o. **Aorta surgery** – Surgery of aneurysm, coarctation or aortic dissection performed via laparotomy or thoracotomy, involving the removal of pathologically altered aorta and replacing it with a graft. The necessity of a surgery must be confirmed by the treating Physician specialising in vascular surgery or cardiac surgery and be confirmed by the results of medical examinations. For the purposes of this definition, the aorta is understood as abdominal and thoracic aorta, without its branches. Surgical methods using microsurgery and endovascular techniques, including percutaneous repair procedures are not covered by the Insurance.

p. **Paresis (paralysis)** – Total, permanent and irreversible loss of function in two or more limbs due to an injury or Illness that prevents the Insured from doing at least 3 of the 5 following daily activities on his/her own:
   I. bathing – the ability to wash in the bath or shower (including getting into and out of the bath or shower);
   II. dressing – the ability to put on and to take off clothes;
   III. movement – the ability to move (including climbing stairs);
   IV. toilet – the ability to use the toilet;
   V. eating – the ability to eat a prepared and served meal.

   The paresis must show no chances for improvement and must be present over a period of at least 3 months. The diagnosis and scope of lesions must be confirmed by the treating Physician specialising in neurology or neurosurgery. The coverage does not include any cases of partial paralysis, transient paralysis (including that resulting from viral infections), paralysis caused by psychological or psychiatric disorders or resulting from self-harm or a suicide attempt.

q. **Aphasia** – Total, permanent and irreversible loss of speech caused by irreversible damage to the larynx or damage to the speech centre in the brain as a result of trauma, tumor growth or Disease. The total loss of speech must be present for a minimum of 6 consecutive months. The diagnosis must be confirmed by the treating Physician specialising in otolaryngology or audiology and phoniatrics. The coverage does not include any cases of loss of speech caused by psychological or psychiatric disorders.

§2 What is the subject matter of the Module?

1. The scope of the Critical Illness Insurance Module covers the occurrence of a critical illness in the Insured for the first time in his/her life. The scope of Critical Illnesses covered by insurance depends on the option selected by the Policyholder.

Option 1:	Option 2:

• Malignant neoplasm (cancer); • Acute myocardial infarction (MI); • Stroke; • Transplantation of major organs; • Benign brain tumour; • Loss of limb; • Heart valve surgery; • Coma.	• Malignant neoplasm (cancer); • Acute myocardial infarction (MI); • Stroke; • Transplantation of major organs; • Benign brain tumor; • Loss of limb; • Heart valve surgery; • Coma; • Multiple sclerosis; • Surgical treatment of coronary artery disease (by-pass); • Third-degree burns; • Loss of sight; • Loss of hearing; • Renal failure; • Surgery of the aorta; • Paresis (paralysis); • Loss of speech

2. The date of the Insured event, i.e. the date of occurrence of the Critical illness in the Insured, shall be:
   a. the date of the final diagnosis by the Physician confirming the compliance of the disease unit with the description of the Critical Illness;
   b. the date of the surgery in the case of surgeries related to the occurrence of a Critical Illness.

3. In the event of a Critical Illness, we will pay a cash benefit in the amount of the sum insured specified below:

Option 1:	**Option 2:**
PLN 30,000	PLN 50,000

4. Under the Module, one Insured is entitled to one Benefit, regardless of the number of Critical Illnesses during the coverage period.

5. We provide the following types of Module: Critical Illness Insurance;
   a. Individual,
   b. Partner,
   c. Family,
   d. Parent.
   The Policyholder may choose all or selected types of Module which will be available to be selected by the Insured under the Agreement.

6. Within the Module 24/7 worldwide insurance coverage is provided.

§3 How can the insurance be used?

1. In order to benefit from the Insurance, the Insured may notify us of the occurrence of a Critical Illness in the following forms:
   a. electronically – to the following email address: roszczenia.ubezpieczenia@luxmed.pl;
   b. in writing – by sending documents to the following address: LMG Försäkrings AB S.A. Branch in Poland, ul. Szturmowa 2, 02-676 Warsaw, Poland, with a note: LMG Reimbursement.

2. In order to decide on the payment of the Benefit, we need the following documents:
   a. a complete and properly completed application for the provision of the Service;
   b. a copy of the medical documentation confirming the final diagnosis of the Critical Illness or the performance of a surgical procedure;

3. In certain situations, it shall not be possible to benefit from the insurance. This is related to the grace period (described in §4 of this Module) and exceptional situations of limitation of our liability (described in §14 of the General Part of the GTC and §5 of this Module).

4. Upon receipt of the event notification, we follow the steps described in §4 sections 2–5 of the General Part of the GTC.

§4 What is the grace period?

1. In the Agreement, we apply a grace period; this is the period that must elapse from the beginning of the coverage period before the Insured is entitled to the benefit.

2. 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.

3. The deferred period for the Critical Illness shall be 3 months.

4. We do not apply a deferred period to events resulting from an accident.

5. If the Insured was covered by the insurance in which we were the Insurer and which covered a Critical Illness, the duration of the previous insurance shall be included in the deferred period to the extent corresponding to the previously held Module variant. 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 in the range of this Module. If the Insured was covered by several insurances, this rule applies only to the insurance agreement with the latest termination date.

§5 What are the additional exclusions from the coverage that will prevent us from implementing the Benefits within the Module?

In addition to the exclusions set out in § 1 section 1 of this Module and §14 of the General Part of the GTC, our liability in the Module: Critical Illness Insurance shall not cover events resulting from:

a. treatment of infection with HIV (AIDS), SARS-CoV-2 or hepatitis (with the exception of hepatitis A) viruses, and diseases resulting from those infections;
b. the Insured's 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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13th Commercial Division of the National Court Register
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Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

Module: Personal Accident Insurance

The provisions of this Module shall apply to insurance agreements concluded on the basis of the GTC, which include the Personal Accident Insurance Module. Inclusion of the Module in the Insurance Agreement shall be decided by the Policyholder.

§1 What is the subject matter of the Agreement?

1. The scope of the module covers the death of the Insured as a result of an accident which took place within 6 months from the date of the accident.
2. We provide the following types of Module – Personal Accident Insurance:
   a. Individual,
   b. Partner,
   c. Family.
   The Policyholder may choose all or selected types of Module which will be available to be selected by the Insured under the Agreement.
3. We will pay a cash Benefit in the amount of 100% of the sum insured due to an Event.
4. The sum insured for death in the Accident shall amount to PLN 50,000.
5. Within the Module 24/7 worldwide insurance coverage is provided;

§2 How to indicate the persons entitled to receive the Benefit?

1. The Insured may indicate the person entitled to receive the Benefit for the death of the Insured both before entering into the Module Agreement and at any time during the period of insurance coverage within the Module under the Agreement. At any time during the period of coverage under the Module, the Insured shall have the right to change or revoke the designation of the eligible party and to change the eligible party's percentage of Benefit.
2. The Insured may indicate to us one or more persons entitled to receive a Benefit under the Module and the percentage of their participation in the Benefit.
3. The Insured shall identify the Eligible party by submitting a request for identification or change of the Eligible party. The change concerning the designation of the Eligible party shall apply from the day following the date of submission of the application.
4. In the event of the death of the Eligible party or his/her loss of entitlement to the Benefit, his/her entitlement to the Benefit shall be taken over by the remaining persons indicated as Eligible (if there were more than one person indicated), in proportion to their percentage share in the Benefit.
5. If the Insured failed to indicate Eligible persons, or all Eligible persons died before the date of death of the Insured or lost the right to Benefit, the Eligible persons shall become:
   a. spouse, and if there is none:
   b. children (in equal parts), or in the absence thereof;
   c. parents (in equal parts), or failing that;
   d. siblings (in equal parts), or failing that;
   e. other heirs resulting from appropriate legal regulations, excluding district authorities and the State Treasury.

§3 How can the Personal Accident Insurance be used?

1. We will pay the benefit for the death of the Insured Person as a result of an Accident to the Eligible Party.
2. We will pay the Benefit under this Module to the Eligible party upon delivery of the following documents to us:
   a. a complete and properly completed application for the provision of the Service;
   b. the Insured's death certificate;
   c. a copy of the police/prosecutor's report or a court decision describing the course of the Accident, in the possession of the Insured.
3. The documents referred to in section 2 may be provided to us
   a. in writing – by personal delivery or by mail to the following address: LMG Försäkrings AB S.A. Branch in Poland, ul. Szturmowa 2, 02-676 Warsaw, Poland, with the note: LMG Reimbursement
   b. electronically – by sending a legible scan of the documents to the following address: roszczenia.ubezpieczenia@luxmed.pl
4. In certain situations, it may not be possible to benefit from the Insurance. This is due to exceptional situations of limitation of our liability (described in §14 of the General Part of the GTC and §4 of this Module).
5. Upon receipt of the Event notification, we follow the steps described in §4 sections 2 ¬ 5 of the General Part of the GTC.

§4 What are the exclusions from the coverage that will prevent us from implementing the Benefits within the Module?

In addition to the exclusions set out in §14 of the General Part of the GTC, our liability in the field of Personal Accident Insurance does not include Air accidents in which the Insured participated as a pilot, a crew Member or a passenger of a military or private aircraft of unlicensed airlines.

Appendix No. 1 to the General Terms and Conditions of LUX MED Group Insurance for Companies - GTC Code G/004/2024/C

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Additional information regarding designations in the content of the Detailed List of Benefits

names of medical procedures marked with "*" and described as "**Standard**" - means medical procedures that are commonly available and commonly used in the Republic of Poland.

Scope of services within the Module: Outpatient Care

§1 Medical Helpline 24/7

1. Medical Helpline is a healthcare service provided in situations requiring urgent assistance. This service includes the possibility of using Medical Helpline serviced by medical specialists (doctors, nurses) in the fields of internal medicine, family medicine, paediatrics and nursing, using the LUX MED Group 24/7 nationwide Infoline.
2. In medically justified cases, a medical specialist may refer the Entitled Person to an in-person consultation with a doctor, decide to call an ambulance, or refer him/her for urgent admission to the Hospital Emergency Department.
3. During the Medical Call Centre, the following are not issued:
   1) e-prescriptions for vaccines,
   2) potent medicines,
   3) medicines with potential for addiction,
   4) postcoital contraception (emergency contraception),
   5) referrals for examinations where ionizing radiation is used,
   6) referrals for biopsies,
   7) referrals for endoscopic examinations,
   8) referrals for exercise tests.
4. The provision of services in the form of Medical Helpline consultation is carried out exclusively for the benefit of the person who is indicated as a Person entitled to Health Services for the Medical Helpline on the basis of the concluded Agreement. The Entitled Person may not provide the service in the form of Medical Helpline to another person and bears full civil and criminal liability for ensuring that the data he/she provides are genuine. Medical Helpline service does not replace emergency services in a state of medical emergency.
5. Medical Helpline does not replace:
   1) services in a life or health emergency;
   2) in-person consultations because no direct examinations can be performed.
6. The final decision to issue an e-prescription/e-sick leave during a Medical Helpline consultation is at the discretion of the Physician who may refuse to issue an e-prescription/e-sick leave, based on medical indications and the Entitled Person's welfare.

§2 The Online Consultation

1. The Online Consultation is a Medical Service provided by the Operator through IT or communication systems. The Insurer enables the Insured an interactive individual consultation with a medical specialist (doctor, midwife or nurse) via means of distance communication i.e. the Patient Portal. The Insured with full access to the Patient Portal may benefit from Online Consultations. Time accessibility of Online Consultations with a doctor, a midwife and a nurse is a consequence of the schedule of medical specialists and is visible under "Online Consultation" ("Konsultacje online") tab. The Insured can choose a communication channel: video, audio or text.
2. Since medical specialists answering questions have access to the medical records of the Insured, in situations of medical necessity, they can order specific tests or refer the Insured to a different specialist. Online Consultations is exclusively available for the Insured who has logged in the Patient Portal and the content of Online Consultation is saved and constitutes a part of the medical documentation of the Insured.
3. Online Consultations include listed below medical specialists' consultations which do not require contact with a specialist in person:
   - ❍ internal medicine/family medicine (from the age of 18 years)
   - ❍ paediatrics (under the age of 18 years)
   - ❍ paediatric nursing
   - ❍ obstetrics
4. Online Consultation with a specialist does not replace an outpatient consultation because it does not enable direct examination.
5. In order to use the Online Consultation, the Insured after logging into the account on the Patient Portal in the "Online Consultations" tab sets himself in the queue waiting to use the insurance.
6. The provision of services in the form of Online Consultations is only for the benefit of the Insured who has concluded the Agreement or who is indicated as an Insured entitled to Medical Services under Online Consultations. The Insured cannot make Online Consultation service available to other individuals. The Insured bears full civil and criminal liability for the fact that the data provided are consistent with the facts.
7. Within the Online Consultation the Insured receives a Medical Service, and as a part of that service may be issued:
   1) a referral for diagnostics;
   2) a referral to another specialist for the purpose of obtaining another Telemedicine Advice;
   3) a referral to another specialist in order to obtain a Medical Service as part of an outpatient service,
   4) an e-Prescription for drugs for the continuation of chronic treatment,
   5) a de novo e-Prescription based on medical records and medical indications arising in the course of an Online Consultation;
   6) a medical certificate for medical indications.
8. In medically justified cases, while carrying out Online Consultation, a medical specialist may refuse to give advice at a distance and refer the Insured to an outpatient consultation with a doctor, a nurse or a midwife.

9. During the Online Consultation, the following are not issued:
   1) e-referrals;
   2) referrals for examinations during which ionizing radiation is used;
   3) referrals for biopsies;
   4) referrals for endoscopic examinations;
   5) referrals for exercise tests.
10. The final decision to issue an e-Prescription during Online Consultation is at the discretion of the physician who may refuse to issue an e-Prescription based on medical indications and the Insured's welfare.
11. A doctor during an Online Consultation will not issue an e-prescription for:
    1) vaccines;
    2) potent medicines;
    3) medicines with potential for addiction;
    4) postcoital contraception (emergency contraception).

§3 Healthcare specialists' consultations

1. The insurance provides an opportunity to obtain medical consultations in cases, such as onset of an illness, emergency medical assistance and general medical advice **without a referral.**
2. Consultations are available in the following forms:

1) in outpatient medical clinics indicated by us – in the form of on-site visits;
2) via communication systems – in the form of telephone or video consultations;
3) in Infection Treatment Centres – in the form of on-site visits for Entitled Persons with symptoms of infections, provided in selected Medical facilities indicated by the Insurer.

3. The insurance includes: medical history taking, physician's advice and basic procedures necessary for making a diagnosis, taking an appropriate therapeutic decision and monitoring of treatment and refers to consultations within the following scope:

- ❍ Internal medicine
- ❍ Family doctor
- ❍ Paediatrics

4. The benefit Specialist Consultation basic option does not include:

1) consultation of Doctors on duty,
2) consultation of Doctors with a post-doctoral degree or academic title of professor, as well as Doctors who hold the position of associate professor, associate professor and full professor.

§4 Healthcare specialists' consultations

1. The insurance provides an opportunity to obtain medical consultations in cases, such as onset of an illness, emergency medical assistance and general medical advice.
2. Consultations are available in the following forms:

1) in outpatient medical clinics indicated by us – in the form of on-site visits;
2) via communication systems – in the form of telephone or video consultations;
3) in Infection Treatment Centers – in the form of on-site visits for Entitled Persons with symptoms of infections, provided in selected medical facilities indicated by the Insurer.

3. The service - depending on the form of delivery - includes: an interview, advice from a specialist, together with the basic steps necessary for making a diagnosis, making the right therapeutic decision and monitoring treatment, and applies to consultations within the following scope:

1) for Insured **over 18 years of age** – visits **without a referral** relate to consultations within the following scope:

- ❍ allergology
- ❍ general surgery
- ❍ dermatology
- ❍ diabetology
- ❍ endocrinology
- ❍ gastroenterology
- ❍ gynaecology
- ❍ gynaecological endocrinology
- ❍ haematology
- ❍ cardiology
- ❍ laryngology
- ❍ nephrology
- ❍ neurology
- ❍ ophthalmology
- ❍ optometry
- ❍ oncology
- ❍ orthopaedics
- ❍ proctology
- ❍ pulmonology
- ❍ rheumatology
- ❍ urology

2) for Insured **under 18 years of age**– visits **without a referral** relate to consultations within the following scope:

- ❍ anaesthesiology
- ❍ geriatrics

- ❍ angiology
- ❍ audiology
- ❍ balneology and physical medicine
- ❍ vascular surgery
- ❍ surgical oncology
- ❍ infectious diseases
- ❍ phlebology
- ❍ phoniatry
- ❍ gynaecological oncology
- ❍ hepatology
- ❍ hypertension therapy
- ❍ immunology
- ❍ travel medicine
- ❍ neurosurgery
- ❍ medical rehabilitation

3) for Insured **over 18 years of age** – visits **require a referral** from a physician employed by a Clinic and relate to consultations within the following scope:

- ❍ anaesthesiology
- ❍ angiology
- ❍ audiology
- ❍ balneology and physical medicine
- ❍ vascular surgery
- ❍ surgical oncology
- ❍ infectious diseases
- ❍ phlebology
- ❍ phoniatry
- ❍ geriatrics
- ❍ gynaecologic oncology
- ❍ hepatology
- ❍ hypertension therapy
- ❍ immunology
- ❍ travel medicine
- ❍ neurosurgery
- ❍ medical rehabilitation

4) for Insured **under 18 years of age** – visits require a referral from a physician employed by a Clinic and relate to consultations within the following scope:

- ❍ allergology
- ❍ anaesthesiology
- ❍ infectious diseases
- ❍ diabetology
- ❍ endocrinology
- ❍ gastroenterology
- ❍ gynaecology (under 16)
- ❍ haematology
- ❍ immunology
- ❍ cardiology
- ❍ travel medicine
- ❍ nephrology
- ❍ neonathology
- ❍ neurosurgery
- ❍ oncology
- ❍ pulmonology
- ❍ medical rehabilitation doctor
- ❍ rheumatology
- ❍ urology

4. The Specialist Consultation benefit (Option III) does not include:

1) consultation of Doctors on duty;

2) consultation of Doctors with a post-doctoral degree or academic title of professor, as well as Doctors who hold the position of associate professor, associate professor and full professor.

1. Other consultations are also chargeable.

§5 Consultation of mental health and speech development specialists

1. The insurance entitles to attend consultation in outpatient Medical Facilities indicated by the Insurer, within the following scope:
2. I case:

1) **The Insured over 18 years of age – total of 3 consultation within a 12-month term of the agreement**) **without a referral** relate to consultations within the following scope:

- ❍ psychiatry
- ❍ psychology
- ❍ sex therapy
- ❍ speech therapy

2) **The Insured up to 18 years of age – total of 3 consultation within a 12-month term of the agreement visits without a referral** relate to consultations within the following scope:

- ❍ psychology
- ❍ speech therapy

3) **The Insured s up to 18 years of age – 1 consultation within a 12-month term of the agreement without a referral** relate to consultations within the following scope:

- ❍ psychiatry

3. This includes: medical history taking, specialist advice and basic procedures necessary for making a diagnosis, taking an appropriate therapeutic decision and monitoring of treatment.
4. The service does not include professor consultations, neuro speech therapy or speech therapy in deaf and hearing-impaired patients or conducting therapy.

§6 Dietician consultations

1. The insurance entitles the Insured to attend dietary consultations, including interview, dietary recommendations (without creating an individual diet) in Medical Facilities indicated by the Insurer.
2. In case of:
   1) the Insured over 18 years of age – visits without a referral;
   2) the Insured up to 18 years of age – visits require a referral from a physician employed by a Clinic.

§7 On-duty physician consultations

1. The insurance includes exclusively basic emergency assistance in a sudden onset of an illness which has occurred within 24 hours preceding the receipt of a consultation request by the Operator. On-duty doctors are available within the working hours of Medical Facilities indicated by the Insurer, only on the day of reporting it.
2. The insurance does not include healthcare services provided to save life and health in accordance with the National Medical Rescue Act (Journal of Laws 2006.191.1410, as amended).
3. The insurance includes: medical history taking, physician's advice and basic procedures necessary for making an initial diagnosis, taking an appropriate therapeutic decision and refers to consultations within the following scope:

- ❍ Internal medicine
- ❍ Paediatrics
- ❍ Family doctor

4. In the case of Insured **over 18 years of age**, in addition (as long as the above mentioned consultations are available at the facility):

- ❍ general surgery
- ❍ orthopaedics

§8 Professor consultations

1. The insurance entitles the Insured with a referral issued by a physician from a Clinic indicated by the Insurer to use the consultations of physicians with the degree of "doktor habilitowany" (associate professor) or the scientific title of "profesor" (professor) as well as physicians holding the positions of "docent" (assistant professor), "profesor nadzwyczajny" (associate professor) and "profesor zwyczajny" (full professor).
2. The insurance (if available in the Medical Facilities indicated by the Insurer) covers the same range of consultations, which the Insured is entitled to on the grounds of the Agreement within the Specialists consultations

§9 Nursing procedures

1. The insurance including basic measurements, minor procedures, including diagnostic ones, performed by a nurse or midwife on their own or according to the Physician's order, in line with their competences, in Medical Facilities indicated by the Insurer.
2. The scope of outpatient consultation procedures depends on the range of physician consultation which the Insured is entitled to under the insurance coverage, the age of the Insured and on the availability of a given procedure in a Clinic indicated by the Insurer.
3. Nursing procedures include:

- ❍ Intravenous injection
- ❍ Subcutaneous/intramuscular injection
- ❍ Emergency drip
- ❍ Oral medication in an emergency situation
- ❍ Measurement of body temperature (without referral)
- ❍ Application / change / removal - small dressing
- ❍ Blood sampling
- ❍ RR/pressure measurement (without referral)
- ❍ Height and weight measurement (without referral)
- ❍ Midwifery service in the office - breast palpation

4. Medical materials and supplies such as:

- ❍ dressings,
- ❍ swabs
- ❍ bandages
- ❍ plasters
- ❍ venflon
- ❍ syringes
- ❍ needles
- ❍ serum - tetanus antitoxin,
- ❍ disinfectants,

2. used for the above-mentioned treatments are free of charge.
5. A fee shall be charged to the Insured for other medical materials and supplies not mentioned in point 4, but used for the aforementioned treatments.

§10 Outpatient procedures

1. The insurances including basic measurements and procedures (including the diagnostic ones) not requiring hospitalization and operating room regimen. Performed in accordance with the competences by a physician or a nurse or an obstetrician during a procedure-specific consultation or beyond the medical consultation, in Medical Facilities indicated by the Insurer.

2. The scope of outpatient consultation procedures depends on the range of physician consultation which the Insured is entitled to under the insurance coverage, the age of the Insured and on the availability of a given procedure in a Clinic indicated by the Insurer.
3. Outpatient procedures include:

1) outpatient general medical procedures:

- Blood pressure measurement
- Height and body weight measurement
- Non-surgical tick removal

2) outpatient surgical procedures:

- Classical surgical excision of a skin lesion of up to 1,5 cm due to medical indications (does not include lesions excised due to aesthetic, plastic indications) with standard histopathological examination – specimen from the skin lesion removed
- Ingrown nail procedure (onychoplasty) – bilateral
- Ingrown nail procedure (onychoplasty) – unilateral
- Nail surgery – cleaning / removal
- Non-surgical tick removal
- Placement/change/removal – small dressing (not requiring surgical debridement)
- Removal of a boil / small skin abscess (up to 2 cm).
- Removal of another foreign body without incision
- Sampling of skin tissue for specialist examination
- Skin procedure – incision of haematoma / abscess, with drainage
- Skin procedure – removal of a foreign body, with wound debridement (removal of a foreign body from the skin with wound debridement)
- Stitching a wound of up to 3 cm (in emergency situations requiring immediate help);
- Surgical tick removal
- Suture removal after procedures performed outside of Medical Facilities indicated by the Insurer, qualification based on the doctor's assessment (we do not remove stitches after childbirth)
- Suture removal in a treatment room after procedures performed in the Medical Facilities indicated by the Insurer
- Suturing of a wound up to 1,5 cm
- Wound cleansing / excision

3) outpatient laryngological procedures:

- Application/change/removal of a drain in the ear canal
- Bilateral dressing of nasal hemorrhage
- Catheterisation of the Eustachian tube
- Closed reduction of the nose
- Coagulation of blood vessels of the nasal septum
- Cryosurgery (does not include snoring therapy)
- Ear irrigation
- Electrocoagulation of blood vessels of the nasal septum
- Eustachian tube examination, insufflation
- Incision of auricular haematomas
- Incision of haematomas of the nasal septum
- Incision of the lingual frenulum in the oral cavity
- Laryngeal clysis
- Nasal administration of mucosa-shrinking medicine as needed
- Nasal tamponade removal
- obliteration of varicose veins at the base of tongue;
- Pretz sinus rinse
- Removal of a foreign body from the nose/ear
- Simple laryngological dressing
- Sinus puncture
- Sinus rinse
- Suture removal after laryngological procedures performed outside of Medical Facilities indicated by the Insurer, qualification based on the doctor's assessment;
- Suture removal in a treatment room after laryngological procedures performed in Medical Facilities indicated by the Insurer
- Unilateral dressing of nasal hemorrhage

4) outpatient ophthalmologic procedures:

- Corrective lens selection (excludes varifocal lenses)
- Gonioscopy (iridocorneal angle assessment)
- Lacrimal duct irrigation (refers to: the Insured over 18 years of age)
- Medicine instillation into the conjunctival sac
- Removal of a foreign body from the eye
- Standard* autorefractometry
- Standard* intraocular pressure measurement
- Standard* ocular fundus examination
- Standard* stereoscopic vision examination
- Visual acuity examination

5) outpatient orthopaedic procedures:

- Adjustment of small orthopaedic devices – big joints
- Adjustment of small orthopaedic devices — small joints
- Dessault type immobilisation (small/large)
- Intra-articular and peri-articular block;
- Intra-articular injection and peri-articular injection
- Upper limb plaster cast removal
- Intra-articular puncture – taking sample material for examination
- Lower limb plaster cast removal Placement of a jacket type traditional plaster cast
- Placement/change/removal - small dressing
- Plaster cast application
- Preparation: traditional cast – tape
- Reposition of a dislocation or fracture

6) outpatient dermatological procedures:

- Aesthetic cryotherapy dermatological procedure 1 to 6 lesions
- Aesthetic cryotherapy dermatological procedure 7 to 10 lesions
- Dermatological procedure – curettage/destruction of skin lesion
- Dermatological procedure – cutting and coagulation of skin fibromas
- Dermatological procedure – PUVA lamp

- ❍ Aesthetic electrotherapy dermatological procedure 1 to 6 lesions
- ❍ Aesthetic electrotherapy dermatological procedure 7 to 10 lesions
- ❍ Standard* dermatoscopy

7) Outpatient gynecological procedures:

- ❍ Standard* sample collection for Pap smear
- ❍ Removal of an intrauterine contraceptive device
- ❍ Insertion of an intrauterine contraceptive device
- ❍ Cervical procedures by crycoagulation - preventing cervical erosion
- ❍ Cervical and vulvar procedures by cryocoagulation

8) Outpatient allergological procedures:

- ❍ Desensitisation with allergist consultation

9) Anaesthesia:

- ❍ Local (infiltration or permeation) anaesthesia
- ❍ Simple anaesthesia for colonoscopy
- ❍ Simple anaesthesia for gastroscopy
- ❍ Local (topical) anesthesia for endoscopy

10) Biopsy with standard histopathological examination – fine-needle biopsy material:

- ❍ Fine-needle biopsy – skin / subcutaneous tissue
- ❍ Fine-needle biopsy – breast
- ❍ Fine-needle biopsy - salivary gland
- ❍ Fine-needle biopsy – thyroid gland
- ❍ Fine-needle biopsy – lymph nodes

11) Other:

- ❍ Foley catheter application
- ❍ Foley catheter removal
- ❍ Performing an enema
- ❍ Removal of a polyp up to 1 cm during colonoscopy
- ❍ Removal of a polyp up to 1 cm during gastroscopy

4. Medical materials and supplies such as:

- ❍ dressings
- ❍ bandages
- ❍ plasters
- ❍ venflon
- ❍ syringes
- ❍ cotton wools
- ❍ plasters
- ❍ needles
- ❍ serum - tetanus antitoxin
- ❍ disinfectants
- ❍ sutures and surgical sutures

3. used for the above-mentioned treatments are free of charge.

5. A fee shall be charged to the Insured for other medical materials and supplies not mentioned in point 4, but used for the aforementioned treatments.

§11 Influenza and tetanus vaccinations

1. As part of infectious disease prevention, the insurance includes vaccinations against seasonal flu and administer tetanus anatoxin (anti-tetanus anatoxin).
2. The insurance includes:

- ❍ Medical consultation before vaccination (consists of a medical consultation with a doctor or nurse before vaccination
- ❍ Performance of a nursing service (injection)
- ❍ Vaccine (the medicinal product

3. Flu vaccinations are performed in Medical Facilities indicated by the Insurer.

§12 Additional recommended preventive vaccinations

1. The insurance is available within the additional prophylaxis of infectious diseases in Medical Facilities indicated by the Insurer, following referral issued by a physician of the abovementioned Clinic.
2. The insurance covers the following vaccinations (this also refers to combination vaccines) against:

- ❍ Tick-borne encephalitis
- ❍ Hepatitis A
- ❍ Hepatitis A and B
- ❍ Rubella, mumps, measles

3. The insurance includes:

- ❍ Medical consultation before vaccination (consists of a medical consultation with a doctor or nurse before vaccination
- ❍ Performance of a nursing service (injection).
- ❍ Vaccine (the medicinal product)

§13 Laboratory test panel (no referral needed)

4. The insurance is provided only in Medical Facilities indicated by the Insurer. The insurance includes a one-time performance of a panel of laboratory tests, composed of the following items, without a referral from a physician (within 12 months of the Insurance Period):

1) in the case of Insureds **aged 18 and over**:

- Urine - general examination
- Morphology + platelets + automated smear
- Lipid panel
- Fasting glucose
- Standard* Pap smear
- TSH
- beta-hCG

2) for Insureds **under 18 years of age**:

- Urine - general examination
- Morphology + platelets + automated smear
- Fasting glucose
- Strip CRP
- Standard* Pap smear (available for Insureds over 16 years of age)

§14 Laboratory and imaging diagnostics

1. The benefit covers the following laboratory, imaging and functional diagnostic tests, performed in Medical Facilities indicated by the Insurer.
2. All diagnostic tests and examinations available within the insurance are performed following referrals issued by physicians from Medical Facilities, only based on medical indications as part of a diagnostic and therapeutic process conducted in these Medical Facilities:

1) Laboratory diagnosis - **hematological and coagulological tests including taking of material (blood) for examination:**

- Absolute eosinophil count
- Antithrombin III
- APTT
- Blood count + platelet count + automated smear
- C protein activity
- D – dimers
- ESR
- Factor V Leiden – PCR method
- Fibrinogen
- INR / Prothrombin time
- Manual blood smear
- Platelets
- S protein free
- Thrombin time – TT

2) Laboratory diagnostics **- biochemical and hormonal tests and tumour markers together with collection of material (blood) for examination:**

- 17 – OH Progesterone
- ACE
- Acid phosphatase
- Adrenocorticotropic hormone (ACTH)
- AFP – alpha-fetoprotein
- Albumins
- Aldolase
- Aldosterone
- Alkaline phosphatase
- Alkaline phosphatase – bone fraction
- Alpha-1 – antitrypsin
- Alpha-1 acid glycoprotein (Orosomucoid)
- Amylase
- Androstendione
- Apo A1
- Apolipoprotein A1
- Blood-cell cholinesterase / Blood-cell acetylcholinesterase
- BNP
- BRCA1, method: PCR
- CA 125
- CA 15.3 – breast cancer antigen
- CA 19.9 – digestive cancer antigen
- CA 21-1 – lung tumour marker
- CA 72-4 – colon tumour marker
- Caeruloplasmin
- Caeruloplasmin
- Calcitonin
- Calcium (Ca)
- CEA – carcinoembryonic antigen
- Chlorides (Cl)
- Cholesterol
- Cholinesterase
- CK – MB activity
- CK – MB mass
- Immunoglobulin IgG
- Immunoglobulin IgM
- Insulin – 1 hour after 75 g glucose ingestion
- Insulin – 2 hours after 75 g glucose ingestion
- Insulin – 3 hours after 75 g glucose ingestion
- Insulin – 4 hours after 75 g glucose ingestion
- Insulin – 5 hours after 75 g glucose ingestion
- Insulin / Insulin 120'
- Insulin / Insulin 60'
- Iron (Fe)
- Iron / Fe 120 mins after administration (absorption curve)
- Iron / Fe 180 mins after administration (absorption curve)
- Iron / Fe 240 mins after administration (absorption curve)
- Iron / Fe 300 mins after administration (absorption curve)
- Iron / Fe 60 mins after administration (absorption curve)
- Kappa light chains in serum
- Lambda light chains in serum
- LDH – Lactate dehydrogenase
- LDL cholesterol
- Leptin
- LH
- Lipase
- Lipid profile (CHOL, HDL, LDL, TG)
- Macroprolactin
- Magnesium (Mg)
- Myoglobin
- NSE – Neuro-specific enolase
- NT pro – BNP
- Occult iron binding capacity (UIBC)
- Osteocalcin (bone formation marker)
- PAPP – a protein
- Parathyroid hormone
- Phosphorus (P)
- Potassium (K)

- ❍ CK (creatine kinase)
- ❍ Copper
- ❍ Cortisol in the afternoon
- ❍ Cortisol in the morning
- ❍ C-peptide
- ❍ Creatinine
- ❍ Creatinine clearance
- ❍ CRP quantitative
- ❍ Cystatin C
- ❍ Dehydroepiandrosterone (DHEA)
- ❍ DHEA – S
- ❍ Direct bilirubin
- ❍ Directly measured LDL cholesterol
- ❍ Erythropetin
- ❍ Estradiol
- ❍ Fasting glucose
- ❍ Fasting insulin
- ❍ Fee testosterone
- ❍ Ferritin
- ❍ Folic acid
- ❍ Free estriol
- ❍ Free PSA
- ❍ Free T3
- ❍ Free T4
- ❍ FSH
- ❍ Gastrin
- ❍ GGTP
- ❍ Glucose 120'/120' after a meal
- ❍ Glucose 60'/60' after a meal
- ❍ Glucose 75 g, 4-hour glucose challenge test
- ❍ Glucose 75 g, 5-hour glucose challenge test
- ❍ Glucose tolerance test (4 points, 75 g, 0, 1, 2, 3 h)
- ❍ GOT/AST transaminase
- ❍ GPT/ALT transaminase
- ❍ Growth hormone (GH)
- ❍ Haptoglobin
- ❍ Hb A1c – Glycated haemoglobin
- ❍ HDL cholesterol
- ❍ Homocysteine
- ❍ IGF – BP 3
- ❍ Immunoglobulin IgA
- ❍ Immunoglobulin IgE (total IgE)
- ❍ Progesterone
- ❍ Prolactin
- ❍ Prolactin 120' after administration MCP 1 tablet
- ❍ Prolactin 30' after administration of MCP 1 tablet
- ❍ Prolactin 60' after administration of MCP 1 tablet
- ❍ Prostatic acid phosphatase
- ❍ Protein profile
- ❍ PSA panel (PSA, FPSA, FPSA / PSA index)
- ❍ Renin activity of plasma
- ❍ Reticulocytes
- ❍ S100
- ❍ SCC – squamous cell carcinoma antigen
- ❍ SHBG
- ❍ Sodium (Na)
- ❍ Somatomedin – (IGF – 1)
- ❍ Testosterone
- ❍ Thyroglobulin
- ❍ TIBC – total iron binding capacity (alternative to Fe saturation)
- ❍ Total Beta-hCG
- ❍ Total bilirubin
- ❍ Total protein
- ❍ Total PSA
- ❍ Total T3
- ❍ Total T4
- ❍ TPS
- ❍ Transferrin
- ❍ Triglycerides
- ❍ TSH / hTSH
- ❍ Urea/blood urea nitrogen, BUN
- ❍ Uric acid
- ❍ Vitamin B12
- ❍ Vitamin D3 – 1,25 (OH)2 metabolite
- ❍ Vitamin D3 – 25-OH metabolite
- ❍ Zinc
- ❍ Zinc protoporphyrin (ZnPP)
- ❍ β2 microglobulin

3) laboratory diagnosis **- serological tests and infection diagnosis with collection of material (blood) for examination**:

- ❍ A-microsomal/anti-TPO antibodies
- ❍ Anti-beta-2–glicoprotein I IGG antibodies
- ❍ Anti-beta-2–glicoprotein I IGM antibodies
- ❍ Anti-beta-2-glicoprotein IgG and IgM antibodies (total)
- ❍ Antibodies against striated muscles and cardiac muscle (myasthenia gravis), method: IIF
- ❍ Antibodies against striated muscles, method: IIF
- ❍ Antibodies to acetylocholine receptors (AChR-Ab)
- ❍ Antibodies to adrenal cortex
- ❍ Antibodies to Ascaris lumbricoides, IgG
- ❍ Antibodies to Castle's intrinsic factor and anti-parietal cell antibodies (APCA), method: IIF
- ❍ Antibodies to double-stranded / native DNA – dsDNA (nDNA)
- ❍ Antibodies to dsDNA method: IIF
- ❍ Antibodies to myocardial cells (HMA)
- ❍ Chlamydia pneumoniae IgM antibodies
- ❍ Chlamydia trachomatis IgA antibodies
- ❍ Chlamydia trachomatis IgG antibodies
- ❍ Chlamydia trachomatis IgM antibodies
- ❍ CMV antibodies IgG
- ❍ CMV antibodies IgM
- ❍ Complement component 3 (C3)
- ❍ Complement component 4 (C4
- ❍ Coxackie antibodies
- ❍ Cytomegalovirus (CMV), method: Qualitative PCR
- ❍ Cytomegaly – IgG avidity test
- ❍ EBV / mononucleosis IgG
- ❍ EBV / mononucleosis IgM
- ❍ EBV, method: Qualitative PCR
- ❍ EBV, method: Quantitative PCR

- Antibodies to ovary antigen, method: IIF
- Antibodies to pancreatic islets, pancreatic exocrine cells and goblet cells in intestines, method: IIF
- Antibodies to pemphigus and pemphigoid, method: IIF
- Antibodies to TSH receptors (TRAb)
- Anticardiolipin antibodies – IgG
- Anticardiolipin antibodies – IgG and IgM
- Anticardiolipin antibodies – IgM
- Anti-CCP antibodies
- Anti-endomysial and anti-reticulin IgA antibodies
- Anti-endomysial and anti-reticulin IgG antibodies
- Anti-endomysial, anti-reticulin and anti-gliadin antibodies, IgA+IgG
- Anti-endomysial, anti-reticulin and anti-gliadin antibodies, IgG
- Anti-gliadin IgG and IgA (AGA) antibodies (total), method: IIF
- Anti-glomerular basement membrane (GBM) antibodies and anti-alveolar basement membrane (ABM) antibodies, method: IIF
- Anti-HAV – IgM
- Anti-HAV – total
- Anti-liver cytosol antibodies Type 1 (anti-LC1), method: Western blot
- Anti-liver kidney microsomal antibodies (Anti-LKM), method: IIF
- Anti-mitochondrial antibodies (AMA)
- Anti-mitochondrial antibodies (AMA) type M2
- Anti-neutrophil cytoplasmic antigen antibody ANCA (pANCA and cANCA), method: IIF
- Anti-nuclear (including histone, Ku, rib-P-Protein) antibodies (ANA3), method: Western blot
- Anti-nuclear and anti-cytoplasmatic antibodies (ANA1), screening, method: IIF
- Anti-nuclear and anti-cytoplasmatic antibodies (ANA2), method: IIF, DID
- Anti-nucleosome antibodies (ANuA) (IMMUNOBLOT)
- Anti-parietal cell antibodies (APCA), method: IIF
- Anti-phosphatidylinositol IgG antibodies
- Anti-phosphatidylinositol IgM antibodies
- Anti-phosphatidylserine IgG antibodies
- Anti-phosphatidylserine IgM antibodies
- Anti-prothrombin IgG antibodies
- Anti-prothrombin IgM antibodies
- Anti-reticulin antibodies (ARA) IgA and IgG (total), method: IIF
- Anti-reticulin antibodies (ARA) IgA, method: IIF
- Anti-reticulin antibodies (ARA) IgG, method: IIF
- Anti-Saccharomyces cerevisiae antibodies (ASCA) IgG, method: IIF
- Anti-smooth muscle antibodies (ASMA)
- Anti-tGT (anti-tissue transglutaminase) IgA antibodies, method: ELISA
- Anti-tGT (anti-tissue transglutaminase) IgG and IgA antibodies, method: ELISA
- Anti-tGT (anti-tissue transglutaminase) IgG antibodies, method: ELISA
- Antithyroglobulin / anti-TG antibodies
- Ascaris lumbricoides (ASCARIS) IGG
- ASO qualitative
- ASO quantitative
- Basic syphilis serology (VDRL or USR or anti-TP), formerly WR
- Bile duct antibodies, method: IIF
- Blood group (AB0), Rh factor and antibody screening
- Borelia burgdorferii, method: Qualitative PCR
- Borreliosis (Lyme disease) IgG
- Borreliosis (Lyme disease) IgM
- Borreliosis IgG Western-blot method (confirmatory test)
- Borreliosis IgM Western-blot method (confirmatory test)
- Brucellosis – IgG
- EBV/mononucleosis – latex
- Echinococcosis (Echinococcus granulosus) IgG
- Endomysium IgA antibodies – EmA IgA
- Endomysium IgG antibodies – EmA IgG
- Endomysium IgG, IgA antibodies – EmA
- FTA test
- Full liver panel antibodies (ANA2, AMA, ASMA, anti-LKM, anti-LSP, anti-SLA), method: IIF, DID
- Glutamic acid decarboxylase (anti-GAD) antibodies
- HBc Ab IgM
- HBc Ab total
- HBe Ab
- Hbe Ag
- HBs Ab/antibodies;
- HBs Ag/antigen
- HBV, method: Qualitative PCR
- HBV, method: Quantitative PCR
- HCV Ab/antibodies
- HCV, method: Qualitative PCR
- HCV, method: Quantitative PCR
- Helicobacter pylori IgG, quantitative;
- Hemochromatosis, method: PCR
- HIV-1/HIV-2
- HLA B27 antigen assay
- HPV (Human papillomavirus), method: Qualitative PCR – swab
- hsCRP
- HSV / Herpes 1 and 2 – IgG – qualitative
- HSV / Herpes 1 and 2 – IgM – qualitative
- IgA and IgG antibodies to endomysium and gliadin (total), method: IIF
- IgA antibodies to endomysium and gliadin (total), method: IIF
- IgA anti-gliadin antibodies – AGA
- IgG antibodies to endomysium and gliadin (total), method: IIF
- IgG anti-gliadin antibodies – AGA
- Immune antibody screening / alloantibodies (replaces anti-Rh /-/ antibodies)
- Intestinal panel (antibodies to pancreatic exocrine cells and goblet cells in intestines, ASCA, ANCA), method: IIF
- Listeriosis – qualitative
- Liver panel antibodies – (anti-LKM, anti-LSP, anti-SLA), method: IIF
- Lupus anticoagulant
- Measles – IgG
- Measles – IgM
- Mumps – IgG
- Mumps – IgM
- Mycoplasma pneumoniae – IgG
- Mycoplasma pneumoniae – IgM
- Mycoplasma pneumoniae, method: Qualitative PCR
- Parvovirus B19 – IgG and IgM
- PCR HSV – herpes, qualitative
- Pertussis – IgA
- Pertussis – IgG
- Pertussis – IgM
- Pneumocystosis IgG – quantitatively
- Pneumocystosis IgM – quantitatively
- RF – Rheumatoid Factor – quantitative
- Rubella IgG
- Rubella IgM
- SLE – semi-quantitative
- Toxoplasma IgM

- ❍ Brucellosis – IgM
- ❍ BTA test
- ❍ C1 – inhibitor
- ❍ C1 – inhibitor (activity)
- ❍ Chlamydia pneumoniae IgA antibodies
- ❍ Chlamydia pneumoniae IgG antibodies
- ❍ Syphilis serology – FTA – ABS confirmatory test
- ❍ Tick-borne encephalitis IgM antibodies
- ❍ Toxocariasis IgG (semi-quantitative)
- ❍ Toxoplasma gondii, method: Qualitative PCR
- ❍ Toxoplasma IgG
- ❍ Toxoplasmosis – IgG avidity test
- ❍ TPHA test
- ❍ Trichinosis, IgG
- ❍ Tyrosine phosphatase (IA2) antibodies
- ❍ Ureaplasma urealyticum, method: Qualitative PCR
- ❍ Varicella IgG
- ❍ Varicella IgM
- ❍ Waaler-Rose test
- ❍ Yersinia enterocolitica antibodies – IgG
- ❍ Yersinia enterocolitica antibodies – IgG, IgM, IgA (total)
- ❍ Yersinia enterocolitica antibodies – IgM

4) laboratory diagnosis - **urine tests including taking material (urine) for examination**:

- ❍ 17 – hydroxycorticosteroids in 24-hour urine collection
- ❍ 17 - ketosteroids in 24-hour urine collection
- ❍ 5-Hydroxyindoleacetic acid in 24-hour urine collection (5 – HIAA)
- ❍ Albumin / Albumins
- ❍ Albumin in 24-hour urine collection
- ❍ Albumin/creatinine ratio in urine (ACR) (former microalbuminuria in urine)
- ❍ Aldosterone in 24-hour urine collection
- ❍ Amylase in urine
- ❍ Bence–Jones protein in urine
- ❍ Bence–Jones protein in urine
- ❍ Cadmium in blood
- ❍ Calcium in urine
- ❍ Calcium/Ca in urine / 24-hour urine collection
- ❍ Catecholamines (noradrenaline, adrenaline) in 24-hour urine collection
- ❍ Chemical composition of renal calculus
- ❍ Chlorides / Cl in urine
- ❍ Chlorides / Cl in urine / 24-hour urine collection
- ❍ Coproporphyrines in urine
- ❍ Cortisol in 24-hour urine collection
- ❍ Creatinine – urine / 24-hour urine collection
- ❍ Creatinine in urine
- ❍ Delta - aminolevulinic acid (ALA)
- ❍ D-Pyrilinks (bone resorption marker)
- ❍ Delta - aminolevulinic acid (ALA) in 24-hour urine collection
- ❍ Hippuric acid in urine / 24-hour urine collection
- ❍ Kappa light chains in urine
- ❍ Lambda light chains in urine
- ❍ Lead/Pb in urine
- ❍ Magnesium / Mg / 24-hour urine collection
- ❍ Magnesium / Mg in urine
- ❍ Mercury/Hg in urine
- ❍ Metoxycatecholamines in 24-hour urine collection
- ❍ Oxalates in urine
- ❍ Phosphorus in urine
- ❍ Phosphorus in urine / 24-hour urine collection
- ❍ Potassium (K) — urine
- ❍ Potassium (K) — urine/ 24-hour urine collection
- ❍ Sodium/Na in urine
- ❍ Sodium/Na in urine / 24-hour urine collection
- ❍ Total protein / 24-hour urine collection
- ❍ Urea/blood urea nitrogen, BUN in urine
- ❍ Urea/blood urea nitrogen, BUN in urine / 24-hour urine collection
- ❍ Uric acid in urine
- ❍ Uric acid in urine / 24-hour urine collection
- ❍ Urine – general analysis
- ❍ Urine glucose and ketones
- ❍ Urine protein
- ❍ Vanillylmandelic acid (VMA) in urine

5) laboratory diagnosis **- Bacteriological tests with taking smear for examination (The insurance does not include tests performed using molecular biology techniques):**

- ❍ Abscess content – anaerobic culture
- ❍ Abscess content culture
- ❍ Anal and vaginal swab culture for Streptococcus GBS
- ❍ Anal swab – aerobic culture
- ❍ Anal swab culture for SS
- ❍ Breast discharge – aerobic culture
- ❍ Chlamydia pneumoniae antigen, method: IIF – Throat swab
- ❍ Chlamydia pneumoniae antigen, method: IIF swab
- ❍ Chlamydia pneumoniae antigen, method: IIF swab – other material
- ❍ Chlamydia pneumoniae PCR swab
- ❍ Chlamydia trachomatis antigen, method: IIF – Endocervical swab
- ❍ Chlamydia trachomatis antigen, method: IIF – urethral swab
- ❍ Chlamydia trachomatis antigen, method: IIF swab – other material
- ❍ Chlamydia trachomatis, method: PCR – qualitative method (vaginal swab, urethral swab or urine)
- ❍ Culture for GC (GNC) Endocervical swab
- ❍ Culture for GC (GNC) Vaginal swab
- ❍ Culture of human milk from left breast – aerobic
- ❍ Left ear seton – aerobic culture
- ❍ Liquid from sinuses – aerobic culture
- ❍ Mycoplasma hominis and Ureaplasma urealiticum endocervical swab
- ❍ Mycoplasma hominis and Ureaplasma urealiticum urethral swab
- ❍ Nasal swab
- ❍ Nasal swab – aerobic culture
- ❍ Nasopharyngeal swab – aerobic culture
- ❍ Nasopharyngeal swab – anaerobic culture
- ❍ Oral cavity swab — aerobic culture
- ❍ Penile swab – aerobic culture
- ❍ Pharyngeal / tonsil swab – aerobic culture
- ❍ Pinworms – anal swab
- ❍ Right ear seton – aerobic culture
- ❍ Sputum culture
- ❍ Stool culture for Pathogenic E. Coli in children up to 2 years
- ❍ Stool culture for SS
- ❍ Stool culture for Yersinia enterocolitica
- ❍ Synovial fluid – cytology

- ❍ Culture of human milk from right breast – aerobic
- ❍ Ear swab – aerobic culture
- ❍ Ear swab – anaerobic culture
- ❍ Endocervical smear – anaerobic culture
- ❍ Endocervical swab
- ❍ Eosilophils in nasal swab
- ❍ Eye swab – aerobic culture
- ❍ Foreskin swab – aerobic culture
- ❍ Furuncle swab
- ❍ General faeces culture
- ❍ Gingival swab – aerobic culture
- ❍ Laryngeal swab – aerobic culture
- ❍ Laryngeal swab for Pneumocystis carini
- ❍ Semen culture — aerobic
- ❍ Skin lesion swab – aerobic culture
- ❍ Synovial fluid – general analysis
- ❍ Tongue swab – aerobic culture
- ❍ Ulceration swab – aerobic culture
- ❍ Umbilical swab – aerobic culture
- ❍ Urethral swab
- ❍ Urethral swab – anaerobic culture
- ❍ Urethral swab for GC (GNC) culture
- ❍ Urine culture
- ❍ Vaginal microbiological test (vaginal biocenosis)
- ❍ Vaginal swab – aerobic culture
- ❍ Vaginal swab – anaerobic culture
- ❍ Vulvar swab – aerobic culture
- ❍ Wound swab
- ❍ Wound swab – anaerobic culture

6) laboratory diagnosis **- faecal tests including taking material for examination:**

- ❍ Faecal analysis for rota- and adenovirus
- ❍ Faecal ELISA analysis for lamblia
- ❍ Faecal occult blood (FOB)
- ❍ Faeces analysis for parasites, 1 assay
- ❍ Helicobacter pylori – faecal antigen
- ❍ Stool analysis
- ❍ Stool analysis Clostridium difficile – GDH antigen and A / B toxin

7) laboratory diagnosis **- cytological tests including taking material for examination:**

- ❍ Standard* Pap smear

Standard* nasal mucosa cytological test

8) laboratory diagnosis - **mycological tests with taking smear (The insurance does not include tests performed using molecular biology techniques):**

- ❍ Abscess content culture for yeast-like fungi
- ❍ Anal area swab – culture for fungi
- ❍ Ear swab culture for yeast-like fungi
- ❍ Endocervical smear, culture for yeast-like fungi
- ❍ eye swab culture for yeast-like fungi;
- ❍ Foreskin swab – culture for yeast-like fungi
- ❍ Gingival swab culture for yeast-like fungi
- ❍ Laryngeal swab culture for yeast-like fungi
- ❍ Mycological examination – fingernail fungal culture
- ❍ Mycological examination – foot epidermis fungal culture – scrapings
- ❍ Mycological examination – fungal culture – hairy head skin – scraping
- ❍ Mycological examination – hair fungal culture
- ❍ Mycological examination – hand epidermis fungal culture – scrapings
- ❍ Mycological examination – skin fungal culture
- ❍ Mycological examination – skin scraping fungal culture
- ❍ Mycological examination – toenail fungal culture
- ❍ Nasal swab culture for yeast-like fungi
- ❍ Nasopharyngeal swab – culture for yeast-like fungi
- ❍ Oral swab – culture for yeast-like fungi
- ❍ Penile swab culture for yeast-like fungi
- ❍ Pharyngeal / tonsil swab culture for yeast-like fungi
- ❍ Secretion culture for yeast-like fungi
- ❍ Sement culture for yeast-like fungi
- ❍ Skin lesion swab – culture for fungi
- ❍ Sputum culture for yeast-like fungi
- ❍ Stool culture for yeast-like fungi
- ❍ Swab culture for yeast-like fungi
- ❍ Tongue swab culture for yeast-like fungi
- ❍ Ulceration swab – culture for fungi
- ❍ Urethral swab culture for yeast-like fungi
- ❍ Urine culture for yeast-like fungi
- ❍ Vaginal swab culture for yeast-like fungi
- ❍ Vulvar swab – culture for yeast-like fungi
- ❍ Wound smear culture for yeast-like fungi

9) laboratory diagnosis – **toxicological tests with taking material (blood) for examination**:

- ❍ Bile acids
- ❍ Carbamazepine
- ❍ Ciclosporin A, quantitative
- ❍ Digoxin
- ❍ Lead
- ❍ Lithium
- ❍ Phenytoin, quantitative
- ❍ Toxicological test – methemoglobin quantitative
- ❍ Valproic acid

10) laboratory diagnosis - **rapid strip tests with taking material (blood) for examination**:

- ❍ CRP – strip test
- ❍ Cholesterol strip test
- ❍ Glucose meter test
- ❍ Troponin – strip test
- ❍ Pharyngeal swab for Streptococcus a. quick test

11) diagnostic imaging **- ECG examinations**:

- ❍ Mounting Holter ECG monitor with 12 leads (for 24h)
- ❍ Mounting of a standard* Holter ECG monitor (for 24h) in an office
- ❍ Mounting Holter RR (for 24h) device in an office
- ❍ Resting ECG
- ❍ Stress test

- ❍ Stress test Exercise ECG using an cycloergometer

12) diagnostic imaging - **X-ray examinations (medium conforming with the standard applicable in a given clinic):**

- ❍ Abdominal X-ray, erect
- ❍ Abdominal X-ray, other
- ❍ Abdominal X-ray, supine
- ❍ Ankle joint X-ray, AP + lateral
- ❍ Ankle joint X-ray, AP + lateral bilateral
- ❍ Bilateral forearm X-ray, AP + lateral
- ❍ Bilateral hip joint X-ray, AP
- ❍ Bilateral patellar X-ray, axial in 2 positions
- ❍ Bilateral patellar X-ray, axial in 3 positions
- ❍ Cervical functional X-ray
- ❍ Cervical X-ray
- ❍ Cervical X-ray, AP + lateral
- ❍ Cervical X-ray, lateral
- ❍ Cervical X-ray, lateral + oblique (3 views)
- ❍ Cervical X-ray, oblique views
- ❍ Chest X-ray
- ❍ Chest X-ray – X-ray tomography
- ❍ Chest X-ray – X-ray tomography
- ❍ Chest X-ray + lateral
- ❍ Chest X-ray PA + lateral with barium
- ❍ Chest X-ray, lateral with barite
- ❍ Chest X-ray, other
- ❍ Clavicular X-ray
- ❍ Cranial X-ray orbits
- ❍ Cranial X-ray PA + lateral
- ❍ Cranial X-ray PA + lateral + base
- ❍ Cranial X-ray, base
- ❍ Cranial X-ray, cranial nerve canals
- ❍ Cranial X-ray, sella turcica
- ❍ Cranial X-ray, semi-axial by Orley
- ❍ Cranial X-ray, tangential
- ❍ Elbow joint X-ray
- ❍ Elbow/forearm X-ray, AP + lateral
- ❍ Elbow/forearm X-ray, AP + lateral, bilateral
- ❍ Esophagus, stomach and duodenum X-ray (with standard contrast agents)
- ❍ Femoral bone X-ray, AP + left lateral
- ❍ Femoral bone X-ray, AP + right, lateral
- ❍ Finger(s) X-ray, PA + lateral/oblique
- ❍ Finger(s) X-ray, PA + lateral/oblique bilateral
- ❍ Foot X-ray, AP (comparative)
- ❍ Foot X-ray, AP + lateral/oblique
- ❍ Foot X-ray, AP + lateral/oblique bilateral
- ❍ Foot X-ray, AP + lateral/oblique bilateral, erect
- ❍ Foot X-ray, AP + lateral/oblique., erect
- ❍ Forearm X-ray, AP + lateral
- ❍ Hand X-ray PA, bilateral
- ❍ Hand X-ray, lateral
- ❍ Hand X-ray, PA
- ❍ Hand X-ray, PA + oblique
- ❍ Hand X-ray, PA + oblique, bilateral
- ❍ Heel X-ray + axial
- ❍ Heel X-ray, lateral
- ❍ Hip joint X-ray, AP
- ❍ Hip joint X-ray, axial
- ❍ Knee joint X-ray, AP + bilateral lateral
- ❍ Larynx X-ray – tomography
- ❍ Lateral nasal X-ray
- ❍ Lower leg X-ray, AP + bilateral lateral
- ❍ Lower leg X-ray, AP + lateral
- ❍ Lumbar functional X-ray
- ❍ Lumbar X-ray: AP + lateral
- ❍ Mandibular X-ray
- ❍ Metatarsal X-ray
- ❍ Paranasal sinus X-ray
- ❍ Pelvic and hip joint X-ray
- ❍ Rib X-ray (unilateral), 2 oblique views
- ❍ Sacrococcygeal X-ray
- ❍ Scaphoid X-ray
- ❍ Scapular X-ray
- ❍ Shoulder X-ray (transthoracic)
- ❍ Shoulder X-ray, AP
- ❍ Shoulder X-ray, AP + axial
- ❍ Shoulder X-ray, AP + lateral
- ❍ Shoulder X-ray, AP, both – comparative image
- ❍ Shoulder X-ray, axial
- ❍ Shoulder X-ray, bilateral axial
- ❍ Shoulder X-ray: AP + bilateral – comparative image
- ❍ Spinal X-ray AP, erect (scoliosis)
- ❍ Spinal X-ray AP, erect + lateral (scoliosis)
- ❍ Splanchnocranium X-ray
- ❍ Temporal bone pyramid X-ray, transorbital
- ❍ Temporomandibular joint functional X-ray
- ❍ Thoracic X-ray
- ❍ Thoracic X-ray AP + lateral
- ❍ Thoracic X-ray, AP + lateral + oblique
- ❍ Thoracic X-ray, lateral
- ❍ Thoracic X-ray, oblique views
- ❍ Toe(s) X-ray, AP + lateral/oblique
- ❍ Upper leg and lower leg X-ray
- ❍ Urography (with standard contrast agents)
- ❍ Wrist X-ray, lateral
- ❍ Wrist X-ray, PA + bilateral lateral
- ❍ Wrist X-ray, PA + lateral
- ❍ Wrist/hand X-ray, PA + lateral/oblique bilateral
- ❍ Wrist/hand X-ray, PA + lateral/oblique bilateral
- ❍ Wrist/hand X-ray, PA + lateral/oblique left
- ❍ Wrist/hand X-ray, PA + lateral/oblique right
- ❍ X-ray of both patellae axial
- ❍ X-ray of both wrists, lateral
- ❍ X-ray of chest, thyroid, trachea
- ❍ X-ray of lumbar spine, AP + lateral + oblique
- ❍ X-ray of lumbar spine, lateral
- ❍ X-ray of lumbosacral spine AP + lateral
- ❍ X-ray of lumbosacral spine, oblique
- ❍ X-ray of nasopharynx
- ❍ X-ray of orbits + lateral (2 views)
- ❍ X-ray of sacroiliac joints – oblique
- ❍ X-ray of sacroiliac joints – PA
- ❍ X-ray of sternum, AP
- ❍ X-ray of temporal bones by Schuller/Stevers
- ❍ X-ray of temporal bones, transorbital

- ❍ Knee joint X-ray, AP + bilateral lateral, erect
- ❍ Knee joint X-ray, AP + lateral
- ❍ Knee joint X-ray, lateral
- ❍ Large intestine X-ray – rectal enema (with standard contrast agents)
- ❍ X-ray sternum / chest lateral
- ❍ X-ray teleradiogram – digital cephalometry
- ❍ X-ray, small intestine passage (with standard contrast agents)

13) diagnostic imaging - **ultrasound examinations:**

- ❍ Abdominal ultrasound
- ❍ Achilles tendon ultrasound
- ❍ Ankle joint ultrasound
- ❍ Breast ultrasound
- ❍ Echocardiography – cardiac ultrasound
- ❍ Echocardiography – cardiac ultrasound (foetal)
- ❍ Elbow joint ultrasound
- ❍ Finger and metacarpophalangeal joint ultrasound
- ❍ Hip joint ultrasound
- ❍ Hip joints ultrasound – for children
- ❍ Hip joints ultrasound + orthopaedic consultation (up to 1 year of age);
- ❍ Knee joint ultrasound
- ❍ laryngeal ultrasound;
- ❍ Lymph node ultrasound
- ❍ Obstetric ultrasound – extended examination (4 D)
- ❍ Post-traumatic muscle haematoma ultrasound
- ❍ Salivary gland ultrasound
- ❍ Shoulder ultrasound
- ❍ Subcutaneous tissue ultrasound (lipomas, fibromas, etc.)
- ❍ Testicular ultrasound
- ❍ Thyroid ultrasound
- ❍ Transabdominal gynaecological ultrasound
- ❍ Transabdominal prostate ultrasound
- ❍ Trans-fontanelle ultrasound
- ❍ Transrectal prostate ultrasound
- ❍ Transvaginal gynaecological ultrasound
- ❍ Ultrasound / Doppler ultrasound of carotid arteries and vertebral arteries
- ❍ Ultrasound / Doppler ultrasound of lower limb arteries
- ❍ Ultrasound of eyeballs and orbits
- ❍ Ultrasound of ligaments, muscles, small joints
- ❍ Ultrasound of metatarsal
- ❍ Ultrasound of pleura
- ❍ Ultrasound of the plantar aponeurosis
- ❍ Ultrasound/Doppler ultrasound of hepatic vessels (assessment of hepatic portal circulation)
- ❍ Ultrasound/Doppler ultrasound of intracranial arteries
- ❍ Ultrasound/Doppler ultrasound of lower limb veins
- ❍ Ultrasound/Doppler ultrasound of renal arteries
- ❍ Ultrasound/Doppler ultrasound of the abdominal aorta and pelvic arteries
- ❍ Ultrasound/Doppler ultrasound of upper limb arteries
- ❍ Ultrasound/Doppler ultrasound of upper limb veins
- ❍ Urinary tract ultrasound
- ❍ Urinary tract ultrasound + TRUS
- ❍ Wrist ultrasound

14) diagnostic imaging **- endoscopic examinations with endoscopic biopsy specimen sampling:**

- ❍ Anoscopy
- ❍ Colonoscopy
- ❍ Gastroscopy (with urease test)
- ❍ Histopathological examination — endoscopy biopsy material
- ❍ Laryngological endoscopy
- ❍ Rectoscopy
- ❍ Sigmoidoscopy

15) diagnostic imaging **- magnetic resonance imaging with standard contrast agents:**

- ❍ MR – magnetic resonance – arteriography of lower limb arteries
- ❍ MR – magnetic resonance – Cholangiography MR
- ❍ MR – magnetic resonance – heart examination with quantitative assessment of systolic function, viability, perfusion at rest and viability assessment
- ❍ MR – magnetic resonance – heart examination with quantitative assessment of systolic function
- ❍ MR – magnetic resonance – heart examination with quantitative assessment of blood flow
- ❍ MR – magnetic resonance – heart morphological examination with quantitative assessment of systolic function and viability assessment
- ❍ MR – magnetic resonance – Mammography MR
- ❍ MR – magnetic resonance head + angiography
- ❍ MR – magnetic resonance of abdomen
- ❍ MR – magnetic resonance of abdomen and cholangiography
- ❍ MR – magnetic resonance of abdomen and small pelvis;
- ❍ MR – magnetic resonance of adrenal glands
- ❍ MR – magnetic resonance of ankle joint
- ❍ MR – magnetic resonance of arm
- ❍ MR – magnetic resonance of bone pelvis
- ❍ MR – magnetic resonance of cervical spine
- ❍ MR – magnetic resonance of elbow joint
- ❍ MR – magnetic resonance of hip joint
- ❍ MR – magnetic resonance of joint with colorful cartilage imaging
- ❍ MR – magnetic resonance of knee joint
- ❍ MR – magnetic resonance of lower leg
- ❍ MR – magnetic resonance of lumbar spine
- ❍ MR – magnetic resonance of neck
- ❍ MR – magnetic resonance of orbits
- ❍ MR – magnetic resonance of pituitary gland
- ❍ MR – magnetic resonance of sacroiliac joints
- ❍ MR – magnetic resonance of shoulder joint
- ❍ MR – magnetic resonance of sinuses
- ❍ MR – magnetic resonance of small pelvis
- ❍ MR – magnetic resonance of thoracic spine
- ❍ MR – magnetic resonance of thorax
- ❍ MR – magnetic resonance of upper leg
- ❍ MR – magnetic resonance of wrist
- ❍ MR – magnetic resonance, angiography head
- ❍ MR – magnetic resonance, angiography of the great vessels of the chest
- ❍ MR — magnetic resonance, arteriography of renal arteries
- ❍ MR – magnetic resonance, head and pituitary gland
- ❍ MR – magnetic resonance, splanchnocranium
- ❍ MR – magnetic resonance; Urography

- ❍ MR – magnetic resonance of fetus
- ❍ MR – magnetic resonance of foot
- ❍ MR – magnetic resonance of forearm
- ❍ MR – magnetic resonance of hand
- ❍ MR – magnetic resonance of head
- ❍ MR arthrography of ankle joint
- ❍ MR arthrography of elbow joint
- ❍ MR arthrography of knee joint
- ❍ MR arthrography of shoulder joint
- ❍ MR arthrography of wrist

16) diagnostic imaging **- computed tomography with standard contrast agents:**

- ❍ CT – arthrography of shoulder joint
- ❍ CT – computed tomography – Angio of abdominal aorta
- ❍ CT – computed tomography – Angio of carotid arteries
- ❍ CT – computed tomography – Angio of epigastrium
- ❍ CT – computed tomography – Angio of lesser pelvis arteries
- ❍ CT – computed tomography – Angio of lower limbs
- ❍ CT – computed tomography – Angio of the abdomen and small pelvis
- ❍ CT – computed tomography – Angio of the head – arteries
- ❍ CT – computed tomography – Angio of the head – examination of veins and sinuses of the brain
- ❍ CT – computed tomography – Angio of thoracic aorta
- ❍ CT – computed tomography – Angio of thorax
- ❍ CT – computed tomography – Angio of upper limb
- ❍ CT – computed tomography – Bronchography CT
- ❍ CT – computed tomography – Colonography
- ❍ CT – computed tomography – coronary vessels – arteries
- ❍ CT – computed tomography of abdomen
- ❍ CT – computed tomography of abdomen and small pelvis
- ❍ CT – computed tomography of ankle joint
- ❍ CT – computed tomography of arm
- ❍ CT – computed tomography of bone pelvis
- ❍ CT – computed tomography of cervical + lumbar spine
- ❍ CT – computed tomography of cervical + thoracic + lumbar spine
- ❍ CT – computed tomography of cervical + thoracic spine
- ❍ CT – computed tomography of cervical spine
- ❍ CT – computed tomography of elbow joint
- ❍ CT – computed tomography of facial skeleton
- ❍ CT – computed tomography of foot
- ❍ CT – computed tomography of forearm
- ❍ CT – computed tomography of hand
- ❍ CT – computed tomography of head
- ❍ CT – computed tomography of hip joint
- ❍ CT – computed tomography of jaw, mandible – dental examination (implantology)
- ❍ CT – computed tomography of knee joint
- ❍ CT – computed tomography of larynx
- ❍ CT – computed tomography of lower leg
- ❍ CT – computed tomography of lumbar spine
- ❍ CT – computed tomography of neck
- ❍ CT – computed tomography of neck, thorax, abdomen, small pelvis
- ❍ CT – computed tomography of orbits
- ❍ CT – computed tomography of pituitary gland
- ❍ CT – computed tomography of shoulder joint
- ❍ CT – computed tomography of sinuses
- ❍ CT – computed tomography of small pelvis
- ❍ CT – computed tomography of temporal bones
- ❍ CT – computed tomography of thoracic + lumbar spine
- ❍ CT – computed tomography of thoracic spine
- ❍ CT – computed tomography of thorax
- ❍ CT – computed tomography of thorax (HRCT)
- ❍ CT – computed tomography of thorax and abdomen
- ❍ CT – computed tomography of thorax, abdomen, small pelvis
- ❍ CT – computed tomography of upper leg
- ❍ CT – computed tomography of wrist
- ❍ CT – computed tomography, abdomen (3 phases)
- ❍ CT – computed tomography, lumbar + sacral spine
- ❍ CT – low-dose computed tomography of thorax
- ❍ CT arthrography of ankle joint
- ❍ CT arthrography of elbow joint
- ❍ CT arthrography of knee joint
- ❍ CT arthrography of wrist

17) diagnostic imaging - **EEG examinations**:

- ❍ Standard* EEG
- ❍ Standard* EEG – children

18) diagnostic imaging - **EMG examinations**:

- ❍ EMG – electromyography – assessment of muscle function at rest
- ❍ EMG – electromyography – carpal tunnel syndrome
- ❍ EMG – electromyography – facial nerve
- ❍ EMG – electromyography – ischemic (tetany) test
- ❍ EMG – electromyography – motor neuron disease / amyotrophic lateral sclerosis (MND / SLA)
- ❍ EMG – electromyography – myasthenia test
- ❍ EMG – electromyography – non-traumatic nerve injury
- ❍ EMG – electromyography – plexus injury
- ❍ EMG – electromyography – polyneuropathy/myopathy
- ❍ EMG – electromyography – quantitative assessment of the muscle
- ❍ EMG – electromyography – traumatic nerve injury

19) diagnostic imaging **- electroneurographic examinations:**

- ❍ Electroneurography (ENG) – sensory nerve
- ❍ Electroneurography (ENG) – motor nerve (long)
- ❍ Electroneurography (ENG) – motor nerve (short sections

20) diagnostic imaging **- other diagnostic tests and examinations:**

- ❍ ABR – differential diagnostics
- ❍ ABR – latencies
- ❍ Anomaloscope test
- ❍ Audiometric test – Characteristics of tinnitus
- ❍ Labyrinth test
- ❍ Lumbar spine densitometry (trabecular bone assessment) – screening ;
- ❍ Mammography
- ❍ Mammography – targeted image

- ❍ Audiometric test – determination of Uncomfortable Listening Level (UCL)
- ❍ Audiometric test – whisper test
- ❍ Cold provocation test
- ❍ Cold provocation test with skin thermometry and compression test
- ❍ Colposcopy
- ❍ Computerised visual field test
- ❍ Dark adaptation test
- ❍ Densitometry femoral collum (cortical bone assessment) – screening
- ❍ Electronystagmography (ENG)
- ❍ Fluorescein angiography
- ❍ GDX examination
- ❍ Impedance audiometry – with tympanometry and stapedial muscle reflex evaluation (IA)
- ❍ OCT examination – both eyes
- ❍ OCT examination – one eye
- ❍ Otoacoustic emission
- ❍ Pachymetry
- ❍ Spirometry – diastolic test
- ❍ Spirometry without medication
- ❍ Standard audiometry – supraliminal audiometry
- ❍ Standard audiometry – verbal audiometry
- ❍ Standard audiometry*
- ❍ Tilt Test
- ❍ Tympanometry
- ❍ Uroflowmetric examination
- ❍ Vibratory perception
- ❍ Videonystagmography (VNG)

3. As technology advances, the names or methods of specific diagnostic tests may be subject to change, which shall not limit the scope of services provided in the insurance agreement. If as a result of the application of a new method, the above scope of services is extended, then The insurances resulting from the scope extensions shall not be covered by the scope of the package. Examination results are stored on a medium conforming with the standard applicable in a given facility. Unless stated otherwise, the insurance does not include strip tests, and CT, MRI and ultrasound diagnostic imaging includes a 2D image with no additional options (including extended genetic ultrasound).

§15 Allergy tests

1. The insurance includes allergy skin tests, patch tests or contact tests and blood allergy tests. The tests are ordered by a Physician from a Medical Facility, in the following scope:

   1) Allergist consultation – qualification for tests

   2) **Allergy skin tests** – skin prick tests with a product for allergy tests:

- ❍ skin allergy tests – 1 spot
- ❍ skin allergy tests – food allergy panel
- ❍ skin allergy tests – inhaled allergens panel

   3) **Patch/contact tests** – patch tests with a product for allergy tests:

- ❍ Patch/contact tests – 1 spot
- ❍ Patch/contact tests – basic panel
- ❍ Patch/contact tests – cosmetic panel
- ❍ patch/contact tests – crural ulceration panel
- ❍ Patch/contact tests – hairdresser panel

   4) **Allergy blood tests** with taking test samples (blood:

- ❍ IGE SP. Acarus Siro D70 (in dust)
- ❍ IGE SP. Alternaria Tenuis M6
- ❍ IGE SP. Amoxycillin C204
- ❍ IGE SP. Aspergillus Fumigatus M3
- ❍ IGE SP. Ribwort plantain W9
- ❍ IGE SP. Banana F92
- ❍ IGE SP. Egg white F1
- ❍ IGE SP. Silver birch T3
- ❍ IGE SP. Mugwort W6
- ❍ IGE SP. Candida Albicans M5
- ❍ IGE SP. Onion F48
- ❍ IGE SP. Chironimus Plumosus 173
- ❍ IGE SP. Weeds – blend: mugwort (W6), stinging nettle (W20), European goldenrod (W12), ribwort plantain (W9), Chenopodium album (W10)
- ❍ IGE SP. Cladosporium Herbarum M2
- ❍ IGE SP. Chocolate F105
- ❍ IGE SP. Cod F3
- ❍ IGE SP. Brewer's yeast F403
- ❍ IGE SP. Trees – blend: alder (T2), birch (T3), hazel (T4), oak (T7), willow (T12)
- ❍ IGE SP. Bean F15
- ❍ IGE SP. FP5 – food blend (paediatric): cod (F3), egg white (F1), peanut (F13), cow's milk (F2), soy (F14), wheat flour (F4)
- ❍ IGE SP. Human ascaris P1
- ❍ Specific IgE – mould blend MP1: Alternaria tenuis (M6), Penicilium notatum (M1), Cladosporium herbarum (M2), Aspergillus fumigatus (M3), Candida ablicans (M5)
- ❍ IGE SP. Cow's milk – Beta-lactoglobulin F77
- ❍ IGE SP. Cow's milk F2
- ❍ IGE SP. Cow's milk – alpha-lactalbumin F76
- ❍ IGE SP. Mucor racemosus M4
- ❍ IGE SP. Mustard F89
- ❍ IGE SP. Hamster epidermis E84
- ❍ IGE SP. Rabbit epidermis E82
- ❍ IGE SP. Sheep epidermis E81
- ❍ IGE SP. Guinea pig epidermis E6
- ❍ IGE SP. Pigeon droppings E7
- ❍ IGE SP. Cucumber F244
- ❍ IGE SP. Alder T2
- ❍ IGE SP. Hazelnut F17
- ❍ IGE SP. Walnut F256
- ❍ IGE SP. Peanut F13
- ❍ IGE SP. Oat F7
- ❍ IGE SP. Inhalant panel
- ❍ IGE SP. Mixed panel
- ❍ IGE SP. Food panel
- ❍ IGE SP. Penicilium notatum M1
- ❍ IGE SP. Black pepper F280

- IGE SP. Gluten (gliadin) F79
- IGE SP. GP4 – late grass blend: sweet vernal grass (G1), perennial rye grass (G5), timothy grass (G6), common reed grass (G7), rye (G12), yorkshire fog (G13)
- IGE SP. Pea F12
- IGE SP. Pear F94
- IGE SP. Buckwheat F11
- IGE SP. Turkey F284
- IGE SP. Apple F20
- IGE SP. Vespula wasp venom SP.I3
- IGE SP. Bee venom I1
- IGE SP. European hornet venom I5
- IGE SP. Lamb (mutton) F88
- IGE SP. Whole egg F245
- IGE SP. Barley F6
- IGE SP. Cocoa F93
- IGE SP. Cockroach – German cockroach I6
- IGE SP. Coffee F221
- IGE SP. Casein F78
- IGE SP. Kiwi fruit F84
- IGE SP. Mosquito I71
- IGE SP. Chenopodium album W10
- IGE SP. Dill 277
- IGE SP. Meadow fescue G4
- IGE SP. Orchard grass G3
- IGE SP. Maize F8
- IGE SP. Chicken F83
- IGE SP. Dust – blend (Bencard)
- IGE SP. Latex K82
- IGE SP. Lepidoglyphus destructor D71
- IGE SP. Common hazel T4
- IGE SP. Carrot F31
- Specific IgE – epidermis blend EP1: dog (E5), cat (E1), horse (E3), cow (E4)
- IGE SP. Feather blend EP71: duck feathers (E86), goose feathers (E70), hen feathers, turkey feathers
- IGE SP. Feathers (goose) E70
- IGE SP. Parsley F86
- IGE SP. Duck feathers E86
- IGE SP. Canary feathers E201
- IGE SP. Budgerigar feathers E78
- IGE SP. Orange F33
- IGE SP. Tomato F25
- IGE SP. Wheat F4
- IGE SP. Rye pollen G12
- IGE SP. Mite Dermathopag Pteronys. D1
- IGE SP. Mite Dermathophag Farinae D2
- IGE SP. Rice F9
- IGE SP. Celery F85
- IGE SP. Cheddar cheese F81
- IGE SP. Horse hair E3
- IGE SP. Cat fur E1
- IGE SP. Dog coat E2
- IGE SP. Soy F14
- IGE SP. Poplar T14
- IGE SP. Strawberry F44
- IGE SP. Tuna F40
- IGE SP. Grasses – blend GP1 (orchard grass G3, meadow fescue G4, perennial rye grass G5, timothy grass G6, Kentucky bluegrass G8)
- IGE SP. Timothy G6
- IGE SP. Tyrophagus putescentiae
- IGE SP. Pork F26
- IGE SP. Willow T12
- IGE SP. Beef F27
- IGE SP. Potato F35
- IGE SP. Egg yolk F75
- IGE SP. Rye F5
- IGE SP. – blend FP2 – fish, crustacean, seafood: cod (F3), shrimp (F24), salmon (F41), mussel (F37), tuna (F40)

2. As technology advances, the names or methods of specific diagnostic tests may be subject to change, which shall not limit the scope of services provided in the insurance agreement. If as a result of the application of a new method, the above scope of services is extended, then The insurances resulting from the scope extensions shall not be covered by the scope of the package.

§16 Pregnancy care

1. This scope of insurance includes monitoring of physiological pregnancy by a physician in outpatient Medical Facilities indicated by LUX MED in accordance with the standards of LUX MED and consists of active health counseling in the field of physiology of pregnancy and childbirth in the following scope:

- Anal and vaginal swab culture for Streptococcus GBS
- basic syphilis serology (VDRL or USR or anti-TP);
- Blood count + platelet count + automated smear
- Blood group (AB0), Rh factor and antibody screening
- Culture for GC (GNC) Endocervical swab
- Culture for GC (GNC) Vaginal swab
- Fasting glucose
- Free estriol
- Glucose 75 g, 1-hour glucose challenge test
- Glucose 75 g, 2-hour glucose challenge test
- Gynaecologist consultation – pregnancy care
- HBs Ab/antibodies;
- HBs Ag/antigen
- HCV Ab/antibodies
- HIV-1/HIV-2
- Immune antibody screening / alloantibodies (replaces anti-Rh /-/ antibodies)
- obstetric ultrasound;
- Prenatal midwife education – a limit of 6 meetings in the 12-month period of the Agreement
- Rubella IgG
- Rubella IgM
- Standard* Pap smear
- Total Beta-hCG
- Toxoplasma IgG
- Toxoplasma IgM
- Transabdominal gynaecological ultrasound
- Transvaginal gynaecological ultrasound
- transvaginal obstetric ultrasound;
- Urine – general analysis

2. The insurance does not cover:

1) molecular biology tests;

2) ultrasound examinations include only a 2D image with no extended genetic ultrasound. Performance of the above range of services is available based on pregnancy care sheet issued to the Patient by outpatient Medical Facility indicated by LUX MED.

3. The above scope of tests and examinations does not limit the possibility of being referred to tests and examinations not covered by the scheme and agreement, but does not include their cost. This pertains also to cases of the Patient's pregnancy and medical indications for test and examinations not included in the above scheme and the scope of the agreement.

4. In accordance with the current Regulation of the Minister of Health on the organisational standard of perinatal care, pregnancy care does not include pathological pregnancies, including multiple pregnancies. In such cases, the Eligible Person is referred to the reference centres. In the event of a change in the legal provisions concerning the organisational standard of perinatal care, the services within the above scope, including the scope of tests and examinations, may be subject to change as a result of their adaptation to the generally applicable provisions of law.

§17 Preventive health check

1. Preventive health check (option II) is an annual (available once during a 12-month term of the agreement) health check, depending on the age and sex of the Insured, including a range of examinations and consultations for the Insured over 18 years of age.

2. The health check starts with an internist visit when medical history is taken and referrals for examinations (according to the indications). The health check concludes with an internist consultation, during which the Insured obtains information on their health status and further recommendations.

3. The scope of the check for **women** includes:

1) Physician consultations:

a) Internist or nurse telephone opening consultation — medical history;
b) Gynecological consultation;
c) Ophthalmological or optometric consultation;

2) Laboratory tests:

- Blood count + platelet count + automated smear
- Creatinine
- ESR
- faecal occult blood (FOB);
- Fasting glucose
- GPT/ALT transaminase
- HBs Ag/antigen
- HCV Ab/antibodies
- Lipid profile (CHOL, HDL, LDL, TG)
- Standard* Pap smear
- TSH / hTSH
- Uric acid
- Urine – general analysis

3) Imaging examinations - in justified medical cases

- Abdominal ultrasound
- Breast ultrasound and Mammography - women, depending on medical indication
- PA chest X-ray - depending on medical indications
- Thyroid ultrasound
- Transabdominal gynaecological ultrasound or transvaginal gynaecological ultrasound

4) Functional examinations:

- Resting ECG
- Spirometry without medication

5) Internist consultation — closing consultation.

4. The scope of the check for **men** includes:

1) Physician consultations:

a) Internist consultation — medical history
b) urological consultation;
c) Ophthalmological/ optometrist consultation
d) Dermatological consultation with standard* dermatoscopy.

2) Laboratory tests:

- Blood count + platelet count + automated smear
- Creatinine
- ESR
- Faecal occult blood (FOB);
- Fasting glucose
- GPT/ALT transaminase
- HBs Ag/antigen
- HCV Ab/antibodies
- Lipid profile (CHOL, HDL, LDL, TG)
- PSA panel (PSA, FPSA, FPSA / PSA index)
- TSH / hTSH
- Uric acid
- Urine – general analysis

3) Imaging examinations Imaging examinations in justified medical cases

- PA chest X-ray - depending on medical indications
- Prostate ultrasound
- Thyroid ultrasound
- Testicular ultrasound

- ❍ Abdominal ultrasound

4) Functional examinations:

- ❍ Resting ECG
- ❍ Spirometry without medication

5) Internist consultation — closing consultation

5. The scheme is available in outpatient Medical Facilities indicated by LUX MED. In order to make an appointment for scheme implementation, the Patient should contact using the on-line form available on https://www.luxmed.pl/strona-glowna/kontakt/infolinia.html

§18 Physiotherapy

1. As part of the Physiotherapy (option III) Insurance, the Insured is entitled to access to **consultations with a physical therapist**.
2. The scope of insurance includes:
   1) a medical history interview,
   2) a functional examination,
   3) the physical therapist's advice and procedures necessary to make a diagnosis, adopting an appropriate therapeutic decision and determining the mode of rehabilitation.: ,
3. Consultations with a physical therapist does not include rehabilitation and kinesiotherapy activities..
4. The insurance only includes rehabilitation of the locomotor system and it is provided for the following indications (qualification criteria); i.e. it applies to the Insured with:
   1) orthopaedic traumas
   2) osteoarthritis
   3) occupational disorders of the motor organ (confirmed by a relevant medical certificate)
   4) neurological pain syndromes
   5) muscle tone disorders (refers to neurokinesiological rehabilitation for children up to 18 years of age)
   6) post-operative scars
   7) postural defects (refers to postural defects rehabilitation for children up to 18 years of age)
5. The procedures are provided on the basis of referrals from physical therapists or Physicians (specialists in the field of orthopaedic, neurology, neurosurgery, rheumatology, rehabilitation medicine, balneology) from an outpatient Medical Facility, specifying the scope and type of rehabilitation procedures, and includes physiotherapy services available at outpatient Medical Facilities indicated by the Insurer.
6. The service is and covers performance of a total of 5 of rehabilitation services (neurokinesilogy or postural defects) within a 12-month term of the agreement.
7. Physiotherapy covers the following range of physiotherapy and kinesitherapy procedures:

- ❍ Individual therapy using neurokinesiology / neurophysiology methods for children
- ❍ Kinesitherapy – cervical spine traction
- ❍ Kinesitherapy – exercises improving postural defects in children
- ❍ Kinesitherapy – function-improving exercises ankle joint
- ❍ Kinesitherapy – function-improving exercises arm
- ❍ Kinesitherapy – function-improving exercises cervical spine
- ❍ Kinesitherapy – function-improving exercises elbow joint
- ❍ Kinesitherapy – function-improving exercises foot
- ❍ Kinesitherapy – function-improving exercises forearm
- ❍ Kinesitherapy – function-improving exercises hand
- ❍ Kinesitherapy – function-improving exercises hip joint
- ❍ Kinesitherapy – function-improving exercises knee joint
- ❍ Kinesitherapy – function-improving exercises lumbar spine
- ❍ Kinesitherapy – function-improving exercises shank
- ❍ Kinesitherapy – function-improving exercises shoulder joint
- ❍ Kinesitherapy – function-improving exercises thigh
- ❍ Kinesitherapy – function-improving exercises thoracic spine
- ❍ Kinesitherapy – function-improving exercises wrist
- ❍ Kinesitherapy – individual therapy ankle joint
- ❍ Kinesitherapy – individual therapy arm
- ❍ Kinesitherapy – individual therapy cervical spine
- ❍ Kinesitherapy – individual therapy elbow joint
- ❍ Kinesitherapy – individual therapy foot
- ❍ Kinesitherapy – individual therapy for scars
- ❍ Physical therapy – ionophoresis lower leg
- ❍ Physical therapy – ionophoresis lumbar spine
- ❍ Physical therapy – ionophoresis shoulder joint
- ❍ Physical therapy – ionophoresis thoracic spine
- ❍ Physical therapy – ionophoresis upper leg
- ❍ Physical therapy – ionophoresis wrist
- ❍ Physical therapy – local cryotherapy ankle joint
- ❍ Physical therapy – local cryotherapy arm
- ❍ Physical therapy – local cryotherapy cervical spine
- ❍ Physical therapy – local cryotherapy elbow joint
- ❍ Physical therapy – local cryotherapy foot
- ❍ Physical therapy – local cryotherapy forearm
- ❍ Physical therapy – local cryotherapy hand
- ❍ Physical therapy – local cryotherapy hip joint
- ❍ Physical therapy – local cryotherapy knee joint
- ❍ Physical therapy – local cryotherapy lower leg
- ❍ Physical therapy – local cryotherapy lumbar spine
- ❍ Physical therapy – local cryotherapy shoulder joint
- ❍ Physical therapy – local cryotherapy thoracic spine
- ❍ Physical therapy – local cryotherapy upper leg
- ❍ Physical therapy – local cryotherapy wrist
- ❍ Physical therapy – low- Energy laser
- ❍ Physical therapy – low-energy laser therapy ankle joint
- ❍ Physical therapy – low-energy laser therapy arm
- ❍ Physical therapy – low-energy laser therapy cervical spine

- Kinesitherapy – individual therapy forearm
- Kinesitherapy – individual therapy hand
- Kinesitherapy – individual therapy hip joint
- Kinesitherapy – individual therapy knee joint
- Kinesitherapy – individual therapy lower leg
- Kinesitherapy – individual therapy lumbar spine
- Kinesitherapy – individual therapy shoulder joint
- Kinesitherapy – individual therapy thoracic spine
- Kinesitherapy – individual therapy upper leg
- Kinesitherapy – individual therapy wrist
- Kinesitherapy – instructional exercises ankle joint
- Kinesitherapy – instructional exercises arm
- Kinesitherapy – instructional exercises cervical spine
- Kinesitherapy – instructional exercises elbow joint
- Kinesitherapy – instructional exercises foot
- Kinesitherapy – instructional exercises forearm
- Kinesitherapy – instructional exercises hand
- Kinesitherapy – instructional exercises hip joint
- Kinesitherapy – instructional exercises knee joint
- Kinesitherapy – instructional exercises lumbar spine
- Kinesitherapy – instructional exercises shank
- Kinesitherapy – instructional exercises shoulder joint
- Kinesitherapy – instructional exercises thigh
- Kinesitherapy – instructional exercises thoracic spine
- Kinesitherapy – instructional exercises wrist
- Kinesitherapy – lumbar spine traction
- Myorelaxation therapy – Therapeutic spinal massage
- Phisical therapy – ultrasound therapy for scars
- Physical therapy – diadynamic currents therapy ankle joint
- Physical therapy – diadynamic currents therapy arm
- Physical therapy – diadynamic currents therapy cervical spine
- Physical therapy – diadynamic currents therapy elbow joint
- Physical therapy – diadynamic currents therapy foot
- Physical therapy – diadynamic currents therapy forearm
- Physical therapy – diadynamic currents therapy hand
- Physical therapy – diadynamic currents therapy hip joint
- Physical therapy – diadynamic currents therapy knee joint
- Physical therapy – diadynamic currents therapy lower leg
- Physical therapy – diadynamic currents therapy lumbar spine
- Physical therapy – diadynamic currents therapy shoulder joint
- Physical therapy – diadynamic currents therapy thoracic spine
- Physical therapy – diadynamic currents therapy upper leg
- Physical therapy – diadynamic currents therapy wrist
- Physical therapy – electrical stimulation of muscle of the lower limb
- Physical therapy – electrical stimulation of muscle of the upper limb
- Physical therapy – galvanisation ankle joint
- Physical therapy – galvanisation arm
- Physical therapy – galvanisation elbow joint
- Physical therapy – galvanisation foot
- Physical therapy – galvanisation forearm
- Physical therapy – galvanisation hand
- Physical therapy – galvanisation hip joint
- Physical therapy – galvanisation knee joint
- Physical therapy – galvanisation lower leg
- Physical therapy – galvanisation shoulder joint
- Physical therapy – galvanisation upper leg
- Physical therapy – galvanisation wrist
- Physical therapy – galvanotherapy cervical spine
- Physical therapy – galvanotherapy lumbar spine
- Physical therapy – low-energy laser therapy elbow joint
- Physical therapy – low-energy laser therapy foot
- Physical therapy – low-energy laser therapy forearm
- Physical therapy – low-energy laser therapy hand
- Physical therapy – low-energy laser therapy hip joint
- Physical therapy – low-energy laser therapy knee joint
- Physical therapy – low-energy laser therapy lower leg
- Physical therapy – low-energy laser therapy lumbar spine
- Physical therapy – low-energy laser therapy shoulder joint
- Physical therapy – low-energy laser therapy thoracic spine
- Physical therapy – low-energy laser therapy upper leg
- Physical therapy – low-energy laser therapy wrist
- Physical therapy – magnetic field therapy ankle joint
- Physical therapy – magnetic field therapy arm
- Physical therapy – magnetic field therapy cervical spine
- Physical therapy – magnetic field therapy elbow joint
- Physical therapy – magnetic field therapy foot
- Physical therapy – magnetic field therapy forearm
- Physical therapy – magnetic field therapy hand
- Physical therapy – magnetic field therapy hip joint
- Physical therapy – magnetic field therapy knee joint
- Physical therapy – magnetic field therapy lower leg
- Physical therapy – magnetic field therapy lumbar spine
- Physical therapy – magnetic field therapy shoulder joint
- Physical therapy – magnetic field therapy thoracic spine
- Physical therapy – magnetic field therapy upper leg
- Physical therapy – magnetic field therapy wrist
- Physical therapy – phonophoresis ankle joint
- Physical therapy – phonophoresis arm
- Physical therapy – phonophoresis cervical spine
- Physical therapy – phonophoresis elbow joint
- Physical therapy – phonophoresis foot
- Physical therapy – phonophoresis forearm
- Physical therapy – phonophoresis hand
- Physical therapy – phonophoresis hip joint
- Physical therapy – phonophoresis knee joint
- Physical therapy – phonophoresis lower leg
- Physical therapy – phonophoresis lumbar spine
- Physical therapy – phonophoresis shoulder joint
- Physical therapy – phonophoresis thoracic spine
- Physical therapy – phonophoresis upper leg
- Physical therapy – phonophoresis wrist
- Physical therapy – TENS currents therapy ankle joint
- Physical therapy – TENS currents therapy arm
- Physical therapy – TENS currents therapy cervical spine
- Physical therapy – TENS currents therapy elbow joint
- Physical therapy – TENS currents therapy foot
- Physical therapy – TENS currents therapy forearm
- Physical therapy – TENS currents therapy hand
- Physical therapy – TENS currents therapy hip joint
- Physical therapy – TENS currents therapy knee joint
- Physical therapy – TENS currents therapy lower leg
- Physical therapy – TENS currents therapy lumbar spine
- Physical therapy – TENS currents therapy shoulder joint
- Physical therapy – TENS currents therapy thoracic spine
- Physical therapy – TENS currents therapy upper leg
- Physical therapy – TENS currents therapy wrist
- Physical therapy – Trabert's current therapy ankle joint
- Physical therapy – Trabert's current therapy arm

- Physical therapy – galvanotherapy thoracic spine
- Physical therapy – interferential currents therapy ankle joint
- Physical therapy – interferential currents therapy arm
- Physical therapy – interferential currents therapy cervical spine
- Physical therapy – interferential currents therapy elbow joint
- Physical therapy – interferential currents therapy foot
- Physical therapy – interferential currents therapy forearm
- Physical therapy – interferential currents therapy hand
- Physical therapy – interferential currents therapy hip joint
- Physical therapy – interferential currents therapy knee joint
- Physical therapy – interferential currents therapy lower leg
- Physical therapy – interferential currents therapy lumbar spine
- Physical therapy – interferential currents therapy shoulder joint
- Physical therapy – interferential currents therapy thoracic spine
- Physical therapy – interferential currents therapy upper leg
- Physical therapy – interferential currents therapy wrist
- Physical therapy – ionophoresis ankle joint
- Physical therapy – ionophoresis arm
- Physical therapy – ionophoresis cervical spine
- Physical therapy – ionophoresis elbow joint
- Physical therapy – ionophoresis foot
- Physical therapy – ionophoresis forearm
- Physical therapy – ionophoresis hand
- Physical therapy – ionophoresis hip joint
- Physical therapy – ionophoresis knee joint
- Physical therapy – Trabert's current therapy cervical spine
- Physical therapy – Trabert's current therapy elbow joint
- Physical therapy – Trabert's current therapy foot
- Physical therapy – Trabert's current therapy forearm
- Physical therapy – Trabert's current therapy hand
- Physical therapy – Trabert's current therapy hip joint
- Physical therapy – Trabert's current therapy knee joint
- Physical therapy – Trabert's current therapy lower leg
- Physical therapy – Trabert's current therapy lumbar spine
- Physical therapy – Trabert's current therapy shoulder joint
- Physical therapy – Trabert's current therapy thoracic spine
- Physical therapy – Trabert's current therapy upper leg
- Physical therapy – Trabert's current therapy wrist
- Physical therapy – ultrasound (in water)
- Physical therapy – ultrasound therapy ankle joint
- Physical therapy – ultrasound therapy arm
- Physical therapy – ultrasound therapy cervical spine
- Physical therapy – ultrasound therapy elbow joint
- Physical therapy – ultrasound therapy foot
- Physical therapy – ultrasound therapy forearm
- Physical therapy – ultrasound therapy hand
- Physical therapy – ultrasound therapy hip joint
- Physical therapy – ultrasound therapy knee joint
- Physical therapy – ultrasound therapy lower leg
- Physical therapy – ultrasound therapy lumbar spine
- Physical therapy – ultrasound therapy shoulder joint
- Physical therapy – ultrasound therapy thoracic spine
- Physical therapy – ultrasound therapy upper leg
- Physical therapy — ultrasound therapy wrist

8. The scope of services does not include the costs of physiotherapy for:
   1) congenital malformations and their consequences,
   2) postural defects,
   3) perinatal traumas,
   4) chronic connective tissue diseases and their consequences,
   5) demyelinating diseases and their consequences;
   6) neurodegenerative diseases and their consequences;
   7) physiotherapy after: surgical procedures not performed in Hospitalls of the insurer;
   8) coronary events, neurological and cerebrovascular events;
   9) urogynaecological physiotherapy;
   10) physiotherapy with highly specialist methods (mechanical and neurophysiological methods, osteopathic techniques);
   11) diagnostic and functional training services or corrective gymnastics and fitness services;
   12) necrosis physiotherapy, physiotherapy of scars/keloid scars or post-burn conditions, or visceral manipulation – internal organ therapy.

§19 Dentistry

1. Dental emergency

1) Dental emergency includes, depending on the Medical Facility, coverage or reimbursement of expenses (Reimbursement) up to the maximum limit of **PLN 350** per each 12-moth Insuranace Period, of the following performed by dentists' services:

- Emergency dental abscess incision, including drainage
- Emergency dental intraoral conduction anaesthesia
- Emergency dental local infiltration anaesthesia
- Emergency dental local permeation anaesthesia
- Emergency dry socket irrigation + application of medication
- Emergency extraction of a multi-rooted deciduous tooth
- Emergency extraction of a multi-rooted tooth
- Emergency extraction of a tooth by intra-alveolar chiseling
- Emergency medicinal dressing on a deciduous tooth
- Emergency medicinal dressing on a permanent tooth
- Emergency periapical abscess decompression
- Emergency repositioning and immobilisation of an avulsed tooth
- Emergency single tooth X-ray

- ❍ Emergency extraction of a single-rooted deciduous tooth
- ❍ Emergency extraction of a single-rooted tooth
- ❍ Emergency tooth pulp devitalisation in a deciduous tooth with cavity dressing
- ❍ Emergency tooth pulp devitalisation with cavity dressing

2) Dental emergency services are provided exclusively in the sudden onset of an illness or in case of an accident outside the working hours of the Operator's own facilities.

3) A precondition for obtaining dental emergency services shall be for the Insured to notify the need to attend a dental emergency as a result of a sudden onset of an illness or an accident using our Helpline (on 22 33 22 888), and then avail of The insurances at a medical facility indicated by the Operator, in line with the instructions provided by the Helpline staff. If the indicated medical facility does not offer cashless services, the Insured must cover the costs of The insurances performed in accordance with the applicable price list, then submit an application for a Reimbursement with attached original invoices or receipts for services provided to the Insured. The invoice or receipt should include:

   a) the data of the Insured for whom services were provided, for the reimbursement of costs (at least the Insured t's name, surname, address). In the event that services are provided to a child, the invoice should be issued for the actual carer or legal guardian of the child, and the invoice should include the data of the child for whom The insurances were performed;

   b) a list of services performed for the Insured (indicated in the content of the invoice) or an attached specification issued by the medical facility providing The insurances, indicating the name of The insurance, or a copy of medical records related to the specific service provided;

   c) the number of a specific type of services provided;

   d) service performance date;

   e) service unit price.

4) If, following The insurance cost reimbursement under the Insurer Reimbursement procedure, the Insurer obtains evidence that the Reimbursement was made upon information, invoices or receipts that are inaccurate given the actual situation indicated in the Application or attached documents (e.g. if the Insured submits invoices or receipts for services performed for third parties with the Application), the Insurer shall have the right to claim reimbursement of the amounts paid to the Insured with interest calculated from the date of disbursement of funds under the Reimbursement procedure.

5) Payment by way of Reimbursement shall be made on the basis of the Refund Application filed by the Insured along with accompanying original invoices or receipts and other required documents.

6) The Insurer shall reimburse the costs to the bank account number indicated in the Application Form within 30 days from the date of delivery of the complete Application Form. Should it prove impossible to clarify all circumstances necessary to determine the Insurer's liability or the amount of the benefit within the above-mentioned period, the benefit will be paid out within 14 days from the date on which the clarification of those circumstances with due diligence was possible.

7) The application form for the Cash Benefit is available at: https://www.luxmed.pl/dla-pacjenta/ubezpieczenia-dla-klientow-indywidualnych/indywidualne-ubezpieczenie-zdrowotne-promed.

2. Dental prophylaxis

Dental prophylaxis is a dental examination that involves assessment of the state of dentition and oral hygiene performed **once** in a 12-month Insurance Period in outpatient Medical Facilities indicated by the Insurer by a dentist specialising in conservative dentistry, and oral hygiene procedures performed by a dental hygienist, and includes the following services:

- ❍ Dental consultation
- ❍ Dental fluoride treatment (Fluor Protector) 1 dental arch
- ❍ Dental fluoride treatment (Fluor Protector) 1/2 of dental arch
- ❍ Dental fluoride treatment (Fluor Protector) 2 dental arches
- ❍ Deposit removal — sandblasting
- ❍ Individual fluoride treatment, topical Instructions on oral hygiene
- ❍ Periodontal scaling – complementary
- ❍ Periodontal scaling from 1 dental arch
- ❍ Periodontal scaling from all teeth
- ❍ Tooth polishing

3. Anaesthesia

1) The insurance is performed by dentists in outpatient Medical Facilities indicated by the Insurer and covers the following services:

- ❍ Dental anaesthesia with a WAND device
- ❍ Dental local infiltration anaesthesia
- ❍ Dental local permeation anaesthesia
- ❍ Dental intraoral conduction anaesthesia

2) The Dentistry (option II) insurance does not cover services provided under general anaesthesia.

4. Conservative dentistry

The insurance is performed by dentists in outpatient Medical Facilities indicated by the Insurer and covers the following services including materials:

- ❍ Specialist consultation — conservative dentistry
- ❍ Cauterisation of interdental papilla
- ❍ Circumpulpar pin inlay
- ❍ Cosmetic covering of discoloured dentine in anterior teeth – composite veneer
- ❍ Cosmetic covering of enamel hypoplasia – composite veneer
- ❍ Examination of tooth vitality
- ❍ Periodontal pocket irrigation and drug application
- ❍ Restoration of damaged incisal angle with regular light-cured material
- ❍ Tooth cavity filling 1 surface with regular light-cured material
- ❍ Tooth cavity filling 2 surfaces with regular light-cured material
- ❍ Tooth cavity filling 3 surfaces with regular light-cured material
- ❍ Treatment of changes of the oral mucosa

- Filling – glass ionomer
- Medicinal dressing on a permanent tooth
- Periodontal pocket irrigation

5. Paedodontics

The insurance is performed by dentists in outpatient Medical Facilities indicated by the Insurer and covers the following services including materials:

- Dental consultation – paedodontal
- Adaptation visit (children) – dentistry
- Amputation of devitalised deciduous tooth pulp
- Deciduous tooth cavity filling 1 surface
- Deciduous tooth cavity filling 1 surface, therapeutic
- Deciduous tooth cavity filling 2 surfaces
- Deciduous tooth cavity filling 2 surfaces, therapeutic
- Deciduous tooth cavity filling 3 surfaces
- Deciduous tooth cavity filling 3 surfaces, therapeutic
- Dentine impregnation – per tooth
- Endodontic treatment of a deciduous tooth
- Medicinal dressing on a deciduous tooth
- Prophylactic fissure sealing – limited to 8
- Tooth pulp devitalisation in a deciduous tooth with cavity dressing
- Treatment of pulp necrosis in a deciduous tooth
- Vital pulp amputation in a tooth with unformed root

6. Dental surgery

1) The insurance is performed by dentists in outpatient Medical Facilities indicated by the Insurer and covers the following services:

- Specialist consultation – dental surgery
- Apicoectomy of a posterior tooth
- Apicoectomy of a posterior tooth, with retrograde root canal filling
- Apicoectomy of an anterior tooth
- Apicoectomy of an anterior tooth, with retrograde root canal filling
- Dental abscess incision – including drainage
- Dry socket irrigation + application of medication
- Enucleation of odontogenic cyst
- Excision of a gingival flap within 1 tooth
- Excision of nodule, nodule-like lesion, mucocele – dentistry
- Extraction of a tooth by extra-alveolar chiselling with formation of a mucoperiosteal flap
- Flap procedure with augmentation with Endobon preparation
- Extraction of a tooth by intra-alveolar chiselling
- Frenuloplasty, meloplasty, glossoplasty – dentistry
- Multi-rooted deciduous tooth extraction
- Multi-rooted tooth extraction
- Repositioning and immobilisation of an avulsed tooth
- Sampling of a biopsy specimen in the oral cavity
- Single-rooted deciduous tooth extraction
- Single-rooted tooth extraction
- Surgical dressing – dentistry
- Surgical exposure of an impacted tooth
- Surgical exposure of an impacted tooth with bracket attachment
- Surgical extraction of a partially impacted tooth
- Surgical tooth extraction – surgically complex

2) In addition, the Insured is entitled to a **15% discount** off the price list of the facility indicated by the Insurer for the following services:

- Alveolar regeneration / augmentation following extraction using biomaterial
- Alveolar regeneration / augmentation following extraction using collagen cones
- Alveoloplasty with a transplant – excluding cost of material
- Alveoloplasty within a half of maxilla – preparation for prosthetic restoration
- Application of platelet-rich fibrin (PRF) in dentistry
- Autogenic bone transplant to 3 alveoli
- Bone augmentation 1
- Bone augmentation 2
- Bone augmentation 3
- Closure of oroantral communication or fistula
- Collagen membrane plus application
- Connective tissue replacement membrane plus application
- Connective tissue transplant from a palate – sampling
- Connective tissue transplant from a palate – sampling
- Emdogain and Endobon implantation procedure
- Flap procedure with augmentation using Endobon and Emdogain
- Flap procedure with augmentation with Endobon preparation and Osseoguard membrane
- i-GEN membrane or titanium mesh plus application
- i-Gen membrane removal
- Inferior alveolar nerve transposition
- Maxillary sinus 1 augmentation
- Maxillary sinus 2 augmentation
- Maxillary sinus 3 augmentation
- Membrane plus application
- Removal of salivary duct calculus – dentistry
- Replenishment of the alveolus with bone replacement material, excluding cost of material
- Repositioning and immobilisation of a fractured alveolar process
- Repositioning and immobilisation of an avulsed mandible
- Stitching a lip wound
- Surgical removal of tooth buds
- Temporary management of fractured maxilla
- Tooth reimplantation

7. Endodontics

1) The insurance is performed by dentists in outpatient Medical Facilities indicated by the Insurer and covers the following services:

- Specialist consultation — conservative dentistry
- Chemical and mechanical root canal preparation
- Root canal filling
- Root canal opening

- ❍ Crown-root inlay removal
- ❍ Tooth pulp devitalisation with cavity dressing

2) In addition, the Insured is entitled to a **15% discount** off the price list of the facility indicated by the Insurer for the following services:

- ❍ Crown-root inlay removal under a surgical microscope
- ❍ Endodontal treatment of a molar under a surgical microscope stage I
- ❍ Endodontal treatment of a molar under a surgical microscope stage II
- ❍ Endodontal treatment of a premolar under a surgical microscope stage I
- ❍ Endodontal treatment of a premolar under a surgical microscope stage II
- ❍ Endodontal treatment of an incisor or a canine under a surgical microscope stage I
- ❍ Endodontal treatment of an incisor or a canine under a surgical microscope stage II
- ❍ Interventional appointment during endodontic treatment
- ❍ Removal of a fractured tool from the canal under a surgical microscope
- ❍ Specialised assessment of tissue under a surgical microscope

8. Prosthodontics

1) The insurance is performed by dentists in outpatient Medical Facilities indicated by the Insurer and covers the following services:

- ❍ Specialist prosthetic consultation

2) In addition, the Insured is entitled to a **15% discount** off the price list of the facility indicated by the Insurer for the following services:

- ❍ 1 arch MOCK UP
- ❍ 1 point MOCK UP
- ❍ Acrylic microdenture
- ❍ Adhesive bridge – 1 point
- ❍ All-ceramic crown-root inlay
- ❍ All-ceramic crown-root inlay Stage I
- ❍ All-ceramic crown-root inlay Stage II
- ❍ All-composite crown
- ❍ All-gold cast crown, anterior tooth
- ❍ All-gold cast crown, anterior tooth Stage I
- ❍ All-gold cast crown, anterior tooth Stage II
- ❍ All-gold cast crown, molar
- ❍ All-gold cast crown, molar Stage I
- ❍ All-gold cast crown, molar Stage II
- ❍ All-gold cast crown, premolar
- ❍ All-gold cast crown, premolar Stage I
- ❍ All-gold cast crown, premolar Stage II
- ❍ All-metal cast crown
- ❍ All-metal cast crown Stage I
- ❍ All-metal cast crown Stage II
- ❍ All-porcelain crown
- ❍ All-porcelain crown on zirconia
- ❍ All-porcelain crown on zirconia Stage I
- ❍ All-porcelain crown on zirconia Stage II
- ❍ All-porcelain crown Stage I
- ❍ All-porcelain crown Stage II
- ❍ ASC bracket
- ❍ Bredent latch – 1 element
- ❍ Cementation of a bridge
- ❍ Cementation of a prosthetic crown
- ❍ Composite crown on glass fibre
- ❍ Composite crown ONLAY INLAY OVERLAY
- ❍ Crown-root inlay cast metal
- ❍ Crown-root inlay cast metal combined
- ❍ Crown-root inlay cast metal combined Stage I
- ❍ Crown-root inlay cast metal combined Stage II
- ❍ Crown-root inlay cast metal Stage I
- ❍ Crown-root inlay cast metal Stage II
- ❍ Crown-root inlay made of gold
- ❍ Crown-root inlay made of gold combined
- ❍ Crown-root inlay made of gold combined Stage I
- ❍ Crown-root inlay made of gold combined Stage II
- ❍ Crown-root inlay made of gold Stage I
- ❍ Metal, ceramic, glass fibre crown-root inlay – standard
- ❍ Models for diagnostic or planning purposes – doctor
- ❍ Models for diagnostic or planning purposes – doctor
- ❍ Occlusion alignment using articulator
- ❍ Overdenture on gold latch Stage I
- ❍ Overdenture on gold latch Stage II
- ❍ Overdenture on telescopic crowns Stage I
- ❍ Overdenture on telescopic crowns Stage II
- ❍ Partial denture – 1 point
- ❍ Partial denture supporting 1–4 missing teeth
- ❍ Partial denture supporting 1–4 missing teeth Stage I
- ❍ Partial denture supporting 1–4 missing teeth Stage II
- ❍ Partial denture supporting 5–8 missing teeth
- ❍ Partial denture supporting 5–8 missing teeth Stage I
- ❍ Partial denture supporting 5–8 missing teeth Stage II
- ❍ Partial denture supporting more than 8 teeth
- ❍ Partial denture supporting more than 8 teeth Stage I
- ❍ Partial denture supporting more than 8 teeth Stage II
- ❍ Porcelain crown on galvanised metal Stage I
- ❍ Porcelain crown on galvanised metal Stage II
- ❍ Porcelain crown on gold molar tooth Stage I
- ❍ Porcelain crown on gold molar tooth Stage II
- ❍ Porcelain crown on gold premolar tooth Stage I
- ❍ Porcelain crown on gold premolar tooth Stage II
- ❍ Porcelain crown on gold, anterior tooth
- ❍ Porcelain crown on gold, anterior tooth Stage I
- ❍ Porcelain crown on gold, anterior tooth Stage II
- ❍ Porcelain crown on gold, molar
- ❍ Porcelain crown on gold, premolar
- ❍ Porcelain crown on metal with a ceramic margin
- ❍ Porcelain crown on metal with a ceramic margin Stage I
- ❍ Porcelain crown on metal with a ceramic margin Stage II
- ❍ Porcelain crown on metal without margin
- ❍ Porcelain crown on metal without margin, Stage I
- ❍ Porcelain crown on metal without margin, Stage II
- ❍ Porcelain crown on zirconia using CADCAM Lava Everest method
- ❍ Porcelain crown on zirconia using CADCAM Lava Everest method Stage I
- ❍ Porcelain crown on zirconia using CADCAM Lava Everest method Stage II
- ❍ Porcelain crown ONLAY INLAY OVERLAY
- ❍ Porcelain crown ONLAY INLAY OVERLAY Stage I
- ❍ Porcelain crown ONLAY INLAY OVERLAY Stage II
- ❍ Porcelain veneer
- ❍ Porcelain veneer posterior

- Crown-root inlay made of gold Stage II
- Denture repair – 1 element
- Direct denture lining
- Face-bow examination and placement in articulator
- Frame denture
- Frame denture metal control and correction
- Frame denture Stage I
- Frame denture Stage II
- Frame denture with latches without latch cost
- Frame denture with latches without latch cost Stage I
- Frame denture with latches without latch cost Stage II
- Full denture with metal palate
- Full mandibular denture
- Full mandibular denture Stage I
- Full mandibular denture Stage II
- Full maxillary denture
- Full maxillary denture Stage I
- Full maxillary denture Stage II
- Functional impression using individual tray
- Galvanised telescopic crown, gold
- Galvanised telescopic crown, gold Stage I
- Galvanised telescopic crown, gold Stage II
- Gold crown inlay
- Gradia gingival mask
- Gradia gingival mask Stage I
- Gradia gingival mask Stage II
- Indirect denture lining
- Latch / bolt / retainer point in frame denture
- Latch / bolt / retainer point in frame denture Stage I
- Latch / bolt / retainer point in frame denture Stage II
- Malocclusion correction
- Maryland missing tooth restoration – acrylic
- Maryland missing tooth restoration – composite
- Metal crown ONLAY INLAY OVERLAY
- Metal telescopic crown
- Metal telescopic crown Stage I
- Metal telescopic crown Stage II
- Overdenture on gold latch
- Porcelain veneer posterior Stage I
- Porcelain veneer posterior Stage II
- Porcelain veneer Stage I
- Porcelain veneer Stage II
- Protective splint sport
- Protective splint sport colour
- Provisional crown using indirect method
- Reinforcement of a denture with a gold-plated mesh
- Reinforcement of a denture with a steel mesh
- Reinforcement of a denture with an arch
- Removal of a prosthetic crown – 1 element
- Replacement of Rhein inlay – 1 element
- Rhein latch – 1 element
- Silver-palladium crown-root inlay
- Silver-palladium crown-root inlay
- Silver-palladium crown-root inlay
- Silver-palladium crown-root inlay combined
- Silver-palladium crown-root inlay combined Stage I
- Silver-palladium crown-root inlay combined Stage II
- Spherical inlays
- Splint denture
- Stage I
- Stage II
- Teflon replacement
- Visualisation of prosthodontic treatment on a model
- Wax teeth control and correction
- WAX UP
- WAX UP INTERDENT

9. Orthodontics

1) The insurance is performed by dentists in outpatient Medical Facilities indicated by the Insurer and covers the following services:

- Orthodontist's consultation

2) In addition, the Insured is entitled to a **15% discount** off the price list of the facility indicated by the Insurer for the following services:

- 1/2 segment arch
- 1/3 segment arch
- Acrylic bite splint
- Additional orthodontic element 1
- Additional orthodontic element 2
- Additional orthodontic element 3
- Attachment of a crystal bracket
- Attachment of a metal bracket
- Block braces
- Block braces Stage I
- Block braces Stage II
- Block braces with modification
- Braces repair
- Braces repair replacement of 1 element
- One brace of metal, fixed braces
- One brace of metal, transparent braces
- One wire arch of fixed brace with crystal brackets Stage I
- One wire arch of fixed brace with crystal brackets Stage II
- One wire arch of fixed braces crystal brackets
- One wire arch of fixed braces individual lingual brackets
- One wire arch of fixed braces individual lingual brackets Stage I
- One wire arch of fixed braces individual lingual brackets Stage II
- One wire arch of fixed braces metal and crystal brackets
- One wire arch of fixed braces metal and crystal brackets Stage I
- One wire arch of fixed braces metal and crystal brackets Stage II
- One wire arch of fixed braces metal brackets
- One wire arch of fixed braces nickel-free brackets
- One wire arch of fixed braces nickel-free brackets Stage I

- Braces repair replacement of 2 elements
- Braces repair replacement of 3 elements
- Braces repair, 1 arch wire replacement 2D lingual brackets
- Braces repair, 1 arch wire replacement ceramic brackets
- Braces repair, 1 arch wire replacement metal brackets
- Braces repair, 1 screw replacement
- Braces repair, 2 arch wires replacement 2D lingual brackets
- Braces repair, 2 arch wires replacement ceramic brackets
- Braces repair, 2 arch wires replacement metal brackets
- Braces repair, 2 screws replacement
- Braces repair, addition of a wire element
- Braces repair, arch wire replacement
- Braces repair, plate breakage
- Carriere distalizer
- Chin cap
- Class II corrector
- Clear aligner follow-up
- Clear aligner impression
- Derichsweiler apparatus
- Expander braces
- Fixed aesthetic braces 2x4
- Fixed aesthetic braces 2x4 Stage I
- Fixed aesthetic braces 2x4 Stage II
- Fixed braces – 2D lingual brackets 1 arch
- Fixed braces – aesthetic brackets 1 arch
- Fixed braces – aesthetic brackets part of arch 1
- Fixed braces – aesthetic brackets part of arch 2
- Fixed braces – aesthetic, non-ligature brackets 1 arch
- Fixed braces – aesthetic, non-ligature Damon brackets 1 arch
- Fixed braces – closed metal 1 arch
- Fixed braces – metal, non-ligature brackets 1 arch
- Fixed braces – metal, non-ligature Damon brackets 1 arch
- Fixed metal braces 2x4
- Flexible orthodontic appliance
- Follow-up visit – fixed braces, 2D lingual brackets
- Follow-up visit – fixed braces, crystal brackets
- Follow-up visit – fixed braces, metal brackets
- Follow-up visit – fixed braces, porcelain brackets
- Follow-up visit in the course of treatment with fixed braces with non-ligature Damon brackets – 1 arch
- Follow-up visit in the course of treatment with fixed braces x 1
- Follow-up visit in the course of treatment with fixed partial braces
- Follow-up visit in the course of treatment with removable braces
- Fragmentary fixed braces
- Guray / OBC wedging
- Hass braces
- Headgear
- Headgear application
- Herbst hinge
- Herbst hinge Stage I
- Herbst hinge Stage II
- Hyrax braces
- Hyrax braces Stage I
- Hyrax braces Stage II
- Lip-bumper
- MALU appliance
- Models for diagnostic or planning purposes – orthodontist
- Multifunctional braces Molar rotator
- Multi-P braces
- One wire arch of fixed braces nickel-free brackets Stage II
- One wire arch of fixed braces porcelain brackets
- One wire arch of fixed braces with metal brackets Stage I
- One wire arch of fixed braces with metal brackets Stage II
- One wire arch of fixed metal braces
- Orthodontic acrylic splint
- Orthodontist consultation in the course of treatment with fixed braces
- Orthodontist consultation in the course of treatment with removable braces
- Orthodontist's consultation with an impression
- Orthognathic treatment planning
- Palatal expander
- Pendulum braces
- Pendulum braces Stage I
- Pendulum braces Stage II
- Plate denture for children
- Plate denture for children Stage I
- Plate denture for children Stage II
- Removable braces
- Removable braces – Schwarz plate
- Removable braces – Schwarz plate Stage I
- Removable braces – Schwarz plate Stage II
- Removal of fixed braces
- Removal of retention arch
- Replacement of a 2D lingual metal bracket
- Replacement of a metal bracket
- Replacement of a porcelain bracket
- Replacement of an aesthetic bracket
- Replacement of an individual lingual bracket
- Retainer 1
- Retainer 2
- Retainer 3
- Retainer arch 1 tooth
- Retainer arch 6 teeth
- Retention arch application
- Retention arch application – mandible
- Retention arch application – maxilla
- Retention control
- Retention plate
- Space maintainer
- Stochfisch braces
- Stripping – 1 tooth
- System Benefit braces Stage I
- System Benefit braces Stage II
- Tooth separation procedure
- TWIN-BLOCK braces
- TWIN-BLOCK braces Stage I
- TWIN-BLOCK braces Stage II
- TWIN-BLOCK braces with a screw – modified
- TWIN-BLOCK braces with a screw – modified Stage I
- TWIN-BLOCK braces with a screw – modified StageII
- Vestibular plate
- Vestibular plate – infant trainer
- Visit with a chin cap
- Visit with a vestibular plate
- Visit with cusp grinding
- Wide-arch braces – palatal arch
- Wide-arch braces – tongue arch
- Wide-arch braces Bi-helix, Quad – helix

- Nance braces
- Nance plate
- NiTi palatal expander
- Occlusal analysis and treatment plan development
- Wide-arch braces Bi-helix, Quad – helix Stage I
- Wide-arch braces Bi-helix, Quad – helix Stage II
- Wire arch replacement individual lingual brackets

10. Biological dentistry

5. The insurance is performed by dentists in outpatient Medical Facilities indicated by the Insurer with a **15% discount** off the price list of the facility indicated by the Insurer for the following services:

- Application of bioactive dentin substitute – Biodentine (Septodont)
- Bioreconstruction of lost tooth tissue using ACTIVA (Pulpdent)
- Enamel remineralisation with a Tooth Mousse preparation
- Local application of MI VARNISH (GC) releasing bioavailable calcium, phosphate and fluoride
- Maintenance treatment using bioavailable calcium, phosphate and fluoride – GC MI Paste Plus
- Minimally invasive tooth decay treatment using glass hybrid technology – EQUIA FORTE
- Molecular and biological assay for pathogens causing periodontitis/periimplantitis using Real-Time PCR – PET standard (MIP PHARMA) method
- Molecular and biological assay for pathogens causing periodontitis/periimplantitis using Real-Time PCR – PET plus (MIP PHARMA) method
- Molecular and biological assay for pathogens causing periodontitis/periimplantitis using Real-Time PCR – PET deluxe (MIP PHARMA) method
- Restoration of lost tooth tissue using BPA-free Gaenial
- Saliva-Check Buffer (GC) test
- Streptococcus mutans saliva concentration using Saliva-Check Mutans (GC)
- Tooth decay infiltration – ICON (DMG)
- Tri Plaque ID Gel (GC) control

11. Periodontology

1) The insurance is performed by dentists in outpatient Medical Facilities indicated by the Insurer and covers the following services:

- Specialist periodontal consultation

2) In addition, the Insured is entitled to a **15% discount** off the price list of the facility indicated by the Insurer for the following services:

- Treatment of oral mucosa lesions – ozonotherapy – doctor
- Open curettage within 1 tooth
- Teeth immobilisation with wire ligature – tooth
- Teeth immobilisation with composite splint – 1 tooth
- Teeth immobilisation with composite splint with additional reinforcements – 1 tooth
- Biomaterial implantation procedure 1
- Emdogain implantation procedure 1 tooth
- Covering exposed teeth roots procedure
- Periodontal dressing
- Treatment of oral mucosa lesions – ozonotherapy – dental hygienist
- Biomaterial implantation procedure 2
- Biomaterial implantation procedure 3
- Emdogain implantation procedure 2 teeth
- Emdogain implantation procedure 3 teeth
- Gingivoplasty within 1 tooth
- Gingival osteoplasty within 1 tooth
- Periodontology Splinting of maxilla and mandible
- Periodontology Crown lengthening of a double-rooted tooth
- Periodontology Crown lengthening of a single-rooted tooth
- Periodontology Bone regeneration control
- Periodontology Gingival transplant – up to 2 teeth
- Dental biostimulation laser
- NanoBone bone replacement material implantation procedure
- Oral cancer Vizilite screening test
- Root planning one arch
- Periodontology Crown lengthening (up to 6 teeth)
- Performance of a test for presence of pathogens causing periodontitis / periimplantitis
- Specialist periodontal consultation follow-up visit
- Covering exposed teeth roots procedure of 1 tooth area
- Covering exposed teeth roots procedure of a 2 teeth area
- Covering exposed teeth roots procedure of a 3 teeth area
- Periodontology Tunnelization
- Preparation of a written plan and costs of periodontal treatment
- Regular curettage within 1 tooth
- Periodontology Flap (1 tooth)
- Vector periodontal apparatus procedure 2 arches
- Vector periodontal apparatus procedure 1 arch
- Vector prosthetic apparatus procedure 2 arches
- Vector prosthetic apparatus procedure 1 arch
- Vector prosthetic apparatus procedure 1 tooth (1 to 6 teeth)
- Root planning 1/2 arch
- Simple curettage within 1/4 of dental arch

11. Implantology

1) The insurance is performed by dentists in outpatient Medical Facilities indicated by the Insurer and covers the following services:

- Specialist implantological consultation

2) In addition, the Insured is entitled to a **10% discount** off the price list of the facility indicated by the Insurer for the following services:

- Denture on 2 implants with a bar
- Denture on 2 implants with a bar Stage I
- Denture on 2 implants with a bar Stage II
- Denture on 2 implants with locators
- Porcelain bridge on implants with individual crowns 1 point Stage I
- Porcelain bridge on implants with individual crowns 1 point Stage II
- Porcelain crown on implant, two-structure on steel
- Porcelain crown on implant, two-structure on steel Stage I

- Denture on 2 implants with locators Stage I
- Denture on 2 implants with locators Stage II
- Denture on 4 implants with a bar
- Denture on 4 implants with a bar Stage I
- Denture on 4 implants with a bar Stage II
- Denture on 4 implants with locators
- Denture on 4 implants with locators Stage I
- Denture on 4 implants with locators Stage II
- Implant splint with titanium positioners
- Implant splint, model
- Implant uncovering with a healing screw 1 point
- Insertion of a BEGO implant
- Insertion of a micro implant
- Insertion of a Straumann implant
- Insertion of an Astra implant
- Insertion of an Astra implant and support one-stage
- Insertion of Dentium implant
- Insertion of Neodent implant
- Insertion of Straumann SL Actve implant
- Locator attachment on an implant
- Porcelain bridge on implants 1 arch
- Porcelain bridge on implants 1 arch Stage I
- Porcelain bridge on implants 1 arch Stage II
- Porcelain bridge on implants with individual crowns 1 point
- Porcelain crown on implant, two-structure on steel Stage II
- Provisional immediate crown on an implant made by a dentist
- Provisional immediate crown on an implant made by a technician
- Removal of a micro implant
- Removal of a permanent implant
- Renovation of Toronto acrylic bridge on implants, acrylic replacement
- Titanium bar on 6 implants
- Toronto acrylic bridge on implants 1 arch
- Toronto acrylic bridge on implants 1 arch Stage I
- Toronto acrylic bridge on implants 1 arch Stage II
- Zirconium bar on implants 4–5 implants
- Zirconium bar on implants 4–5 implants Stage I
- Zirconium bar on implants 4–5 implants Stage II
- Zirconium bar on implants 6–8 implants
- Zirconium bar on implants 6–8 implants Stage I
- Zirconium bar on implants 6–8 implants Stage II

12. Treatment of functional disorders of the masticatory apparatus

6. The insurance is performed by dentists in outpatient Medical Facilities indicated by the Insurer with a **10% discount** off the price list of the facility indicated by the Insurer for the following services:

- Soft dental guard
- Hard dental guard
- NTI dental guard
- Face-bow examination and placement in articulator with an MDI examination

13. Aesthetic dentistry

7. The insurance is performed by dentists in outpatient Medical Facilities indicated by the Insurer with a **10% discount** off the price list of the facility indicated by the Insurer for the following services:

- Diastema closure – per tooth
- Teeth whitening Beyond lamp 1 dental arch
- Teeth whitening Beyond lamp 2 dental arches
- Teeth whitening using external method – 1 syringe
- Teeth whitening using external method – 1 syringe – dental hygienist
- Teeth whitening using external method – supplemental set
- Teeth whitening using external method – supplemental set – dental hygienist
- Tooth whitening Smile Laser 1 arch
- Tooth whitening Smile Laser 2 arches
- Tooth whitening Smile Laser supplementation
- Tooth whitening using internal method – 1 procedure
- Whitening of group of teeth using external method – 1 dental arch
- Whitening of group of teeth using external method – 1 dental arch using LED lamp

14. Dental X-ray (medium conforming with the standard applicable in a given medical facility).

8. The insurance includes provision of the following services in outpatient Medical Facilities indicated by the Insurer, based on a referral from a dentist from these facilities, and includes the following services:

- Single tooth X-ray
- Panoramic X-ray

15. Guarantee

1) The Insured is provided with a 24-month guarantee for final conservative fillings used in permanent teeth. A precondition to obtaining the guarantee is to attend follow-up visits in outpatient Medical Facilities indicated by the Insurer at least once in a 12-month Insurance Period or according to an individually agreed schedule, and undergo tartar and deposit removal and fluoride treatment procedures once in a 12-month Insurance Period or according to an individually agreed schedule in outpatient Medical Facilities indicated by the Insurer, compliance with dentist's recommendations, maintaining oral hygiene as instructed by the dentist and/or dental hygienist.

2) The guarantee does not cover conditions occurring as a result of: non-attendance at follow-up and prophylaxis visits, non-compliance with dentist's recommendations, mechanical injuries, accidents, missing posterior teeth (lack of support zones), pathological dental wear (bruxism) or other functional impairments of the masticatory apparatus, physiological bone atrophy and periodontal lesions, general co-morbidities affecting the stomatognathic system (diabetes, osteoporosis, epilepsy, history of radiotherapy and chemotherapy), or temporary fillings (e.g. provided until a prosthesis is prepared).

§20 Home visits

1. The scope of insurance is limited to 3 free visits during the 12-month period of the agreement.
2. The insurance is carried out by an Emergency Physician at the Insured's place of residence if the place of residence is within the current territorial range of home visits, only in medically justified cases where the Insured is unable to get to the outpatient Medical Facility indicated by the Insurer, excluding direct life-threatening situations. Reasons making it impossible for the Patient to report to the clinic do not include, among others: inconvenient access to the outpatient Medical Facility indicated by the Insurer, the need to obtain a prescription or issue a medical certificate for sick leave.
3. A house call is an emergency service provided solely on the visit request day and aimed at making a diagnosis and starting treatment, whereas treatment continuation and follow-up visits take place in outpatient Medical Facilities indicated by the Insurer. In the case of a ho me visit, it is impossible to freely choose a physician. A house call request is accepted or refused by a medical dispatcher indicated by the Insurer based on the information provided.
4. The current territorial coverage of home visits can be found at www.luxmed.pl. In cities where home visits are not provided, the Insured will be reimbursed. Details of reimbursement can be found on the above website. Reimbursement shall be considered reasonable only after the Insured has been qualified for a home visit by the dispatcher.

§21 Ambulance team intervention in the workplace

The insurance is available only for the Insured Employees (Main Insured) exclusively for sudden onsets of illnesses and accidents. A sudden onset of an illness is a condition of sudden or expected in a short time occurrence of health exacerbation whose immediate consequence may be a serious impairment of bodily functions or body injury or death, which require immediate medical rescue action and treatment. Each time, the decision to send an ambulance is taken by a medical dispatcher (indicated by the Insurer) after a conversation with the Insured or witness of the event.

Depending on the situation, The insurance may be provided by an intervention team of the Operator, a partner team or a National Medical Rescue System team. The medical rescue team provides medical assistance at the Insuring Party's – Employer's workplace (the detailed territorial coverage is described on www.luxmed.pl) and if necessary, they transport the Insured to a Medical Facility indicated by the Insurer, or to the nearest hospital in a life-threatening situation. The insurance is not an alternative to The insurances provided under the National Emergency Medical Service System.

§22 Ambulance team intervention in the place indicated

The insurance is available to the Insured exclusively for sudden onsets of illnesses and accidents. A sudden onset of an illness covered by The insurance is a condition of sudden or expected in a short time occurrence of health exacerbation whose immediate consequence may be a serious impairment of bodily functions or body injury or death, which require immediate medical rescue action and treatment. Each time, the decision to send an ambulance is taken by a medical dispatcher (indicated by the Insurer) after a conversation with the Insured or his/her family or a witness of the event. Depending on the circumstances, The insurance may be provided by an internal intervention team of the Operator, a cooperating team, or a team of the National Emergency Medical Service System.

The medical rescue team provides medical assistance to the Insured at the site of the event (including at workplace), it it is located within the area, the detailed territorial coverage of which is described on www.luxmed.pl, and if it is necessary to perform examinations, they transport the Insured to a Medical Facility indicated by the Insurer, or to the nearest hospital in a life-threatening situation. The insurance is not an alternative to The insurances provided under the National Emergency Medical Service System.

§23 Medical Transport

The insurance is available in the event of medical indications to transport the Insured between Medical Facilities or to a Medical Facility from the place of residence of the Insured in the following situations:

1) the need for continuity of treatment,
2) the need for treatment at a specialized facility.

The insurance is carried out by means of wheeled sanitary transportation means (free in Poland) and is only elective – it requires reporting to the medical dispatcher indicated by the Insurer at least 24 hours prior to the performance of The insurance. Medical transport is provided only in situations where there are no medical contraindications and transporting the Insured by means of public or individual transport would endanger his/her health and life. Additionally, this service requires consent of the facility, from which the Insured is going to be taken, and consent of the facility to which is going to be taken (confirmation of acceptance). In justified cases, the Insurer may require additional information concerning the transport conditions and limitations related tothe state of health of the Insured. The insurance and does not include healthcare services provided to save life and health in accordance with the National Medical Rescue Act (Journal of Laws 2006.191.1410, as amended). The insurance is separate from transport provided as part of Inpatient Module in the LUX MED Group Health Insurance Agreement.

§24 Oncological Preventive Health Care Program

The Oncological Preventive Health Care Program is a health check optimized for early detection of the most common cancers. The Oncological Preventive Health Care Program is available only for the Employees (Main Insured) from 18 to 70 years of age.

The program includes:

1. Preventive examinations

   During the 12-month Insurance Term, the program provides 1 health assessment session and subsequent referrals for testing based on the medical indications and current scientific recommendations, accounting for age, sex, family history, and individual oncological risk factors. The assessment is concluded with a Physician's consultation to discuss the Employee's health and ways to decrease the risk of cancer.

   The scope of individual preventive check includes:
   1) internal medicine consultation—obtaining the Employee's medical history;

2) Dermatology consultation, including a standard dermatoscopy*;
3) Laboratory diagnostics (referral required):
   - ❍ Blood count + platelet count + automated smear;
   - ❍ PSA panel (PSA, FPSA, FPSA / PSA index)
   - ❍ Standard* pap smear
4) Imaging and endoscopy diagnostics (referral required):
   - ❍ Abdominal ultrasound;
   - ❍ Breast ultrasound;
   - ❍ Mammography (X-ray);
   - ❍ Transvaginal gynaecological ultrasound;
   - ❍ CT – computer tomography of chest (low-dose);
   - ❍ Colonoscopy under local anaesthetic.
5) Internal medicine consultation – concluding the program.

Insurance procedures are available in selected Medical Facilities indicated by the Insurer, listed at the following address: www.luxmed.pl/program-profilaktyki-onkologicznej-LUXMED-placowki.

2. Diagnostics Coordination
In the case of a suspected malignancy diagnosis confirmed by Physicians from Medical Facilities indicated by the Insurer, The insurance covers the support of an oncology coordinator within the following scope:
   1) Advice regarding:
      - ❍ Obtaining the Cancer Diagnosis and Treatment (DiLO) card, which entitles the patient to fast-track oncology diagnostics and treatment (if necessary) financed by the National Health Fund (NFZ);
      - ❍ Selecting a medical center providing diagnosis and treatment of specific types of cancers financed by the National Health Fund (NFZ);
   2) Help in making the initial appointment in recommended by the Insurer specialized oncological diagnostic facility financed by the National Health Fund (NFZ);
   3) Arranging and issuing an Oncological Opinion: an oncologist indicated by the Insurer will issue a medical opinion based on provided by the Employee medical records confirming cancer diagnosis. The Employee is entitled to 1 opinion per diagnosed malignancy.

   The Employee is eligible for the Oncological Opinion within 30 days after a confirmed by a Physician cancer diagnosis, and before the treatment commencement. The Oncological Opinion is realized within 10 working days from the date of the application for the Oncological Opinion was made, provided the Employee applies for the Oncological Opinion within 20 days from the date of the cancer diagnosis confirmation. If the Employee began treatment prior to applying for an Oncological Opinion or the Employee's DiLO card was canceled or expired the Oncological Opinion will not be realized.

   The Employee remains eligible for Diagnostics Coordination within 30 days after the date of expiry or cancellation of the Insurance Agreement, or removal of the Employee from the Insured List (the Insurance Agreement), if the diagnosis of suspected malignancy confirmed by Physicians from Medical Facilities indicated by the Insurer had been made prior to the Insurance Agreement expiry, cancellation, or removal of the Employee from the Insured List (the Insurance Agreement).

3. Education
During the 12-month Insurance Term, the program education day, at the Insuring Party's office, consisting of:
   1) Cancer prevention seminar;
   2) Individual preventive consultation session with an oncology nurse.

§25 HARMONIA in Business: a Prevention Programme

1. HARMONIA in Business: a Prevention Programme is a comprehensive programme focused on mental health prevention consisting of four modules: analysis, education, psychotherapy and psychological phone line. The HARMONIA in Business Programme, hereinafter referred to as the "Programme", is intended only for the Main Insured Persons over 18 years of age. The modules described below comprise one basic service in the field of medical care for mental health prevention, maintenance and improvement in the participants. All modules help to identify risks related to mental health, maintain and improve health, and prevent and counteract those risks. As a result, the Programme constitutes one inseparable whole: the Insuring Party gains access to four modules as part of one medical service in accordance with the rules set forth in this Appendix. The modules are interdependent and together maximise the effect of the Programme: mental health prevention and improvement for the participants.
2. The Programme includes:
   1) Analysis - In this module, once in the 12-month Insurance Period, an anonymous survey is conducted among all the Main Insured Persons signed up for medical care. An expert tool, the Prevention Survey, is applied, which is developed by the Insurer's psychologists. The survey will be made available to the Main Insured Persons via a dedicated link provided to the Insuring Party. The Prevention Survey is designed to investigate the well-being of the Main Insured Persons in the following areas: job satisfaction, professional burnout, depression. The Prevention Survey also aims at capturing the first symptoms of burnout and depression and at providing the Main Insured Persons with recommendations on the possible ways to eliminate them.
      Following completion of the Prevention Survey, each participant will receive a report describing their mental health risks and making a preliminary identification of the need to start treatment.
      Once the data have been collected through the Prevention Survey, the Insurer will prepare a Report for the Insuring Party presenting the results of the Prevention Survey. The results will be presented based on the pooled data, in a manner that ensures full anonymity to the survey participants. No medical data are collected or processed during the Prevention Survey.
   2) Education - In this module, once in the 12-month Insurance Period, one (1) educational day is held at the Insuring Party's location. The educational day involves the following:
      - ❍ The Insurer will conduct a prevention seminar with a topic related to the results presented in the Report;
      - ❍ One (1) psychologist will provide individual preventive consultations to the interested Main Insured Persons during a five-hour duty

The prevention seminar allows one to identify mental health risks that may affect the participants and specify the available forms of treatment and preventive measures to avoid those risks. The Education module is a deeper form of analysis for the prevention, maintenance and improvement of mental health and as such it constitutes the continuation and extension of the Preventive Analysis performed as part of the Analysis module. As a result, it provides the participants with individual information on the potential need to start psychotherapy.

3) Psychotherapy - This module provides the Main Insured Person with three individual sessions with a psychotherapist without referral within the 12-month Insurance Period at the facilities specified by the Insurer. An individual session includes: interview, specialist advice along with the activities necessary to make a diagnosis, essential psychotherapeutic diagnostic procedures and defining the problem area along with determining the direction and schedule of further treatment. The insurance is available at selected Medical Facilities specified by the Insurer and described at https://harmonia.luxmed.pl/harmonia-w-biznesie-program-profilaktyczny-wykaz-placowek/
Sessions with a psychotherapist as part of The insurance are held only as individual meetings and do not include group psychotherapy, family psychotherapy, couples psychotherapy, psychoanalysis, coaching, mentoring, sessions with a trauma psychologist, EMDR psychotherapy, and consultation and psychotherapy in the field of sexual medicine. The selection of psychotherapy diagnostic methods and of the ultimate form and type of psychotherapy is made by the psychotherapist upon reviewing the Patient's medical condition, problems and expectations. In consultation with the Patient, the psychotherapist arranges a meeting schedule and a treatment plan, which the Patient is obliged to follow in order to achieve the appropriate therapeutic results. Psychotherapy is not a substitute for treatment as part of a consultation with a psychiatrist. It is a supplement to the current psychiatric treatment. After the session limit has been achieved, The insurances will be provided on the basis of a facility's price list.

4) Psychological Phone Line - This module involves the possibility to receive psychological support from psychologists over the telephone by calling the number of the Polish nationwide Harmonia phone line. This advice does not replace in-person consultations. In justified cases, a psychologist may refuse to provide consultation and refer the patient to an in-person individual session with a psychologist or decide to call an ambulance.
The insurances in the form of Psychological Phone Line are only provided for the Patient who has entered into the Agreement or who is specified as a person entitled to the Health Services included in the Programme. The Patient must not provide access to Psychological Phone Line services to another person. The Patient bears full civil and criminal liability for ensuring that the data they provide are genuine.

§26 VIP Insured's Personal Assistant

1. Each Insured is assigned a VIP Patient's Personal Assistant.
2. The Assistant contacts the Insured regularly by phone, arranges examinations and medical consultations in selected outpatient Medical Facilities indicated by the Insurer.

§27 Package availability option – Silver

A service consisting in the provision of better access to the Contractor's Specialist Physicians – the Availability Time for the Silver Option is greater than 70%. Under this option, the Patient is entitled to Reimbursement of service costs on the terms specified below.
The Contractor shall reimburse the costs incurred by the Eligible Person amounting to 70% of the unit price of the Health Service carried out during the Reimbursement Period in a Medical Facility other than that indicated by LUX MED, to which the Eligible Person is entitled under the Agreement and the Benefitplan held, up to the quarterly Reimbursement Limit of PLN 650 per Eligible Person.

§28 Package availability option – Gold

A service consisting in the provision of better access to the Contractor's Specialist Physicians – the Availability Time for the Gold Option is greater than 80%. Under this option, the Patient is entitled to a Reimbursement of The insurance costs on the terms specified below.
The Contractor shall reimburse the costs incurred by the Eligible Person amounting to 90% of the unit price of the Health Service carried out during the Reimbursement Period in a Medical Facility other than that indicated by LUX MED, to which the Eligible Person is entitled under the Agreement and the Benefitplan held, up to the quarterly Reimbursement Limit LN 650 per Eligible Person.

§29 Package availability option – Platinum

A service consisting in the provision of better access to the Contractor's Specialist Physicians – the Availability Time for the Platinum Option is greater than 90%. Under this option, the Patient is entitled to a Reimbursement of The insurance costs on the terms specified below.
The Contractor shall reimburse the costs incurred by the Entitled Person amounting to 100% of the unit price of the Health Service carried out during the Reimbursement Period in a Medical Facility other than that indicated by LUX MED, to which the Eligible Person is entitled under the Agreement and the Benefitplan held, up to the quarterly Reimbursement Limit of PLN 650 per Eligible Person.

§30 10% discount on other services offered by LUX MED and Medycyna Rodzinna

1. The Insured is entitled to a 10% discount on medical services, excluding dental services, offered by Medical Facilities indicated by the Insurer – this applies to LUX MED and Medycyna Rodzinna facilities listed on www.luxmed.pl.
2. The discount is calculated from the price list available in the facility.
3. Discounts may not be combined.

§31 10% discount on medical procedures provided in PROFEMED

1. The Insured is entitled to a 10% discount on all medical procedures provided in PROFEMED facilities.
2. The discount is calculated from the price list available in the facility.
3. Discounts may not be combined.

§32 SECOND MEDICAL OPINION SERVICE (for small companies)

1. A service organised in cooperation with WorldCare International Inc. with its registered office in Boston (Massachusetts; USA), enabling the Insured Party to consult the diagnosis and treatment plan prepared in the Republic of Poland with the teams of specialists cooperating with internationally recognised academic medical centres in the USA, belonging to the WorldCare Consortium, the list of which is available at: https://www.worldcare.com/worldcare-consortium-2/, and to obtain the second medical opinion without having to leave Poland.
2. The opinion is issued for the following illnesses or conditions where the diagnosis, injury or the need for surgical treatment or procedure has been identified:

- ❍ Neoplasms
- ❍ Myocardial infarction
- ❍ Coronary artery disease requiring an operation
- ❍ Coma
- ❍ Cerebral stroke
- ❍ Multiple sclerosis
- ❍ Paralysis, Plegia, Paresis
- ❍ Chronic obstructive pulmonary disease
- ❍ Emphysema
- ❍ Inflammatory bowel disease
- ❍ Chronic liver disease
- ❍ Renal failure
- ❍ Chronic pelvic pain
- ❍ Diabetes mellitus
- ❍ Thromboembolism
- ❍ Amputations
- ❍ Rheumatoid arthritis
- ❍ Severe burns
- ❍ Sudden loss of sight due to illness
- ❍ Transplantation of large organs
- ❍ Neurodegenerative disease/Alzheimer's disease
- ❍ Loss of hearing
- ❍ Hip and knee replacement surgery
- ❍ Loss of speech
- ❍ Serious injuries
- ❍ Parkinson's disease

3. Each notification covered by the above-mentioned scope is comprehensively analysed at the leading medical centres in the USA. A team of specialists, based on the submitted medical dossier and the results of imaging and histopathological tests, verifies the diagnosis and treatment plan proposed by the Insured Party's attending physician, and then presents a detailed report that may confirm the previous diagnosis and treatment method or recommend their modification.
4. The report (Second Medical Opinion) shall contain:
   1) case report,
   2) diagnosis,
   3) recommendations for further treatment,
   4) list of questions to be discussed by the Insured Party with his/her physician,
   5) information on the specialist and institution issuing the Second Medical Opinion – translated into Polish, as well as data on recent scientific research and educational materials related to the case.
5. As part of the service, the Insured Party, within 30 days of receiving the Second Medical Opinion, may also ask additional questions concerning a given condition, to which the Insured Party shall respond by electronic means. If necessary, in order to consult the case of the Insured Party, an audio conference may be held between the treating doctor and the specialist issuing the second opinion.
6. In order to obtain a Second Medical Opinion, the Insured Party should contact WorldCare in Poland at **+48 (22) 221 06 41**.
7. The Second Medical Opinion Service shall be provided to the Insured Party no earlier than 90 days after the first day of the Coverage Period.

§33 SECOND MEDICAL OPINION SERVICE

The Insured may request the Insurer for a second medical opinion of the world's best doctors specialising in a given field, provided without the need of leaving Poland. The opinion is issued on the basis of medical records for the following diseases, conditions in which a diagnosis was made, injury was found or the need to perform surgical treatment, procedures was identified:

- ❍ Malignant neoplasm
- ❍ Renal insufficiency
- ❍ End-stage renal disease
- ❍ Chronic viral hepatitis
- ❍ Stroke
- ❍ Benign brain tumor
- ❍ Encephalitis
- ❍ Meningitis
- ❍ Limb paralysis
- ❍ multiple sclerosis,
- ❍ Alzheimer's disease
- ❍ Parkinson's disease,
- ❍ motor neuron diseases.
- ❍ Organ transplant
- ❍ Heart attack
- ❍ Coronary angioplasty
- ❍ Coronary Artery Bypass Graft
- ❍ Heart valve surgery
- ❍ Surgery of the aorta
- ❍ Bacterial endocarditis
- ❍ Aplastic anemia
- ❍ Extensive burns
- ❍ Loss of limb
- ❍ Loss of hearing
- ❍ Loss of sight
- ❍ Loss of speech
- ❍ Coma
- ❍ Type 1 diabetes (insulin-dependent)
- ❍ Tuberculosis
- ❍ HIV infection

Appendix no. 2 to the General Terms and Conditions of LUX MED Group Insurance – GTC CODE G/004/2024/C

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SECTION I: HOSPITAL SERVICE

Module: LUX MED Orthopaedic Care Hospital Insurance

§1 Hospitalisation

Hospitalisation caused by an Accident (confirmed by a referral for a procedure or surgery resulting from the injury. The referral should be issued within 90 days of the occurrence of the Accident). The scope includes:

1. **Orthopaedics**
   a. includes orthopaedic surgeries, orthopaedic materials;
   b. it does not include:
      I. endoprosthesis;
      II. limb lengthening;
      III. osseointegration treatments;
      IV. spinal procedures.

Module: LUX MED Orthopaedic Care Plus Hospital Insurance

§1 Hospitalisation

1. We provide Urgent Hospitalisation and Scheduled Hospitalisation in the field of orthopedics:
   b. includes orthopaedic procedures, including endoprosthesis and orthopaedic fixation materials;
   c. it does not include:
      I. limb lengthening;
      II. osseointegration treatments;
      III. spinal procedures.

§2 Emergency Care

1. Consultation of the Emergency Care Physician is possible provided that the Hospital Coordinator confirms that consultation is necessary and appropriate from the medical point of view.

2. Emergency Care will be provided, depending on the medical indications and the extent of services available at a given location:
   a. interventions by emergency medical service;
   b. providing necessary medical assistance at the place of residence of the Insured;
   c. providing necessary medical assistance at the Outpatient Clinic or Hospital designated by us;
   d. giving recommendations on further conservative management;
   e. transport to hospital.

The scope of services available as part of Emergency Care at a given location is indicated on www.opiekaszpitalna.luxmed.pl.

3. Emergency Care does not replace the assistance provided under the National Medical Emergency System. The Operator is entitled to refer the Insured Person to the facility of a higher level facility if required by the health status and medical safety. This does not constitute an improper performance of the Agreement.

4. Our responsibility in the field of Emergency Care does not cover health situations, in which any delay in providing medical assistance, available in the nearest medical facility, poses immediate threat to the life of the Insured Person. In particular, this includes loss of consciousness, anaphylactic shock, choking; status epilepticus; acute and severe allergic reactions resulting from biting or stinging by venomous animals; poisoning by medicines, chemicals or gases; electrocution; drowning; attempted suicide; a fall from high altitude; an extensive injury resulting from trauma, including traumatic amputations of the limbs or parts of the limbs; multiple traumas; sudden visual or hearing disorders; face-cranial injuries.

5. Item 4 shall not release the Operator from providing a healthcare service to a person who needs immediate provision of a service due to a threat to life or health arising from Article 15 of the Act on Medical Activity of 15 April 2011 (Journal of Laws No 112, item 654), i.e. dated 16 March, 2021 (Journal of Laws of 2021, item 711, as amended).

Module: LUX MED Full Care Hospital Insurance

§1 Hospitalisation

We provide Urgent Hospitalisation and Scheduled Hospitalisation in the following medical areas:

LMG Försäkrings AB S.A. Branch in Poland
Szturmowa 2 Street, 02-678 Warsaw
t: 22 450 45 00, 22 450 50 10, f: 22 331 85 85

District Court for the Capital City of Warsaw in Warsaw
13th Commercial Division of the National Court Register
KRS: 0000395438
Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

1. **Diagnostics and treatment at the non-invasive treatment department**
   a. includes a stay and comprehensive diagnostics and treatment of diseases in the following wards: internal medicine, cardiology, pulmonology, allergology, neurology, diabetology, gastroenterology, dermatology, rheumatology, endocrinology, infectious diseases and nephrology;
   b. it does not include:
      I. diagnostics and treatment in which the aim can be achieved in outpatient conditions;
      II. drug programmes indicated in the Notice of the Minister of Health as a guaranteed service which takes place using innovative, costly active substances which are not financed within the scope of other guaranteed services;
      III. removal of pigmented moles, skin warts, fibromas, lipomas, sebaceous cysts and xanthelasma;
      IV. hospitalisation with the aim of planned use of pharmacology therapy of chronic diseases;
      V. diagnostics and treatment of the consequences of strokes;
      VI. chronic renal replacement therapy, performed outside the period of necessary Hospitalisation within the scope of the Agreement.

2. **Orthopaedics**
   a. includes orthopaedic procedures, including endoprosthesis and orthopaedic fixation materials;
   b. it does not include:
      I. limb lengthening;
      II. osseointegration treatments;
      III. spinal procedures.

3. **General surgery**
   a. includes general surgery procedures;
   b. it does not include:
      I. surgical obesity treatment;
      II. thoracic surgery (i.e. thoracosurgery).
      III. removal of pigmented moles, skin warts, fibromas, lipomas, sebaceous cysts and xanthelasma;

4. **Vascular surgery**
   a. includes surgery on veins and peripheral arteries;
   b. it does not include:
      I. surgery performed in the extracorporeal circulation;
      II. surgery of aneurysms and vascular malformations;
      III. procedures for embolisation of pathological lesions;
      IV. procedures on intracranial vessels.

5. **Gynaecology**
   a. includes gynaecology procedures;
   b. it does not include the diagnosis and treatment of impaired female fertility and assisted reproduction;
   c. removal of pigmented moles, skin warts, fibromas, lipomas, sebaceous cysts.

6. **Laryngology**
   a. includes ENT procedures;
   b. it does not include:
      I. implant insertion for hearing organs and other implants replacing the functions of the senses;
      II. procedures requiring neurosurgery;
      III. treatment of the consequences of facial-cranial injuries, in particular craniofacial reconstruction.

7. **Urology**
   a. includes urology procedures, including robotic surgery of the prostate gland;
   b. it does not include:
      I. procedures for kidney collection or implantation, chronic renal replacement therapy, performed outside the period of necessary Hospitalisation within the scope of the Agreement;
      II. urological procedures associated with correction of the size or shape of the genital organs;
      III. treatment of erectile dysfunction;
      IV. artificial urinary tract sphincter implantation;
      V. treatment of male fertility disorders, e.g. vasectomy reversal.

8. **Ophthalmology**
   a. includes ophthalmologic procedures;
   b. it does not include:
      I. surgical correction of defects of vision (e.g. laser correction of impaired vision or the implantation of intraocular phakic lenses), with the exception of corrective lenses implantation during simultaneous cataract surgery;
      II. corneal transplant procedures;
      III. surgical treatment of conical cornea;
      IV. eye prosthetic procedures;
      V. removal of pigmented moles, skin warts, fibromas, lipomas, sebaceous cysts and xanthelasma.

9. **Spinal neurosurgery**
   a. includes neurosurgery procedures of intervertebral discs and thermolesion;
   b. it does not include:
      I. treatment of secondary and primary scoliosis;
      II. surgical procedures involving three and more intervertebral discs;
      III. neurosurgical procedures involving the brain and skull;
      IV. procedures involving the spinal cord and nerve roots.

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10. Oncological surgery

a. includes:
   I. surgery of neoplastic lesions, including: plastic breast reconstruction after mastectomy;
   II. preventive procedures resulting from oncological indications, covering oophorectomy and mastectomy with breast reconstruction;
   III. advanced methods of treatment of prostate tumours, including robotic surgery of prostate tumours.

b. it does not include:
   I. extensive surgical procedures of head and neck tumours, in particular laryngeal cancer;
   II. systemic therapies (chemotherapy, immunotherapy, CAR-T and others) and oncology radiation therapy, as isolated treatment or as an element of combination treatment;
   III. treatment of neoplastic lesions of the brain, lungs, haematological neoplasms;
   IV. breast reconstruction, in cases of medical contraindications to such a procedure.

We only provide Scheduled Hospitalisation for the following medical area:

11 Invasive cardiology

a. includes planned invasive cardiology procedures, including stays in the intensive care ward which are necessary in the post-surgery period (Anaesthesiology and Intensive Care Ward, Intensive Cardiology Supervision Ward);

b. it does not include:
   I. treatment of acute coronary syndromes, according to the current criteria of the diagnosis of the European Society of Cardiology;
   II. cardiac surgery;
   III. implantation of artificial cardiac pacemakers, heart valves, implantable cardioverter-defibrillator (ICDs) and devices with an analogous or similar function.

§2 Emergency Care

1. Consultation of the Emergency Care Physician is possible provided that the Hospital Coordinator confirms that consultation is necessary and appropriate from the medical point of view.

2. Emergency Care includes, depending on the medical indications and the extent of services available at a given location:
   a. interventions by emergency medical service;
   b. providing necessary medical assistance at the place of residence of the Insured;
   c. providing necessary medical assistance at the Outpatient Clinic or Hospital designated by us;
   d. giving recommendations on further conservative management;
   e. transport to hospital;
   f. organisation of up to 3 medical visits as a continuation of the treatment process within 30 days of the first visit within the framework of Emergency Care and directly related to the services provided during it.

The scope of services available as part of Emergency Care at a given location is indicated on www.opiekaszpitalna.luxmed.pl.

3. Emergency Care does not replace the assistance provided under the National Medical Emergency System. The Operator is entitled to refer the Insured Person to the facility of a higher level of perinatal care if the health status and medical safety require it. This does not constitute an improper performance of the Agreement.

4. Our responsibility in the field of Emergency Care does not cover health situations, in which any delay in providing medical assistance, available in the nearest medical facility, poses immediate threat to the life of the Insured. In particular, this includes loss of consciousness, anaphylactic shock, choking; status epilepticus; acute and severe allergic reactions resulting from biting or stinging by venomous animals; poisoning by medicines, chemicals or gases; electrocution; drowning; attempted suicide; a fall from high altitude; an extensive injury resulting from trauma, including traumatic amputations of the limbs or parts of the limbs; multiple traumas; sudden visual or hearing disorders; face-cranial injuries.

5. Item 4 shall not release the Operator from providing a healthcare service to a person who needs immediate provision of a service due to a threat to life or health arising from Article 15 of the Act on Medical Activity of 15 April 2011 (Journal of Laws No 112, item 654), i.e. dated March 16, 2021 (Journal of Laws of 2021, item 711, as amended).

§3 Psychological consultations

For Insured persons with diagnosed malignant tumour, using Hospitalisation Service in the area of Oncological surgery, we offer psychological consultations. Consultations may be conducted onsite or remotely. We offer up to 5 consultations in 12 months. The date of cancer diagnosis is the date of histopathological examination.

§4 Obstetrics-neonatology services

1. Obstetrics-neonatology services include:
   a. assisting in natural labour or delivery by caesarean section;
   b. individual care of a midwife during childbirth;
   c. participation in antenatal classes;
   d. neonatology care of the neonate.

2. Our responsibility in the field of obstetrics-neonatology services does not include:
   a. Pregnancy care;
   b. Hospitalisation resulting from pathological course of pregnancy (both pathologies of the mother and the foetus), if the pregnancy requires care or delivery in a level III perinatal care centre;
   c. deliveries in cases which the medical safety considerations, in particular closeness for sudden deliveries, require the use of another Hospital than the ones listed on the list of locations referred to in §3(8) of the GTC;
   d. performance of foetal genetic tests, amniocentesis and cordocentesis;
   e. neonatology care of the neonate requiring intensive care at a level III perinatal care centre.

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SECTION II: ADDITIONAL HOSPITAL BENEFITS AVAILABLE IN ALL OPTIONS

§1 Medical care prior to Hospitalisation

1. The services in the field of imaging diagnostics, laboratory tests and specialist consultations necessary for the preparation for Hospitalisation are covered by the scope. The scope of all examinations and consultations shall be specified during preparation of the Insured for Hospitalisation, upon acceptance of the application for the provision of the Service. We do not provide examinations and consultations for medical care prior to Hospitalisation, ordered by another medical facility than the one indicated by us. Medical care prior to Hospitalisation is essential for:
   a. determining the necessity of Planned Hospitalisation, its type, methods and scope of the procedure;
   b. qualifying of the Insured for Hospitalisation;
   c. determining the date of a surgery or procedure;
   d. developing a treatment plan.
2. Medical care prior to Hospitalisation is not the same as:
   a. making a diagnosis;
   b. monitoring of treatment;
   c. general medical advice;
   d. issuing a second medical opinion.
3. The scope does not include:
   a. pregnancy care;
   b. outpatient treatment, including procedures and tests, unless the doctor decides during qualification that hospitalization is necessary.

§2 Medical care after Hospitalisation

1. Care after Hospitalisation includes 8 follow-up visits in the medical facility indicated by us. They are conducted to monitor the effects of the procedure and the recovery process up to 30 days after discharge from the Hospital or until the end of the rehabilitation period specified in §3 below.
2. We also provide care in cases of sudden deterioration of health status of the Insured after the provided Service. In such cases, the scope of care is tailored to the medical situation and needs, and aims to improve or restore the proper health condition of the Insured Person. The scope of the Service is specified by the Physician indicated by us.
3. Medical care after Hospitalisation is provided only in relation to the Service provided under the Insurance Agreement.

§3 Rehabilitation

1. Rehabilitation after Hospitalisation includes:
   a. necessary procedures in the field of physical therapy and kinesitherapy in accordance with the recommendations of medical or physiotherapeutic personnel after orthopaedic procedures for up to 12 weeks from the date of the procedure;
   b. necessary procedures in the field of physical therapy and physiotherapy according to the recommendations of medical or physiotherapeutic personnel after neurosurgery for up to 12 weeks from the date of the procedure;
   c. necessary lymphatic drainage procedures following surgical procedures (e.g. mastectomy) as recommended by medical or physiotherapeutic personnel for up to 12 weeks after the procedure;
   d. Imaging tests necessary to monitor the progress of rehabilitation;
   e. A medical visit summarizing the rehabilitation period.
2. We shall specify the detailed scope of rehabilitation before the end of Hospitalisation. We do not provide rehabilitation services ordered by a medical facility other than that indicated by us.
3. Our responsibility in the scope of rehabilitation does not include:
   a. rehabilitation procedures resulting from indications other than the consequences of the surgical procedure performed as part of insurance coverage;
   b. fracture treatment with bone adhesion stimulators using physical effects (e.g. ultrasound wave);
   c. rehabilitation ordered during qualification but necessary to be performed before the procedure.
4. Rehabilitation is provided only in relation to the Service provided under the Insurance Agreement.

SECTION III: HOSPITAL HEALTH CHECK

(available in the Orthopaedic Care Plus and Full Care options)

1. Hospital Health Check is conducted at the Hospital indicated by us, within one day, within a period agreed with the Insured. Extending the duration of a Hospital Health Check beyond one day may take place in medically justified cases, such as the need to repeat the examination in hospital conditions.
2. Depending on official guidelines, including the internal guidelines of the hospital related to the epidemic situation, the performance of a Hospital Health Check may be conditioned upon the receipt of a negative result of the recommended SARS-CoV-2 (the virus causing COVID-19) test, which is valid on the day of the Check. The test is financed and made available by us before the scheduled Check.
3. The specific scope of services depends on the gender and age of the Insured:

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Hospital Health Check for a woman up to 40 years of age	
• Blood pressure measurement • Height and body weight measurement • Urine – general analysis • Blood count + platelet count + automated smear • Laboratory tests: OB ./ESR, ALT transaminase, GGGTP, creatinine, TSH, FT4, HCV AB antibodies, HBS antigen, urea acid, lipidogram, D-dimers, fasting glucose, Vitamin D3 metabolite 25 (OH), Sod, Potas, blood Group, Ferritin	• Resting ECG • Chest X-ray • Ultrasound of the heart, abdominal cavity, breast, thyroid, gynaecological • Cytology of uterine cervix • Consultation with an internist and gynaecologist
Health status report and recommendations	

Hospital Health Check for a woman aged 40 years or older	
• Having your blood pressure taken • Height and body weight measurement • Urine – general analysis • Blood count + platelet count + automated smear • Laboratory tests: OB ./ESR, ALT transaminase, GGGTP, creatinine, TSH, FT4, HCV AB antibodies, HBS antigen, urea acid, lipidogram, Homocysteine, D-dimers, fasting glucose, HbA1c, insulin/insulin, Vitamin D3 metabolite 25 (OH), Vitamin B12, Calcium, Phosphorus, Sodium, Potassium blood Group, FSH, Testosterone, Ferritin	• Resting ECG • Cardiac stress test • Chest X-ray • Ultrasound of the heart, abdominal cavity, breast, thyroid, gynaecological • Mammography • Standard pap smear • Consultation with an internist, gynaecologist and cardiologist
Health status report and recommendations	

Hospital Health Review for a man up to 40 years of age	
• Having your blood pressure taken • Height and body weight measurement • Urine – general analysis • Blood count + platelet count + automated smear; • Laboratory tests: OB ./ESR, ALT transaminase, GGGTP, creatinine, TSH, FT4, HCV AB antibodies, HBS antigen, urea acid, lipidogram, D-dimers, fasting glucose, Vitamin D3 metabolite 25 (OH), Sodium, Potassium, blood Group, Testosterone	• PSA panel • PSA panel (PSA, FPSA, FPSA/PSA ratio) • Resting ECG • Chest X-ray • Ultrasound of the heart, abdominal cavity, thyroid, testicles, prostate • Consultation with an internist and urologist
Health status report and recommendations	

Hospital Health Check for a man aged 40 years or older	
• Having your blood pressure taken, • Height and body weight measurement, • Urine – general analysis • Blood count + platelet count + automated smear; • Laboratory tests: OB ./ESR, ALT transaminase, GGGTP, creatinine, TSH, FT4, HCV AB antibodies, HBS antigen, urea acid, lipidogram, Homocysteine, D-Dimers, fasting glucose, HbA1c, insulin/insulin, Vitamin D3 metabolite 25 (OH), Vitamin B12, Calcium, Phosphorus, Sodium, Potassium, blood Group, Testosterone	• PSA panel (PSA, FPSA, FPSA/PSA ratio) • Resting ECG • Cardiac stress test • Chest X-ray • Ultrasound of the heart, abdominal cavity, thyroid, testicles, prostate • Consultation with an internist, urologist and cardiologist
Health status report and recommendations	

4. We will not conduct a Hospital Health Check if the Insured has an identified infection, suspected infection or any other health disturbance that may impair the results of the Service.
5. In the case of medical indications, at the request of the doctor conducting the hospital health review, we may extend the scope of services provided during the review by additional tests, the total cost of which shall not exceed the gross amount of PLN 1,000.
6. In the event of failure to appear for a hospital health check-up on the date agreed by the Insured with the Coordinator, we have the right to refuse the claim.
7. We may deviate or limit the scope of the Hospital Health Check in cases of medical contraindications to certain examinations.

SECTION IV: HOSPITAL CARE COORDINATION

1. Immediately after the beginning of the Insurance Coverage Period, we will provide the Insured with contact details for the Hospital Care Coordinating Team. The details will be provided by email, text message or letter, depending on which contact information we have received.
2. The Insured uses the Hospital Care Coordination according to that person's needs. The person may benefit from a part or the entire scope offered.

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3. The scope of services offered as part of the Hospital Care Coordination includes:
   a. accepting an application for the performance of the Service from the Insured and current contact with the Insured during verification of the application, as well as during the term of the Agreement.
   b. coordination of care over the Insured in the case of Emergency Care:
      I. verification of Services entitlements;
      II. providing guidance to the Insured on further proceedings;
      III. contact with the Hospital Admission Ward or Outpatient Clinic;
      IV. help in admission to the Hospital or Outpatient Clinic and assistance in the ongoing organisation of the necessary examinations and consultations as recommended by the Physician;
      V. assistance in collecting medical records of the Insured;
      VI. contact with a person authorised to receive medical information about the Insured.
   c. coordination of care over the Insured before Hospitalisation:
      I. verification of entitlements to the Service, including obtaining the decision of the Insurer in connection with the application submitted;
      II. presenting a proposal for Hospitalisation – presenting a selection of available Hospitals and Physicians, as well as a midwife, in the case of an Insured person planning for childbirth;
      III. arranging a stay and as decided by the Insured;
      IV. assistance in scheduling examinations and consultations eligible for Hospitalisation;
      V. monitoring of the performance of examinations and consultations by the Insured;
      VI. reminding the Insured about the date of admission to the Hospital and the required documents as well as confirmation of the presence of the Insured at the Hospital;
      VII. coordination of the flow of medical documents between the Insured and the Hospital;
      VIII. providing information on Hospital stay.
   d. coordination during the Hospital Service:
      I. transfer of all documents necessary for the Service of the Insured;
      II. current contact with the Hospital;
      III. providing information on the current status of the performance of medical procedures to a person authorised to receive medical information about the Insured;
      IV. arranging a follow-up visit after Hospital stay and presenting a post-service care plan;
      V. organisation of Medical Transport, if it results from medical indications.
   e. coordination of care after Hospitalisation, in accordance with the Physician's recommendations:
      I. arranging for examinations and rehabilitation for the Insured;
      II. organisation of Medical Transport if it is due to medical indications;
      III. completion of the medical documentation of the Insured.
   f. coordination of the Hospital Health Check:
      I. verification of Services entitlements;
      II. presenting a proposal from the Hospital and Physician conducting the Hospital Health Check;
      III. arranging the Hospital Health Check at the discretion of the Insured;
      IV. reminding the Insured of the date of the Service, the required documents and confirmation of attendance at the Hospital;
      V. monitoring of the performance of the Hospital Health Check;
      VI. coordination of the flow of medical documents between the Insured and the Hospital;
      VII. providing general information on the performance of the Hospital Health Check.

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Appendix no. 3 to the General Terms and Conditions of LUX MED Group Insurance – OWU [GTC] CODE G/004/2024/C

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THE SCOPE OF SERVICES PROVIDED AS PART OF LUX MED HOSPITAL INSURANCE – FULL CARE, FOR A MINOR CHILD.

SECTION I: HOSPITAL SERVICE

Module: LUX MED Orthopedic Care Hospital Insurance

§1 Hospitalisation

Hospitalisation caused by an Accident (confirmed by a referral for a procedure or surgery resulting from the injury. The referral should be issued within 90 days of the occurrence of the Accident). The scope includes:

1. **Orthopaedics**
   a. includes orthopaedic procedures, including endoprosthesis and orthopaedic fixation materials;
   b. it does not include:
      I. endoprosthesis;
      II. limb lengthening;
      III. osseointegration treatments;
      IV. spinal procedures.

Module: LUX MED Orthopedic Care Plus Hospital Insurance

§1 Hospitalisation

1. We provide Urgent Hospitalisation and Scheduled Hospitalisation in the following medical areas:
   a. includes orthopaedic procedures, including endoprosthesis and orthopaedic fixation materials;
   b. it does not include:
      I. limb lengthening;
      II. osseointegration treatments;
      III. spinal procedures.

§2 Emergency Care

1. Consultation of the Emergency Care Physician is possible provided that the Hospital Coordinator confirms that consultation is necessary and appropriate from the medical point of view.
2. Emergency Care includes, depending on the medical indications and the extent of services available at a given location:
   a. interventions by emergency medical service;
   b. providing necessary medical assistance at the place of residence of the Insured;
   c. providing necessary medical assistance at the Outpatient Clinic or Hospital designated by us;
   d. giving recommendations on further conservative management;
   e. transport to hospital.

   The scope of services available as part of Emergency Care at a given location is indicated on www.opiekaszpitalna.luxmed.pl.
3. Emergency Care does not replace the assistance provided under the National Medical Emergency System. The Operator is entitled to refer the Insured to the facility of a higher level of perinatal care if the health status and medical safety require it. This does not constitute an improper performance of the Agreement.
4. Our responsibility in the field of Emergency Care does not cover health situations, in which any delay in providing medical assistance poses immediate threat to the life of the Insured. In particular, this includes loss of consciousness, anaphylactic shock, choking; status epilepticus; acute and severe allergic reactions resulting from biting or stinging by venomous animals; poisoning by medicines, chemicals or gases; electrocution; drowning; attempted suicide; a fall from high altitude; an extensive injury resulting from trauma, including traumatic amputations of the limbs or parts of the limbs; multiple traumas; sudden visual or hearing disorders; face-cranial injuries.
5. Item 4 shall not release the Operator from providing a healthcare service to a person who needs immediate provision of a service due to a threat to life or health arising from Article 15 of the Act on Medical Activity of 15 April 2011 (Journal of Laws No 112, item 654), i.e. dated 16 March, 2021 (Journal of Laws of 2021, item 711, as amended).

Module: LUX MED Hospital Insurance – Full Care

§1 Hospitalisation

We provide Urgent Hospitalisation and Scheduled Hospitalisation in the following medical areas:

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1. **Diagnostics and treatment at the non-invasive treatment department**
   a. includes a stay and comprehensive diagnostics and treatment of diseases in the following wards: paediatrics, cardiology, neurology, diabetology, gastroenterology, dermatology, rheumatology, infectious diseases and nephrology;
   b. it does not include:
      I. diagnostics and treatment in which the aim can be achieved in outpatient conditions;
      II. drug programmes indicated in the Notice of the Minister of Health as a guaranteed service which takes place using innovative, costly active substances which are not financed within the scope of other guaranteed services;
      III. removal of pigmented moles, skin warts, fibromas, lipomas, sebaceous cysts and xanthelasma;
      IV. Hospitalisation with the aim of planned use of pharmacology therapy of chronic diseases;
      V. diagnostics and treatment of the consequences of strokes;
      VI. chronic renal replacement therapy, performed outside the period of necessary Hospitalisation within the scope of the Agreement.

2. **Orthopaedics**
   a. includes orthopaedic procedures, including endoprosthesis and orthopaedic fixation materials;
   b. it does not include:
      I. limb lengthening;
      II. osseointegration treatments;
      III. spinal procedures.

3. **Paediatric surgery**
   a. includes general surgery procedures;
   b. it does not include:
      I. surgical obesity treatment;
      II. thoracic surgery (i.e. thoracosurgery);
      III. removal of pigmented moles, skin warts, fibromas, lipomas, sebaceous cysts and xanthelasma.

4. **Gynaecology**
   a. includes gynaecological procedures for children over 16 years of age;
   b. it does not include the diagnosis and treatment of impaired female fertility and assisted reproduction;
   c. removal of pigmented moles, skin warts, fibromas, lipomas, sebaceous cysts..

5. **Laryngology**
   a. includes ENT procedures;
   b. it does not include:
      I. implant insertion for hearing organs and other implants replacing the functions of the senses;
      II. procedures requiring neurosurgery;
      III. treatment of the consequences of facial-cranial injuries, in particular craniofacial reconstruction.

6. Hospital services include also obstetrics-neonatology services in cases which require such services. The scope of obstetrics-neonatology services is compliant with §3 of Appendix 1 to the GTC – scope of Services for the Main Insured, Partner and Adult Child.

§2 Emergency Care

1. Consultation of the Emergency Care Physician is possible provided that the Hospital Coordinator confirms that consultation is necessary and appropriate from the medical point of view.

2. Emergency Care includes, depending on the medical indications and the extent of services available at a given location:
   a. interventions by emergency medical service;
   b. providing necessary medical assistance at the place of residence of the Insured;
   c. providing necessary medical assistance at the Outpatient Clinic or Hospital designated by us;
   d. giving recommendations on further conservative management;
   e. transport to hospital;
   f. organisation of up to 3 medical visits as a continuation of the treatment process within 30 days of the first visit within the framework of Emergency Care and directly related to the services provided during it.

   The scope of services available as part of Emergency Care at a given location is indicated on www.opiekaszpitalna.luxmed.pl.

3. Emergency Care does not replace the assistance provided under the National Medical Emergency System. The Operator is entitled to refer the Insured to the facility of a higher level of perinatal care if the health status and medical safety require it. This does not constitute an improper performance of the Agreement.

4. Our responsibility in the field of Emergency Care does not cover health situations, in which any delay in providing medical assistance poses immediate threat to the life of the Insured. In particular, this includes loss of consciousness, anaphylactic shock, choking; status epilepticus; acute and severe allergic reactions resulting from biting or stinging by venomous animals; poisoning by medicines, chemicals or gases;

electrocution; drowning; attempted suicide; a fall from high altitude; an extensive injury resulting from trauma, including traumatic amputations of the limbs or parts of the limbs; multiple traumas; sudden visual or hearing disorders; face-cranial injuries.

5. Item 4 shall not release the Operator from providing a healthcare service to a person who needs immediate provision of a service due to a threat to life or health arising from Article 15 of the Act on Medical Activity of 15 April 2011. (Journal of Laws No. 112, item 654), i.e. dated 16 March, 2021 (Journal of Laws of 2021, item 711, as amended).

PART II: ADDITIONAL HOSPITAL BENEFITS AVAILABLE IN ALL OPTIONS

§1 Medical care prior to Hospitalisation

1. The insurance covers all services in the fields of diagnostic imaging, laboratory testing and specialist consultations necessary for the preparation for Hospitalisation. Medical care prior to Hospitalisation is essential for:
   a. determining the necessity of Scheduled Hospitalisation, its type, methods and scope of the procedure;
   b. qualifying of the Insured for Hospitalisation;
   c. determining the date of a surgery or procedure;
   d. developing a treatment plan.
2. Medical care prior to Hospitalisation is not the same as:
   a. making a diagnosis;
   b. monitoring of treatment;
   c. general medical advice;
   d. issuing a second medical opinion.
3. The scope does not include:
   a. pregnancy care;
   b. outpatient treatment, including procedures and tests, unless the doctor decides during qualification that hospitalization is necessary.

§2 Medical care after Hospitalisation

1. Care after Hospitalisation includes 8 follow-up visits in the medical facility indicated by us. They are conducted to monitor the effects of the procedure and the recovery process up to 30 days after discharge from the Hospital or until the end of the rehabilitation period specified in §3 below.
2. We also provide care in cases of sudden deterioration of health status of the Insured after the provided Service. In such cases, the scope of care is tailored to the medical situation and needs, and aims to improve or restore the proper health condition of the Insured. The scope of the Service is specified by the Physician indicated by us.
3. Medical care after Hospitalisation is provided only in relation to the Service provided under the Insurance Agreement.

§3 Rehabilitation

1. Rehabilitation after Hospitalisation incudes:
   a. necessary procedures in the field of physical therapy and kinesitherapy in accordance with the recommendations of medical or physiotherapeutic personnel after orthopaedic procedures for up to 12 weeks from the date of the procedure;
   b. Imaging tests necessary to monitor the progress of rehabilitation;
   c. A medical visit summarizing the rehabilitation period.
2. We shall specify the detailed scope of rehabilitation before the end of Hospitalisation. We do not provide rehabilitation services ordered by a medical facility other than that indicated by us.
3. Our responsibility in the scope of rehabilitation does not include:
   a. rehabilitation procedures resulting from indications other than the consequences of the surgical procedure performed as part of insurance coverage;
   b. fracture treatment with bone adhesion stimulators using physical effects (e.g. ultrasound wave);
   c. rehabilitation ordered during qualification but necessary to be performed before the procedure.
4. Rehabilitation is provided only in relation to the Service provided under the Insurance Agreement.

PART III: HOSPITAL CARE COORDINATION

1. Immediately after the beginning of the Insurance Coverage Period, we will provide the legal guardian of the Minor Child with contact details for the Hospital Care Coordinating Team. The details will be provided by email, text message or letter, depending on which contact information we have received.

2. The Insured uses the Hospital Care Coordination through a legal guardian according to that person's needs. The person may benefit from a part or the entire scope offered.

3. The scope of services offered as part of Coordination of Hospital Care includes:
   a. accepting an application for the performance of the Service from the Insured and current contact with the Insured during verification of the application, as well as during the period of the Agreement.
   b. coordination of care over the Insured in the case of Emergency Care:
      I. verification of Services entitlements;
      II. providing guidance to the Insured on further proceedings;
      III. contact with the Admission Ward or Outpatient Clinic;
      IV. help in admission to the Hospital or Outpatient Clinic and assistance in the ongoing organisation of the necessary examinations and consultations as recommended by the Physician;
      V. assistance in collecting medical records of the Insured;
      VI. contact with a person authorised to receive medical information on the Insured.
   c. coordination of care over the Insured before Hospitalisation:
      I. verification of entitlements to the Service, including obtaining the decision of the Insurer in connection with the application submitted;
      II. presenting a proposal for Hospitalisation – presenting a selection of available Hospitals and Physicians, as well as midwife, in the case of an Insured person planning for childbirth;
      III. arranging a stay and as decided by the Insured;
      IV. assistance in scheduling examinations and consultations eligible for Hospitalisation;
      V. monitoring of the performance of examinations and consultations by the Insured;
      VI. reminding the Insured about the date of admission to the Hospital and the required documents as well as confirmation of the presence of the Insured at the Hospital;
      VII. coordination of the flow of medical documents between the Insured and the Hospital;
      VIII. providing information on Hospital stay.
   d. coordination during the Hospital Service:
      I. transfer of all documents necessary for the Service of the Insured;
      II. current contact with the Hospital;
      III. providing information on the current status of the performance of medical procedures to a person authorised to receive medical information about the Insured;
      IV. arranging a follow-up visit after Hospital stay and presenting a post-service care plan;
      V. organisation of Medical Transport, if it results from medical indications.
   e. coordination of care after Hospitalisation, in accordance with the Physician's recommendations:
      I. arranging for examinations and rehabilitation for the Insured;
      II. organisation of Medical Transport if it is due to medical indications;
      III. completion of the medical documentation of the Insured.
   f. coordination of the Hospital Health Check:
      I. verification of Services entitlements;
      II. presenting a proposal from the Hospital and Physician conducting the Hospital Health Check;
      III. arranging the Hospital Health Check at the discretion of the Insured;
      IV. reminding the Insured of the date of the Service, the required documents and confirmation of attendance at the Hospital;
      V. monitoring of the performance of the Hospital Health Check;
      VI. coordination of the flow of medical documents between the Insured and the Hospital;
      VII. providing general information on the performance of the Hospital Health Check.

LMG Försäkrings AB S.A. Branch in Poland
Szturmowa 2 Street, 02-678 Warsaw
t: 22 450 45 00, 22 450 50 10, f: 22 331 85 85

District Court for the Capital City of Warsaw in Warsaw
13th Commercial Division of the National Court Register
KRS: 0000395438
Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

Appendix no. 4 to the General Terms and Conditions of LUX MED Group Insurance - GTC Code G/004/2024/C

INFORMATION OBLIGATION CLAUSE OF LMG FÖRSÄKRINGS AB S.A. BRANCH IN POLAND

Below you will find all the necessary information regarding the processing of your data within the framework of a business relationship, in particular for the purpose of enabling an agreement and providing business contacts.

Who is my data controller?	The controller of your personal data is LMG Försäkrings AB S.A., with its registered office in Stockholm (102 51), Sweden, Box 27093, acting through the Branch in Poland, with its registered office in Warsaw (02-678) at ul. Szturmowa 2 (hereinafter referred to as 'LMG').	
Who can I contact regarding the processing of my personal data?	In any matters related to the processing of your personal data by LUX MED, you can contact our Data Protection Officer, Katarzyna Pisarzewska at email: daneosobowe@luxmed.pl	
What is the source of my data – where are they obtained from?	Your personal data is provided directly by you or by your employer, or by an entity represented by you. Your personal data may also sometimes be obtained from publicly available sources, such as the National Court Register (KRS) or the Central Registration and Information on Business (CEIDG).	
What is the scope of my personal data LUX MED processes?	We process the following personal data: name, surname, telephone number, email address, job position, name of the represented entity and registered office of that entity. If you act as a representative or a body of LMG's business partner, or are a partner of a civil law partnership, or a natural person conducting business activity, LMG may process your personal data in a broader scope, including also the Personal ID No. (PESEL) and any other personal data contained in public registers and as part of the submitted power of attorney.	
What is the purpose and legal basis for the processing of my personal data?	The purpose of processing	Legal basis (full titles of the legal acts are provided at the end of the form)
	We contact you in relation to current matters or when responding to questions or matters you have addressed to us. Usually, we perform these activities as part of the performance of an agreement between LMG and your employer or an entity represented by you.	Article 6(1)(f) of the GDPR as the so-called legitimate interest of the controller, which is to ensure contact in relation to current matters arising from the activities carried out by LMG.
	If you are a natural person conducting business activity or a partner in a civil law partnership, we process your data for the purpose of concluding and performing the agreement, including the settlements and providing ongoing business correspondence as well.	Article 6(1)(b) of the GDPR, i.e. performance of the agreement to which the data subject is a party or taking actions at the request of the data subject prior to the conclusion of the Agreement.
	As a data controller who is an entrepreneur, we have the right to assert and defend against claims arising from our business activities and thus process your data for these purposes.	Article 6(1)(f) of the GDPR as the legitimate interest of the controller, which is pursuing our claims and protecting our rights.
	As a business, we also keep accounting books and we have tax obligations, e.g. we issue invoices for the services we render, which may involve the need to process your personal data.	Article 6(1)(c) of the GDPR, i.e. compliance with a legal obligation to which the controller is subject (e.g. under tax law).
	As we are in constant economic relations, we may, as part of our cooperation, send you information about our activities, offers or other content informing you about the possibility of the cooperation with LMG.	Article 6(1)(f) of the GDPR as the so-called legitimate interest of the controller, which is to build and maintain relationships with our counterparties.

To whom may my personal data be transferred?	Due to the need for appropriate organisation, e.g. in terms of IT infrastructure or in relation to current matters concerning our business as an entrepreneur, we may transfer your personal data to the following categories of recipients: 1. service providers supplying LMG with technical and organisational solutions that enable us to perform our obligations and manage our organisation (in particular, ICT service providers, courier and postal companies); 2. providers of legal and advisory services and services supporting LMG in pursuing due claims (in particular law firms, debt collection companies);
Are my data transferred outside the European Union?	On account of the fact that we use services of other providers, such as email services, your personal data might be transferred outside the European Economic Area (which is composed of member states of the European Union, as well as Norway, Iceland and Liechtenstein). We assure that in such an event, the data will be transferred on the basis of a relevant agreement concluded between LMG and that entity, containing standard 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.
How long are my personal data processed?	We process your personal data for the period of cooperation or cooperation between LMG and your employer or the entity represented by you and, consecutively, after its termination, for the period of limitation of claims. If your personal data has been processed as part of LMG's compliance with legal obligations – for a period specified by law. After the expiry of these periods, your data are deleted or anonymised.
Am I obliged to provide my data?	If you provide us with your data, this is done on a voluntary basis. However, failure to provide the data may result in the inability to respond to your request or provide you with other content you ask us for, and sometimes also in the inability to conclude an agreement with a business partner.
What rights do I have?	As your data controller, we give you the right to access your data. You may also correct them, request their deletion or limit their processing. In addition, you may use the right to object to the processing of your personal data by LMG and the right to have your data transferred to another data controller. If you wish to exercise any of these rights, please contact us at the address of your registered office or by email: daneosobowe@luxmed.pl. Please also be advised that you may lodge a complaint with the authority supervising the observance of personal data protection regulations.
Definitions and abbreviations	**GDPR –** Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data and repealing Directive 95/46/EC.

Appendix no. 5 to the General Terms and Conditions of LUX MED Group Insurance - GTC Code G/004/2024/C

INFORMATION OBLIGATION CLAUSE OF LMG FÖRSÄKRINGS AB S.A. BRANCH IN POLAND

Below you will find all the necessary information regarding the processing of your personal data in connection with your insurance coverage.

Who is the administrator of your data?	The controller of your personal data processed for the purpose of providing insurance coverage is LMG Försäkrings AB S.A. with its registered office in Stockholm (102 51), Sweden, Box 27093, operating through the Branch in Poland with its registered office in Warsaw (02-678) at ul. Szturmowa 2 (hereinafter referred to as 'we' or the 'Insurer'). If you have consented to the processing of your personal data for marketing purposes or to receive marketing communications from us, the controller of your personal data are the entities belonging to LUX MED Group, a list of which can be found at www.luxmed.pl.
Who can I contact in matters related to the processing of personal data?	In all matters related to the processing of your personal data by us, you can contact the Data Protection Officer, Ms. Katarzyna Pisarzewska by writing to the following email address: daneosobowe@luxmed.pl.
What is the source of data – where are the data obtained from?	Insurance coverage is based on an agreement concluded between us and the Policyholder who registers you for insurance coverage. If you submit a declaration via an electronic platform, your personal data in the scope of: • first name • surname • (PESEL (if not available – date of birth) • email address they are provided to us by the Policyholder. If you are a co-insured, the above data is provided to us by the Principal Insured reporting you for insurance coverage. If you join the insurance by filling in a paper declaration, the declaration together with your full personal details, which you complete to the extent indicated in the following section, is provided to us through the entity reporting you to the insurance coverage (this does not apply to a medical questionnaire which, if required, is provided to us directly by you). Other data necessary to ensure that you can receive the benefits under the insurance coverage is provided to us by you at the stage of using the insurance coverage.
What is the scope of personal data we process?	We process your personal data to the extent necessary to verify your identity, to conduct an insurance risk assessment and to provide the services covered by insurance. The scope of data we process includes: • full name • Personal ID Number (PESEL) • sex • date of birth • address of residence • main cover area (MCA) If you are a foreigner, we will additionally ask you for: • nationality • passport number: In order to enable you to submit a declaration of joining insurance coverage via an electronic platform and to facilitate the subsequent process of providing services, we may also ask you for: • phone number • email address Depending on the content of the Insurance Agreement concluded with us, the Policyholder may ask you to complete a medical questionnaire which is an element of the insurance risk assessment. It will include questions about your age, weight, growth, health condition, information about your profession or job position, its characteristics and about your employer. We will be able to approach you or, if you grant us an appropriate authorisation, we will be able to approach the healthcare entities you have used or are using to obtain your medical records, information about your health or other information necessary to make a decision on the performance, correct coordination or adjustment of the claim submitted. If, for the purposes referred to in the preceding sentence, it is necessary to obtain your medical records, we will ask you to provide us with a copy of your medical records to the extent necessary, or on the basis of your consent, we will request the relevant healthcare entities to provide us with such records. Your consent to the processing of data for marketing purposes includes any information you have provided to us in the course of your relationship with us, including identifying information such as: first and last name, sex, date of birth, age, place, scope of insurance. However, we assure you that, as part of our marketing activities, under no circumstances shall we use your medical records that you have provided us with or that we obtain from healthcare entities under your appropriate authorisation – this information may only be accessed by authorised persons. When sending marketing communications, we may use your email/and phone number based on separate consent.
What is the purpose of	We process personal data as an insurance entity and the purpose of this processing is the insurance risk

<table>
<tr><td rowspan="8">processing of personal data?</td><td colspan="2">assessment and the performance of an insurance agreement, which we understand as follows:</td></tr>
<tr><td>The purpose of processing</td><td>Legal basis
(full titles of the legal acts are provided at the end of the form)</td></tr>
<tr><td>• This will then enable us to identify you before providing you with the service, as well as to perform the agreement and contact you.
• Performance of an insurance risk assessment prior to the conclusion of the agreement and the processing of personal data in the course of its performance.
• On the basis of consents granted separately by you to acquisition
• from the healthcare entities you have used or are using, your medical records and make them available to healthcare entities which, as part of insurance coverage, are supposed to provide medical services. LMG also processes the information on your health contained in the documentation in question.</td><td>Article 6(1)(b) of the GDPR in conjunction with Article 41(1) of the Act on Insurance Activity.</td></tr>
<tr><td>• If you shared your opinion about our services or made a complaint, we might process your personal data in order to process the notification and respond to it.</td><td>Article 6(1)(f) of the Regulation, as the ‘legitimate interest’ of the controller, which is the processing of claims and the defence of the Insurer’s interests.</td></tr>
<tr><td>• As a data controller which is a business, we have the right to pursue claims for our business activity and therefore process your data for this purpose.</td><td>Article 6(1)(b) and (f) of the GDPR as the legitimate interest of the controller, which is pursuing our claims and protecting our rights.</td></tr>
<tr><td>• As an entrepreneur, we also keep accounting books and we have tax obligations – we issue invoices for the services we render, which may involve the need to process personal data.</td><td>Article 6(1)(c) of the GDPR in conjunction with Article 74(2) of the Accounting Act of 29 September 1994.</td></tr>
<tr><td>• If you have consented to the processing of your personal data for marketing purposes, we may process your personal data for the purpose of sending you marketing communications concerning the LUX MED Group's activities, such as, in particular, offers, information about services, promotions, events organised by LUX MED Group members and health-oriented articles. On the basis of your consent, we may also process your personal data obtained in the course of our cooperation for marketing purposes. Under this consent, we may also perform what is known as ‘profiling’, which involves an automatic assessment of certain personal factors that concern you. The purpose of profiling performed by LUX MED is to select the appropriate content of materials we provide to you (marketing, promotional).</td><td>Article 6(1)(a) of the Regulation (voluntary consent)</td></tr>
<tr><td>Is my data processed automatically?</td><td colspan="2">As part of the insurance risk assessment, we will process your personal data (including special categories of data in terms of health condition) included in the declaration completed by you, as well as in the medical questionnaire, and this will be done by automated means, also through profiling. This means that your personal data will be processed by an IT system without human intervention, and this process will result in a decision to accept your declaration or to assign you to a specific insurance plan. The legal basis for such an action on the part of LMG includes the regulations governing our business activity as an insurance entity. However, be advised that you always have the right not to accept a decision based on automated processing of personal data.</td></tr>
<tr><td>To whom we transfer your personal data?</td><td colspan="2">Personal data may be transferred to the following categories of recipients in connection with our business activities:
• 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),
• providers of legal and advisory services and services supporting us in pursuing due claims (in particular law firms, debt collection companies),
• reinsurance undertakings which will be engaged in the reinsurance of the risk assumed by us under the Agreement,
• healthcare entities providing healthcare under the Insurance Agreement and other healthcare entities whose services you use,</td></tr>
</table>

	• entities coordinating the provision of healthcare services and services covered by the Insurance Agreement on our behalf, • if your healthcare package entitles you to use the 'Treatment of Critical Illnesses Abroad' module, your personal data will be transferred to the relevant consultants in this regard. As part of the process of coordinating the provision of services, your medical records that you provided to us or that we obtained, on the basis on your consent, from the relevant healthcare entities might be made available by LMG to healthcare entities that provide healthcare under the insurance agreement through the coordinator assigned to you to support the process of your hospitalisation and treatment.
Is my data transferred to third countries?	On account of the fact that we use services of other providers, such as ICT structure services, your personal data might be transferred outside the European Economic Area (comprising the member states of the European Union, Iceland, Norway and Liechtenstein). We assure you that in such an event, the data will be transferred on the basis of a relevant legal basis, e.g. an agreement concluded between LMG and that entity, containing standard data protection clauses, adopted by the European Commission or on the basis of a decision of the European Commission stating the appropriate degree of data protection. In each such case, LMG guarantees that it carries out appropriate verification to ensure that the service provider to whom the personal data are transferred processes the personal data in a compliant and secure manner.
How can LMG profile your data?	Profiling involves the fact that we may create preference profiles based on information about you, and thus, based on this, tailor our services and the content you receive from us – the processing of personal data as part of this process is based on your marketing consent. We assure you that we do not process personal data fully automatically and without human intervention.
How long is my personal data processed?	We keep your personal data for the duration of the agreement and thereafter for the period of limitation of claims under civil law. All data processed for accounting and tax purposes are processed for five years from the end of the calendar year in which the tax obligation arose. If you have consented to the processing of your data for marketing purposes, we process your data from the moment you gave your consent to the moment you withdraw it. After the expiry of these periods, the personal data are deleted or anonymised.
Is the provision of data obligatory?	Accession to the insurance is fully voluntary; however, as an insurer, we are obliged to identify you and perform an insurance risk assessment using your personal data. In such a case, failure to provide data may result in refusal to conclude an agreement or to provide services. Also, for accounting or tax reasons, we have a legal obligation to process the data, failure to do so may result, for example, in the failure to issue an invoice or a named bill. The phone number is provided on a voluntary basis – the lack of this information does not affect the ability to use our services, but it will make it much more difficult for us to contact the authorised person in the process of the agreement. Any consent given for marketing purposes shall be given on a voluntary basis. This means that the refusal to give it does not affect the use of our services and, at the same time, the person who gave consent has the right to withdraw it at any time.
What rights do I have?	As a data controller, we provide you with the right of access to your data, as well as the right of rectification, erasure or restriction of processing of your data. In addition, you may use the right to object to the processing of your personal data by LMG, and the right to have your data transferred to another data controller. To exercise any of these rights, contact us via the Infoline, using the form available on the website or writing directly to our Data Protection Officer. Please also be advised that you may lodge a complaint with the authority supervising the observance of personal data protection regulations.
Definitions and abbreviations	**GDPR** – Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data and repealing Directive 95/46/EC; **Insurance Activity Act** – the Act of 11 September 2015 on Insurance and reinsurance activity.

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: 0000395438
Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

Appendix no. 6 to the General Terms and Conditions of LUX MED Group Insurance - GTC Code G/004/2024/C

STANDARD CONTRACTUAL CLAUSES APPLICABLE TO INSURANCE CONTRACTS CONCLUDED BY LMG FÖRSÄKRINGS AB SA ODDZIAŁ W POLSCE (BRANCH IN POLAND)

§ 1 General Provisions

1. The following clauses constitute an integral part of the group insurance agreement concluded on the basis of the General Terms and Conditions of LUX MED Group Insurance (GTC) – GTC code No. G/004/2024/C (hereinafter: the "**Agreement**") entered into by the **Policy Holder** with LMG Försäkrings AB with its registered office in Stockholm, Sweden, operating in Poland via its branch: LMG Försäkrings AB Spółka Akcyjna Oddział w Polsce with its seat in Warsaw, KRS No. 395438 (hereinafter: the „**Insurer**"). The Policy Holder and the Insurer are jointly referred to as the "**Parties**" or individually as a "**Party**".
2. Each Party represents that their obligations and representations set out in this Appendix, including among others warranties and assurances, shall respectively remain in force and effect throughout the term of the Agreement.
3. If the Party breaches any of the clauses of this Appendix, by failing to comply (fully or partially) with any of the obligations set out in this Appendix or by making any representation given in this Appendix which is found to be (in any respect) untrue, this shall result in (i) a loss of confidence in the Party that has breached such an obligation or made such a representation inconsistent with the factual status ("**Breaching Party**"), (ii) a gross breach of the provisions of the Agreement, and (iii) a valid reason justifying the termination of the Agreement by the Insurer who is not the Breaching Party; in such a case the other Party (the "**Authorised Party**") shall be entitled to terminate the Agreement with immediate effect without notice due to the fault of the Breaching Party, or terminate the Agreement with 1 (one) month notice as well as to claim compensation for damage incurred as a result of an illegal or immoral act or omission of the Breaching Party.
4. The choice any of the right referred to in section 3 above, as well as the decision regarding its application to the Agreement, is at the sole discretion of the Authorised Party.
5. In the event that the Authorised Party exercises any of the rights referred to above, the Breaching Party shall not be entitled to any claims against the Authorised Party (excluding respectively claims for reimbursement of overpaid insurance premium for the period in which insurance cover was not provided or payment of insurance premium for the period of time when the Insurer was liable pursuant to the Agreement).

§ 2 Anti-Corruption Clause

1. Each Party represents that it is aware that the other Party and the companies belonging to the Capital Group of the other Party are guided in their business activities by ethical business principles, providing for zero tolerance for corrupt behaviour and requiring contractors and entities cooperating with the companies belonging to the Capital Group of the other Party to comply with best practices, including laws and regulations and good morals. "**LUX MED Capital Group**", the Insurer belongs to, shall mean LUX MED Sp. z o. o. with its seat in Warsaw, Poland, with KRS No. 265353 (hereinafter "**LUX MED**") and LUX MED's subsidiaries, which shall be understood as: (i) entities in relation to which LUX MED is a parent company or which are a parent company of LUX MED within the meaning of Article 4 § 1 item 4 of the Act of 15 September 2000 - Code of Commercial Companies (hereinafter: "**CCC**") and (ii) affiliated entities of LUX MED within the meaning of Article 4 § 1 item 5 of the CCC, and (iii) entities belonging together with LUX MED to the same corporate group within the meaning of Article 3(1)(44) of the Accounting Act of 29 September 1994 and (iv) entities belonging together with LUX MED to the same tax corporate group within the meaning of Article 1a(1) of the Act on Corporate Income Tax of 15 February 1992. "**Capital Group of the Policy Holder**" constitutes the Policy Holder and companies related to the Policy Holder within the meaning indicated in this subsection
2. Each Party declares that, in connection with the provision of services that are the subject of the Agreement, it undertakes to act only in accordance with the law and good morals. Each Party undertakes not to offer or give any personal or financial benefits to influence the decision of any natural or legal person, and not to participate in any agreements or arrangements intended to influence the decision of any natural or legal person in any manner contrary to the law or good morals. Each Party shall be obliged to comply with all applicable laws and regulations, including anti-corruption laws and regulations, and shall be obliged to refrain from any actions that that might result in the other Party's breach of applicable laws or damage to the other Party's reputation.
3. Without limiting of the Parties' obligations set forth in this article, each Party hereby represents and warrants that during the performance of the Agreement for the benefit of the other Party:
   a. no payment made or due to be made to it has been or shall be made to any other person, unless the obligation to pay resulted or will be resulted from law or from existing documented obligations of it, assumed in good faith;
   b. it has not paid, offered, donated or promised to pay or donate, and did not authorise any person to pay or donate, directly or indirectly, any money or anything of value in exchange for financial benefits or influencing a decision to purchase its goods or services (in particular, a decision to enter into the Agreement).
4. If there is a reasonable suspicion that the other Party is in breach of this clause, the suspecting Party shall be entitled to verify the suspected Party's documentation (including accounting records) relating to the performance of the Agreement. At suspecting Party's request, the suspected Party shall make the documentation available to the suspecting Party immediately, i.e. no later than within 7 (seven) business days, for verification purposes.

§ 3 Social Clause

1. Each Party absolutely requires the other Party to respect human rights and treat employees with dignity and respect.
2. Each Party represents that it does not use and undertakes not to use forced or slave labour, labour resulting from the need to repay a debt to the employer or involuntary labour of prisoners in any of its business activities, and it has never requested and undertakes not to request its newly employed employees to deposit any documents or monetary values.
3. Each Party represents that it does not use and undertakes not to use child labour in any of its business activities. Each Party represents that it knows the rules that juveniles (persons under 18 years of age) may be employed only in conditions that do not threaten their health, and only if the age of the juvenile employee exceeds the minimum age limit for employees applicable in a particular country or the age limit for the compulsory education, and undertakes to comply with these rules.
4. Each Party represents that it provides and undertakes to continue to provide its employees with a workplace in which any forms of harassment or discrimination – such as discrimination because of race, colour, age, gender, sexual orientation, ethnicity, disability, belief, membership in political organisations, trade union membership or marital status – are prohibited, in all its business activities. Each Party represents that it does not apply and undertakes not to apply corporal punishment or cruel or otherwise unlawful disciplinary measures.
5. Each Party represents that it remunerates and undertakes to remunerate employees in accordance with the applicable remuneration regulations, in all its business activities.

§ 4 Economic Sanctions Clause

1. Each Party represents that the Agreement does not obligate the other Party and cannot obligate the other Party to perform any act, including but not limited to payment for any delivery of goods or services, to the extent it would violate trade or economic sanctions imposed under United Nations resolutions or laws or regulations of any jurisdiction to which the other Party is subject, including but not limited to sanctions imposed by:
   a) European Union,
   b) United Kingdom,
   c) USA,
   d) Poland,

   in particular, any sanctions listed or ascertainable on the following pages:
   https://www.un.org/sc/suborg/en/sanctions/information
   https://sanctionssearchapp.ofsi.hmtreasury.gov.uk/
   https://sanctionssearch.ofac.treas.gov/
   https://www.sanctionsmap.eu/#/main
   https://www.gov.pl/web/mswia/lista-osob-i-podmiotow-objetych-sankcjami

   (hereinafter "**Sanctions**" or "**Sanction**", as appropriate).
2. If the need arises to ensure compliance of the Agreement with the regulations imposing Sanctions, each Party reserves the right to take any reasonable action that, in its opinion, is necessary to ensure compliance. The other Party acknowledges that this may limit, delay or prevent the performance, under the Agreement, of the obligations of the Party taking such action and consents to this.
3. Each Party warrants that:
   1) none of the shares in its share capital is owned (directly or indirectly) or controlled in any way, or pledged or subject to usufruct for the benefit of:
      a) to the best of the Party's knowledge - any sanctioned entities (meaning any natural person or any entity, including a legal person or an unincorporated organisational unit, covered by the Sanctions or affected by the Sanctions) and entities related to them either in terms of capital or in terms of persons,
      b) to the best of the Party's knowledge – any entity or person that benefits from the capital or financing provided by the sanctioned entity,
   2) it is not an entity subject to the Sanctions and none of members of its governing bodies and executive-level employees and associates are subject to the Sanctions,
   3) it does not have business relations with entities on which Sanctions have been imposed, (in particular, it does not export, or import, technology or services from or to the Sanctioned Countries, especially in connection with the conflict in Ukraine), and in the event of their imposition in the future, it will immediately terminate or withdraw from contracts concluded with Sanctioned Entities,
   4) it does not, with its financial resources, funds, and economic resources, directly or indirectly support (i) the Russian Federation's aggression against Ukraine, or (ii) human rights violations or repression of civil society and democratic opposition, or (iii) entities whose activities pose other serious threats to democracy or the rule of law in the Russian Federation and Belarus,
   5) its beneficial owner is not a person listed on the Sanction lists mentioned in section 1 of this article.

§ 5 Counteracting Money Laundering and Terrorism Financing Clause

1. The Party which is an obliged institution within the meaning of the Act of 1 March 2018 on counteracting money laundering and terrorist financing ("**Act**") represents that it has in place and maintains all policies, procedures and control systems necessary to prevent violations of the

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Szturmowa 2 Street, 02-678 Warsaw
t: 22 450 45 00, 22 450 50 10, f: 22 331 85 85

District Court for the Capital City of Warsaw in Warsaw
13th Commercial Division of the National Court Register
KRS: 0000395438
Tax ID No (NIP): 108 001 14 94, Statistical ID No (REGON): 145156729
Share capital: EURO 5,800,000.00

Act and the Party which is not an obliged institution represents that, within the scope of its business activities, it takes measures with due diligence to prevent violations of the provisions of this Act.

2. The Party declares that it has not established and does not intend to establish business relations with a high-risk third country or countries, by which is meant a country identified on the basis of information from reliable sources (including reports of evaluations of national anti-money laundering and counter-terrorist financing systems, conducted by the Financial Action Task Force (FATF) and its authorities or organisations related to it), as one of that: (i) not having an effective anti-money laundering or counter-terrorist financing regime or (ii) having significant deficiencies in its anti-money laundering or counter-terrorist financing regime, in particular a third country identified by the European Commission in a delegated act adopted pursuant to Article 9 of Directive 2015/849 or other relevant acts.

§ 6 Tax Clause

1. Each Party undertakes, in connection with the negotiation, conclusion and execution of the Agreement or any part thereof:

   1) not to engage in any activity, practice or behaviour that would constitute:

      a) tax fraud,
      b) tax avoidance
      c) facilitating tax avoidance by other entities; and

   2) to have and apply at all times during the term of the Agreement controls, guidelines or such policies and procedures as are designed to (i) prevent: tax fraud, tax avoidance, facilitation of tax avoidance by other entities (including, but not limited to, employees and associates of the Party) and (ii) ensure compliance with this section; and

   3) promptly notify the other Party, at least in documentary form, sent by an e-mail – otherwise such notification being null and void – of any violation of the provisions of this section by itself or of its becoming aware of tax fraud, tax evasion or facilitation of tax evasion perpetrated by other entities, including its employees or collaborators, in connection with the negotiation, conclusion or performance of the Agreement or any part thereof.

§ 7 Fraud Clause

1. Each Party represents that it is taking all reasonable steps, consistent with good industry practice, to prevent fraud by the Party (including, but not limited to, by its employees, associates, members of bodies) or its subcontractors and will notify the other Party immediately if it becomes aware that fraud has been committed in connection with the conclusion or performance of the Agreement.

2. Each Party shall have the right, in justified cases, to verify all the Agreement-related data (including invoices, statements and other documents) received from the other Party with the relevant authorities (including law enforcement authorities) in order to prevent or detect false or misleading information or fraudulent activity.

§ 8 Beneficial Owner Clause

1. Each Party represents that it is the beneficial owner of all receivables due to it under the Agreement, within the meaning of income tax regulations, i.e. it meets all of the following conditions:

   1) receives the receivables for its own benefit, including deciding for itself what to do with the receivables, and assumes the economic risk associated with the loss of the receivables or a portion thereof,
   2) is not an intermediary, representative, trustee, or other entity obligated to transfer all or part of a receivable to another entity,
   3) carries out actual economic activity in the country of its registered office (residence), if the receivables are obtained in connection with its business activity.

2. This statement of each Party is valid until further notice. The Party undertakes to immediately notify the other Party of any changes in the scope of the statement made by it above. The notification should be at least in documentary form, sent by an e-mail; otherwise it shall be null and void.

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