INSURANCE PRODUCT SHEET

LUXMED UBEZPIECZENIA

LUX MED Group Insurance

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 - OWU [GTC] CODE G/001/2023/C

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Information contained in the General Terms and Conditions of Health Care Services of LUX MED Group Insurance – OWU [GTC] CODE: G/001/2023/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 21 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 of persons notified to the Insurance Agreement, removed from the Insurance Agreement and the list of changes in the Insurance coverage of a given Insured .** The reported persons are those who have submitted a Declaration of Accession (excluding the Occupational Medicine Module) and have successfully passed the risk assessment, if necessary. The list shall be drawn up in accordance with the template provided by us.
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. **High Risk Sports —** sports whose practicing poses a particular health risk. **Under the GTC the High-Risk sports are the following:** — all aviation sports, motor gliding, paragliding, gliding, and piloting of any engine aircraft, ballooning, all types of parachuting, bungee jumping, mountain biking, motor sports and motor boating, jet skiing, kite surfing, mountaineering, high-mountain climbing, rock climbing, wall climbing, caving, mountain cave climbing, ski jumping, snowboarding and skiing except for recreational skiing/snowboarding on designated routes, bobsleighing, rafting and other water sports undertaken on mountain rivers, diving with the use of specialist equipment, martial arts, hunting and horse riding;
16. **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.
17. **Hospital** – a healthcare entity providing hospital services within the meaning of the Act of 15 April 2011 on medical activity, operating in the territory and in accordance with the laws of the Republic of Poland, providing Services under the GTC. The definition of a Hospital within the meaning of the GTC shall also include the outpatient clinics being part of the Hospital.
18. **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.
19. **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.
20. **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.

    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.

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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	-	-	-	-	-	-	-	-

21. **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 4,800,000 fully paid-up, operating in Poland through its branch LMG Försäkrings AB Branch in Poland with its registered office in Warsaw, 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;
22. **Insurance Agreement (also Contract)** — Insurance Agreement concluded by and between the Insurer and the Policyholder on the basis of the GTC set forth herein;
23. **Beneficiary** – a natural person, a legal person or an organisational unit without legal personality, entitled to receive a benefit from us;
24. **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;
25. **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;
26. **Insurance Application** (also: **Application**) – a proposal to conclude the Agreement submitted by the Policyholder in writing, electronically or on a form prepared by us.
27. **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.
28. **Competitive Sports** – practising sports requiring physical activity, covering: participation in training sessions in a sports club, union or association, as well as practising sports for profit, participation in sports competitions (competitions, matches, tournaments, other sports events) and sports training camps. This also refers to expeditions to places with extreme climatic or natural conditions. Practising Sports in a competitive manner is not a leisure sport aimed solely at leisure, regeneration of psychophysical forces or maintaining good health. Within the meaning of these GTC, the Competitive Sports shall not cover the practicing of sports disciplines by children under the age of 18 in a club, class or sports school.
29. **Insured Event (an 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**);

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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.

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.

§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. The Insured may indicate another later date.

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 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. 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. Persons enrolled in the Agreement shall be covered by our insurance coverage on the basis of:
   a. the List of Insureds provided to us by the Policyholder;
   b. Declarations of Accession which are complete and filled in correctly;
   c. other documents, if we have indicated that they are necessary for the conclusion of the Agreement.

2. During the term of the Agreement, the Policyholder may enroll new persons for insurance on the basis of the documents described in section 1.

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3. The first List of the Insured Persons, together with all the required documents referred to in section 1, shall be submitted to us no later than 10 business days before the first day of the term of the Agreement. Subsequent lists of the Insureds should be submitted to us each month, no later than 10 business days before the end of the calendar month.
4. The Period of Coverage shall commence with respect to the Insureds enrolled under the first List of Insureds on the date indicated in the Policy. 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 of our receipt of the List of Insureds, which includes the data of the joining person, provided that the deadline referred to in section 3 is met. If the list is submitted after that date, we shall assume that it relates to the following month. The date of a person's accession to the Agreement shall be the beginning of that person's Insurance Coverage Period.
5. 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.
9. The Insured may change the scope of coverage on condition that the Policyholder provides the following:
   a. a list of persons changing the scope of insurance coverage – to be provided in the format specified by the Insurer;
   b. Declarations of Accession that is complete and correctly filled in.
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 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 Agreement shall be automatically renewed for subsequent 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 will 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.

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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 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: 02-676 Warsaw, ul. Postępu 21C or in electronic format to: ubezpieczenia@luxmed.pl.
3. The Insurer shall have the right to terminate the Agreement with one month's notice if the Policyholder fails to report any Insured within 30 days from the date of entry into force of the Agreement.
4. The Agreement shall also 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.
5. 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.
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.

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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. practising competitive sports or practising High-Risk Sports, whereas this exclusion does not apply to the Module for Treatment of Serious illnesses abroad — BEST HELP;
   e. state of emergency due to natural disaster, natural catastrophes, pandemic and epidemic announced and confirmed by the competent state administration authorities, if they cause disruption or inability to provide services on our side;
   f. the impact of nuclear energy, radioactive radiation, electromagnetic field and biological and chemical agents harmful to a human;
   g. driving a vehicle without a permit or driving a vehicle without a valid MOT certificate, according to the laws currently in force, or driving a vehicle under the influence of voluntarily consumed alcohol, drugs or other intoxicants, psychotropic drugs or substitute drugs within the meaning of the Act of 29 July 2005 on counteracting drug addiction (consolidated text, Journal of Laws [Dz.U.] of 2019, item 852, as amended);
   h. the Insured attempting to commit suicide, self-harm, deliberately cause a health disturbance;
   i. committing or attempting to commit a crime or an offence;
   j. wilful misconduct, self-diagnosis, self-treatment or modification of the prescribed treatment or gross negligence of the Insured;
   k. being under the influence of, abuse of or an intoxication with voluntarily consumed alcohol, drugs, other intoxicants or psychotropic drugs, drugs used contrary to the physician's recommendations and abuse or intoxication with tobacco;
   l. detoxification, detox procedures and treatment;
   m. treatment of mental health illnesses, disorders and other forms of mental disturbances, including Alzheimer's disease, and their consequences;
   n. 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.

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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. We do not provide the continuation of insurance coverage within the scope of the hospital insurance of LUX MED Orthopaedic Care and the hospital insurance of LUX MED Orthopaedic Care Plus.

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

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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.

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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;

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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. Postępu 21C, 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. Postępu 21C 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 claims are covered by the guarantee of the Insurance Guarantee Fund in the amount of 50% of amount due; however, not more than the PLN equivalent of EUR 30,000 converted at the average exchange rate announced by the National Bank of Poland in force on the date of declaration of bankruptcy, dismissal of the bankruptcy petition or discontinuance of bankruptcy proceedings or on the date of ordering compulsory liquidation (if any).
7. The Insurer is subject to 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.
8. Correspondence related to the Agreement shall be sent to the last known address of the Parties to the Agreement.
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 **01.02.2023.**

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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. 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.
4. 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.
5. 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.
6. 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.
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.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 as follows:
   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;

   and agree on the place and date of Service performance.
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 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. Postępu 21C, with the following note: LMG reimbursement.
5. 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 6;
   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.
6. 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.
7. 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.
8. 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.
9. If health services are combined (e.g. psychotherapy for couples), the condition for payment of the Cash Benefit is that all Insureds

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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.

10. 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;
   l. diagnostic tests required for elective hospital treatment, provided as part of health care services financed from public funds.

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.

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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** – medical examinations carried out for all employees after a break due to incapacity for work as a result of an illness lasting longer than 30 days;
   b. **Periodic Examinations** – medical examinations carried out for all Employees performing work in a given position, for whom the validity of the medical certificate issued under the previous Occupational Medicine examination ends;
   c. **Preliminary examinations** – medical examinations carried out for:
      I. persons to be employed,
      II. Employees transferred to a position where there are factors harmful to health or arduous conditions other than the previously occupied position,
      III. juvenile employees transferred to another position;
   d. **Sanitary and epidemiological examinations** – examinations (swabs) for carrying Salmonella and Shigella;
   e. **Specialised and Diagnostic Examinations** – consultations with physicians and additional diagnostic examinations performed in the process of occupational medicine in accordance with the methodological guidelines or as ordered by the occupational physician, closely related to the working conditions and hazards of a specific job..
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. LUX MED shall also provide:
   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.

Note:
The Employer files a request for the participation of the Occupational Medicine doctor in the H&S Committee and occupational risk assessment team. The request should be submitted at least two weeks in advance before the date of the Committee's meeting (required in order for the Occupational Medicine doctor to book the date in their schedule).

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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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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 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 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.
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?

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;
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 listed in Appendix no. 2 or 3 to the GTC;

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c. treatment of Multi-Organ Damage and its consequences;
d. implantation of prostheses or implants other than those listed in Appendix nos. 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. prosthetic, orthodontic, periodontal and implant diagnoses and treatment and their consequences;
g. diagnosis, treatment and procedures or surgeries 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;
h. diagnosis and treatment not provided at Hospitals or Outpatient Clinics designated by us and their consequences;
i. 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);
j. 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;
k. treatment of the consequences of HIV, SARS-CoV-2, viral hepatitis (excluding hepatitis A);
l. home treatment as a continuation of hospital treatment, excluding treatment resulting from procedures covered by and performed under the insurance;
m. 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;
n. diagnosis and treatment without medical indications;
o. treatment resulting from psychological indications;
p. detoxification, detox procedures and treatment and their consequences;
q. treatment of mental disorders, dementia, neurodegenerative diseases (including Alzheimer's disease) and their consequences;
r. 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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Module: LUX MED Hospital Insurance Orthopaedic Care Plus Module;

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. The Insured may benefit from the Hospital Service under the Module if the following events occur:
   a. receiving a referral for hospital treatment (the date of the Event is the date the referral is issued);
   b. occurrence of a Minor Injury or health condition requiring Emergency Care (the date of the event is the day of occurrence of a Minor Injury or deterioration of health condition).
3. 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;
   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.

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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.
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 listed in Appendix no. 2 or 3 to the GTC;
   c. treatment of Multi-Organ Damage and its consequences;
   d. implantation of prostheses or implants other than those listed in Appendix 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 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. diagnosis and treatment not provided at Hospitals or Outpatient Clinics designated by us and their consequences;
   n. 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);

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o. 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;
p. treatment of infection with HIV (AIDS), SARS-CoV-2 or hepatitis (with the exception of hepatitis A) viruses, and diseases resulting from those infections;
q. home treatment as a continuation of hospital treatment, excluding treatment resulting from procedures covered by and performed under the insurance;
r. 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;
s. diagnosis and treatment without medical indications;
t. treatment resulting from psychological indications;
u. treatment of diseases or consequences of Accidents which were not disclosed to us in the documents required by us for the conclusion of the Agreement and which occurred or the reasons for their occurrence were known to the 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;;
v. detoxification, detox procedures and treatment and their consequences;
w. treatment of mental disorders, dementia, neurodegenerative diseases (including Alzheimer's disease) and their consequences;
x. 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.

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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. The Insured may benefit from the Hospital Service under the Module if the following events occur:
   a. receiving a referral for hospital treatment (the date of the Event is the date the referral is issued);
   b. pregnancy (the date of the Event is the date of planned childbirth entered in the pregnancy card; if there are two dates, the date of the Event is the earlier date);
   c. occurrence of a Minor Injury or health condition requiring Emergency Care (the date of the Event is the day of occurrence of a Minor Injury or deterioration of health condition).
3. 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.

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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.

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 listed in Appendices nos. 2 or 3 to the GTC;
   c. treatment of Multi-Organ Damage and its consequences;
   d. implantation of prostheses or implants other than those listed in Appendices 2 or 3 to the GTC, in particular replacing sensory organs (e.g. cochlear implant);
   e. robotic surgery procedures other than those listed in Appendices nos. 2 or 3 to the GTC;
   f. treatment in psychiatric wards;

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g. diagnosis and treatment of fertility disorders and their consequences;
h. diagnosis and treatment of gender adjustment and their consequences;
i. diagnosis and treatment of congenital genetic defects associated with chromosomal aberrations and congenital defects causing the declared malfunction and their consequences;
j. diagnosis and treatment of Rare Diseases and their consequences;
k. performance of abortions and treatment of complications resulting from them;
l. prosthetic, orthodontic, periodontal and implant diagnoses and treatment and their consequences;
m. diagnosis, treatment and procedures or surgeries 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;
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. treatment of diseases or consequences of Accidents which were not disclosed to us in the documents required by us for the conclusion of the Agreement and which occurred or the reasons for their occurrence were known to the 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;
   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.

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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. organisation of Medical Transport.
4. coordination of care after Hospitalisation, in accordance with the Physician's recommendations:
   a. arranging for examinations and rehabilitation recommended for the Insured;
   b. organisation of Medical Transport if it is due to medical indications;
   c. completion of the medical documentation of the Insured.

§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;

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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.

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Module: Treatment for Serious Illnesses Abroad – BEST HELP

§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:

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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;

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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;
      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

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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:

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

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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

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

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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.

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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.

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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.
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:

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• 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. Postępu 21C, 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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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. Postępu 21C, 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.

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Appendix No. 1 to the General Terms and Conditions of LUX MED Group Insurance – OWU [GTC] CODE G/001/2023/C

SCOPE OF OUTPATIENT CARE BENEFITS

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Healthcare specialists consultations

The service covers an unlimited access to consultations with Physicians in Medical Facilities indicated by the Insurer in such cases as onset of an illness, emergency medical assistance and general medical advice. Specialist consultations include an interview, advice by a specialist along with the basic activities necessary to make the diagnosis, taking the appropriate therapeutic decision and treatment monitoring.

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

- internal medicine
- family medicine.
- allergology
- general surgery
- dermatology
- diabetology
- endocrinology
- gastroenterology
- gynaecology
- gynaecological endocrinology
- haematology
- cardiology
- laryngology
- nephrology
- neurology,
- ophthalmology
- oncology
- orthopaedics
- proctology
- pulmonology
- rheumatology
- urology

The Insured up to 18 years of age – **visits without a referral** relate to consultations within the following scope:

- paediatrics
- surgery
- dermatology
- gynaecology (from the age of 16)
- neurology
- ophthalmology
- orthopaedics
- laryngology

The Insured over 18 years of age – **visits require a referral** from a Physician employed by a Clinic indicated by the Insurer 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

The Insured up to 18 years of age – **visits require a referral** from a Physician employed by a Clinic indicated by the Insurer 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

Note:
The service does not include consultation of Physicians on duty, 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). Other consultations are also subject to fees.

Consultations with a dietician

The service entitles the Insured to attend dietary consultations, including interview, dietary recommendations (without creating an individual diet) in Medical Facilities indicated by the Insurer.

The Insured over 18 years of age – **visits without a referral.**
The Insured up to 18 years of age – **visits require a referral** from a Physician employed by a Clinic indicated by the Insurer.

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Specialists consultations: psychiatrist, psychologist, andrologist, sex therapist, speech therapist

The service entitles the Insured to attend a total of 3 consultations in a 12-month Insurance Period in Medical Facilities indicated by the Insurer, within the following scope:

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

- psychiatry
- psychology
- sex therapy
- andrology
- speech therapy

The Insured up to 18 years of age – **visits without a referral** relate to consultations within the following scope:

- psychiatry
- psychology
- speech therapy

Note:

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

Online consultations

Online Consultation is a medical service provided by the Operator through teleinformation systems or communication systems. The Insurer enables the Insured to attend individual interactive consultations with a medical specialist (doctor, midwife or nurse) via means of remote communication i.e. the Patient Portal. Online Consultation are available to the Insured with full access to the Patient Portal. Accessibility of online Consultations with a Physician, a midwife and a nurse depends on the schedule of medical specialists and can be accessed under the "Online Consultation" tab. The Insured can choose a preferred communication channel: video, audio or text.

Since the medical specialists who answer questions have access to the Insured's medical records, they can request specific tests or refer the Patient to a different specialist, if such medical need exists. Online Consultation is provided exclusively to the insured who has logged into the Insured Portal; its content is saved and entered into the Insured's medical records. Online Consultations include medical specialist consultations which are listed below, within the scope not requiring in-person contact with a specialist.

The service covers e-consultations in the fields of:

- intern/family medicine (from the age of 18)
- pediatric (up to the age of 18)
- pediatric nursing
- obstetrics

Note:

Telemedicine Consultations do not replace in-person consultations because there are no direct examinations. In order to benefit from online Consultation, the Insured, after logging into an account on the Patient Portal in the tab "online Consultation", shall be placed in a queue awaiting the use of the service. The provision of services in the form of online consultation shall take place exclusively for the benefit of the Insured Party who concluded the Agreement or who is designated as the person entitled to medical benefits for online Consultation. You may not make online Consultation services available to anyone else. The Insured bears full civil and criminal liability for ensuring that the data they provide are genuine. As part of the Telemedicine Consultation, the Insured receives a healthcare service, and as part of that service he/she may receive a referral for an examination, a referral to another specialist for the purpose of obtaining another Telemedicine Consultation or a referral to another specialist in order to obtain a healthcare service as part of an in-person service, an e-prescription for drugs for the continuation of chronic treatment, a de novo e-Prescription based on medical records and medical indications arising in the course of a Telemedicine Consultation, or a medical certificate/e-Sick leave for medical indications.

If medically justified, a medical specialist providing an online Consultation may refuse to give remote medical advice and refer the Insured to an in-person Physician, midwife or nurse consultation. During the online Consultation, no e-exemptions or referrals are made for studies involving the use of ionizing radiation and referrals to biopsies, endoscopy and stress trials. The final decision to issue an e-Prescription/e-Sick Leave during a Telemedicine 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 Insured's welfare. A Physician does not issue e-Prescriptions for vaccines, potent drugs, drugs that can cause addiction and emergency contraception during Telemedicine Consultations.

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Nursing procedures

Services including basic measurements, minor procedures, including diagnostic ones, performed by a nurse or midwife on their own or according to the Physician's recommendation, in line with their competences, in Medical Facilities indicated by the Insurer. 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.

Nursing procedures include:

Outpatient nursing procedures:

- Intravenous injection
- Subcutaneous/intramuscular injection
- Emergency drip administration
- Oral medicine administration in emergency cases
- Body temperature measurement (no Physician's referral needed)
- Placement/change/removal - small dressing
- Blood drawing
- Blood pressure measurement (no referral needed)
- Height and body weight measurement (no Physician's referral needed)
- Office-based midwife service – palpation of the breast

Note:
Medical materials and products, such as: dressings, bandages, cannulae, syringes, swabs, adhesive strips, needles, serum - tetanus antitoxin, disinfectants, used for the above procedures are free of charge. Other products used in the above procedures need to be paid for by the Insured.

- Family physician

On-duty Physician Consultations

The service includes exclusively basic emergency assistance in a sudden onset of an illness or in injuries requiring initial dressing which have 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. The service 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 service 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 (provided that the consultations are available in the facility):

- internal medicine
- paediatrics
- family doctor

The Insured over 18 years of age, additionally (if the consultations are available in the clinic):

- general surgery
- orthopaedics

Professor consultations

The service 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). The service (if available at medical facilities indicated by the Insurer) shall cover the same scope of consultation as the Insured Party is entitled to under the Agreement from among specialists' consultations in the following options: basic, basic – with additional payments, I, I – with additional payments, I plus, I plus – with additional payments, II, II – with additional payments, II plus, II plus – with a surcharge, III or IV).

Professor consultations: psychiatrist, psychologist

The service entitles the Insured to attend 3 consultations in a 12-month Insurance Period: Consultations of Physicians or psychologists with the degree of "doktor habilitowany" (associate professor) or the scientific title of "profesor" (professor), as well as physicians or psychologists holding the positions of "docent" (assistant professor), "profesor nadzwyczajny"

(associate professor) and “profesor zwyczajny” (full professor) who receive patients in Medical Facilities indicated by the Insurer, within the following scope:

- psychiatry
- psychology

The service is available with a referral issued by a Physician from a Clinic indicated by the Insurer and includes: medical history taking, specialist advice and basic procedures necessary for making a diagnosis, taking an appropriate therapeutic decision and monitoring of treatment. The service does not include neuro speech therapy or speech therapy in deaf and hearing-impaired patients or conducting therapy.

Outpatient procedures

The services including basic measurements and procedures (including diagnostic ones) not requiring hospitalisation and operating room regimen. 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. 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.

Outpatient procedures include:

Outpatient general medical procedures:

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

Outpatient surgical procedures:

- Suturing of a wound up to 1.5 cm
- Surgical tick removal
- Non-surgical tick removal
- Placement/change/removal – small dressing (not requiring surgical debridement)
- Removal of another foreign body without incision
- Suture removal in a treatment room after procedures performed in the Medical Facilities indicated by the Insurer
- Suture removal after procedures performed outside of Medical Facilities indicated by the Insurer, qualification based on the Physician's assessment (we do not remove stitches after childbirth)
- stitching a wound of up to 3 cm (in emergency situations requiring immediate help)
- Removal of a boil / small skin abscess (up to 2 cm)
- 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
- Skin procedure – removal of a foreign body, with wound debridement (removal of a foreign body from the skin with wound debridement)
- Sampling of skin tissue for specialist examination
- Wound cleansing / excision
- Skin procedure – incision of haematoma / abscess, with drainage
- Nail surgery – cleaning / removal
- Ingrown nail procedure (onychoplasty) – bilateral
- Ingrown nail procedure (onychoplasty) – unilateral

Outpatient laryngological procedures:

- Eustachian tube examination, insufflation
- Catheterisation of the Eustachian tube
- Ear irrigation
- Removal of a foreign body from the nose/ear
- Simple laryngological dressing
- Coagulation of blood vessels of the nasal septum
- Electrocoagulation of blood vessels of the nasal septum
- Nasal tamponade removal
- Bilateral dressing of nasal hemorrhage
- Unilateral dressing of nasal hemorrhage
- Suture removal in a treatment room after laryngological procedures performed in Medical Facilities indicated by the Insurer
- Suture removal after laryngological procedures performed outside of Medical Facilities indicated by the Insurer, qualification based on the doctor's assessment
- Nasal administration of mucosa-shrinking medicine as needed

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- Application / change / removal of a drain in the ear canal
- Laryngeal clysis
- Incision of the lingual frenulum in the oral cavity
- Incision of haematomas of the nasal septum
- Incision of auricular haematomas
- Sinus puncture
- Cryosurgery (does not include snoring therapy)
- Closed reduction of the nose
- Obliteration of varicose veins at the base of tongue
- Pretz sinus rinse
- Sinus rinse

Outpatient ophthalmologic procedures:

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

Outpatient orthopaedic procedures:

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

Outpatient dermatological procedures (do not include lesions removed due to aesthetic, plastic indications):

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

Outpatient gynaecological procedures:

- Standard* sample collection for Pap smear
- Removal of an intrauterine contraceptive device
- Insertion of an intrauterine device
- Cervical procedures cryocoagulation – treatment of erosions.
- Cervical and vulvar procedures by cryocoagulation

Outpatient allergological procedures:

- Desensitisation with allergist consultation

Anaesthesia:

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

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Biopsy with standard histopathological examination – fine-needle biopsy material / core-needle biopsy material:

- Fine-needle biopsy – skin / subcutaneous tissue
- Fine-needle biopsy – breast nipple
- Fine-needle biopsy – salivary gland
- Fine-needle biopsy – thyroid
- Fine-needle biopsy – lymph nodes
- Core biopsy of the prostate under ultrasonographic guidance

Other:

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

Note:
Medical materials and products, such as: traditional and synthetic plaster cast, dressings, bandages, cannulae, syringes, swabs, adhesive strips, needles, serum - tetanus antitoxin, disinfectants, surgical sutures and threads, used for the above procedures are free of charge. Other products used in the above procedures need to be paid for by the Insured.

* Standard – commonly available and commonly used in Poland

Influenza and tetanus vaccinations

As part of infectious disease prevention, the service includes vaccinations against seasonal flu and tetanus (anatoxin).

The service includes:

- medical consultation before vaccination
- vaccine (the medicinal product)
- performance of a nursing service (injection).

Flu vaccinations are performed in Medical Facilities indicated by the Insurer. The Insurer may also arrange vaccination against seasonal influenza in a place indicated by the Insuring Party – for groups over 30 persons.

Additional recommended preventive vaccinations

The service is available within the additional prophylaxis of infectious diseases in Medical Facilities indicated by the Insurer, following referral issued by a Physician of the above-mentioned Clinic. The service covers the following vaccinations (this also refers to combination vaccines) against:

- tick-borne encephalitis
- viral hepatitis types A
- viral hepatitis types A and B
- rubella, mumps, measles

The service includes:

- medical consultation before vaccination
- vaccine (the medicinal product)
- performance of a nursing service (injection)

Laboratory test panel (no referral needed)

The service is only available for the Insured over 18 years of age and is provided only in Medical Facilities indicated by the Insurer. The service 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):

- urine – general analysis,
- Blood count + platelet count + automated smear
- Total cholesterol
- Fasting glucose
- Standard Pap smear (available for the Insured over 16 years of age)

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Laboratory tests and diagnostic imaging

This includes the following laboratory, imaging and functional diagnostic tests performed in Medical Facilities indicated by the Insurer. The number of performed tests is unlimited. All diagnostic tests and examinations available within the service are performed following referrals issued by Physicians from Medical Facilities indicated by the Insurer, only based on medical indications as part of a diagnostic and therapeutic process conducted in these Medical Facilities.

Laboratory diagnostics:

Haematology and coagulation tests with taking test samples (blood):

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

Biochemical and hormonal tests, tumour marker tests with taking test samples (blood):

- CRP quantitative
- GPT/ALT transaminase
- GOT/AST transaminase
- Amylase
- Albumins
- Total protein
- PAPP – a protein
- Total bilirubin
- Direct bilirubin
- Chlorides (Cl)
- cholesterol
- HDL cholesterol
- LDL cholesterol
- directly measured LDL cholesterol
- CK (creatine kinase)
- LDH – Lactate dehydrogenase
- Alkaline phosphatase
- Acid phosphatase
- phosphorus (P)
- GGTP
- Glucose tolerance test (4 points, 75 g, 0, 1, 2, 3 h)
- Fasting glucose
- 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
- Creatinine
- Uric acid
- Lipid profile (CHOL, HDL, LDL, TG)
- Magnesium (Mg)
- Urea/blood urea nitrogen (BUN)
- Potassium (K)
- protein profile
- Sodium (Na)
- Triglycerides
- Calcium (Ca)
- iron (Fe)
- IgE immunoglobulin (total IgE)
- IgA immunoglobulin
- IgG immunoglobulin
- IgM immunoglobulin
- folic acid
- Vitamin B12
- TIBC – total iron binding capacity (alternative to Fe saturation)
- Iron / Fe 120 min after administration (absorption curve)
- iron (Fe) 180 min after administration (absorption curve)
- iron (Fe) 240 min after administration (absorption curve)
- iron (Fe) 300 min after administration (absorption curve)
- Iron / Fe 60 min after administration (absorption curve)
- Ferritin
- Caeruloplasmin
- Transferrin
- Thyroglobulin
- Apolipoprotein A1
- Lipase
- 17 – OH Progesterone
- Aldosterone
- Copper
- Cortisol in the afternoon
- Cortisol in the morning
- 120' after administration of 1 MCP tablet
- 30' after administration of 1 MCP tablet
- 60' after administration of 1 MCP tablet
- Prolactin
- TSH / hTSH
- Estradiol
- FSH
- Free T3
- Free T4
- Total Beta-hCG
- LH
- Progesterone
- Testosterone
- Fee testosterone
- AFP – alpha-fetoprotein
- Free PSA
- Total PSA
- CEA – carcinoembryonic antigen
- CA 125
- CA 15.3 – breast cancer antigen
- CA 19.9 – digestive cancer antigen
- CA 72-4 – colon tumour marker
- Alpha-1 – antitrypsin

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- Alpha-1 acid glycoprotein (Orosomucoid)
- Androstendione
- β2 microglobulin
- Caeruloplasmin
- Cholinesterase
- Blood-cell cholinesterase / Blood-cell acetylcholinesterase
- CA 21-1 – lung tumour marker
- Zinc
- Dehydroepiandrosterone (DHEA)
- DHEA – S
- Zinc protoporphyrin (ZnPP)
- Erythropetin
- Free estriol
- Prostatic acid phosphatase
- Alkaline phosphatase – bone fraction
- Gastrin
- Haptoglobin
- Hb A1c – Glycated haemoglobin
- Homocysteine
- Adrenocorticotropic hormone (ACTH)
- Growth hormone (GH)
- IGF – BP 3
- Insulin / Insulin 120'
- Insulin / Insulin 60'
- Fasting insulin
- 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
- CK – MB activity
- CK – MB mass
- BNP
- NT pro – BNP
- Calcitonin
- Creatinine clearance
- Myoglobin
- Osteocalcin (bone formation marker)
- Parathyroid hormone
- C-peptide
- Occult iron binding capacity (UIBC)
- Vitamin D3 – 1,25 (OH)2 metabolite
- Vitamin D3 – 25-OH metabolite
- Total T3
- Total T4
- Somatomedin – (IGF-1)
- PSA panel (PSA, FPSA, FPSA / PSA index)
- Reticulocytes
- SCC – squamous cell carcinoma antigen
- SHBG
- Kappa light chains in serum
- Lambda light chains in serum
- NSE – Neuro-specific enolase
- Cystatin C
- Macroprolactin
- Renin activity of plasma
- ACE
- Leptin
- TPS
- S100
- BRCA1, method: PCR
- Apo A1
- Aldolase

Serology tests and infection diagnostics with taking test samples (blood):

- Basic syphilis serology (VDRL or USR or anti-TP), formerly WR
- ASO, quantitative
- ASO qualitative
- RF — rheumatoid factor — quantitative
- Waaler-Rose test
- BTA test
- Blood group (AB0), Rh factor and antibody screening
- Immune antibody screening / alloantibodies (replaces anti-Rh /–/ antibodies)
- HBs Ag/antigen
- A-microsomal/anti-TPO antibodies
- Antithyroglobulin / anti-TG antibodies
- CMV antibodies IgG
- CMV IgM antibodies
- HBs antibodies
- HCV antibodies
- Helicobacter pylori IgG, quantitative
- HIV-1/HIV-2
- EBV/mononucleosis – latex
- EBV / mononucleosis IgG
- EBV / mononucleosis IgM
- Rubella IgG
- Rubella IgM
- Toxoplasma IgG
- Toxoplasma IgM
- Chlamydia trachomatis IgA antibodies
- Chlamydia trachomatis IgG antibodies
- Chlamydia trachomatis IgM antibodies
- HBc Ab IgM
- C1 – inhibitor
- C1 – inhibitor (activity)
- Complement component 3 (C3)
- Complement component 4 (C4)
- Anti-HAV – IgM
- Anti-HAV – total
- Lupus anticoagulant
- Echinococcosis (Echinococcus granulosus) IgG
- Borelia burgdorferii, method: Qualitative PCR
- Borreliosis (Lyme disease) IgG
- Borreliosis IgG Western-blot method (confirmatory test)
- Borreliosis (Lyme disease) IgM
- Borreliosis IgM Western-blot method (confirmatory test)
- Brucellosis – IgG
- Brucellosis – IgM
- Ascaris lumbricoides (ASCARIS) IGG
- Cytomegalovirus (CMV), method: Qualitative PCR
- Cytomegaly – IgG avidity test
- HBc Ab total
- HBe Ab
- Hbe Ag
- HBV, method: Quantitative PCR
- HBV, method: Qualitative PCR
- HCV, method: Quantitative PCR

- HCV, method: Qualitative PCR
- HPV (Human papillomavirus), method: Qualitative PCR – swab
- HSV / Herpes 1 and 2 – IgG – qualitative
- HSV / Herpes 1 and 2 – IgM – qualitative
- hsCRP
- Mycoplasma pneumoniae – IgG
- Mycoplasma pneumoniae – IgM
- FTA test
- TPHA test
- Measles – IgG
- Measles – IgM
- Varicella IgG
- Varicella IgM
- HLA B27 antigen assay
- Anti-neutrophil cytoplasmic antigen antibody ANCA (pANCA and cANCA), method: IIF
- Antibodies against striated muscles and cardiac muscle (myasthenia gravis), method: IIF
- Anti-nucleosome antibodies (ANuA) (IMMUNOBLOT)
- Anticardiolipin antibodies – IgG
- Anticardiolipin antibodies – IgM
- Anticardiolipin antibodies – IgM and IgG
- P/body of Mr. microsomes of liver and kidneys (ANI - LKM) met. IIF
- Anti-tGT (anti-tissue transglutaminase) IgA antibodies, method: ELISA
- Anti-tGT (anti-tissue transglutaminase) IgG antibodies, method: ELISA
- Anti-beta-2–glicoprotein I IGG antibodies
- Anti-beta-2–glicoprotein I IGM antibodies
- Anti-beta-2-glicoprotein IgG and IgM antibodies (total)
- Anti-CCP antibodies
- IgA antibodies to endomysium and gliadin (total), method: IIF
- IgG antibodies to endomysium and gliadin (total), method: IIF
- IgA and IgG antibodies to endomysium and gliadin (total), method: IIF
- Anti-phosphatidylinositol IgG antibodies
- Anti-phosphatidylinositol IgM antibodies
- Antibodies to adrenal cortex
- Anti-prothrombin IgG antibodies
- Anti-prothrombin IgM antibodies
- Anti-tGT (anti-tissue transglutaminase) IgG and IgA antibodies, method: ELISA
- Antibodies to pancreatic islets, pancreatic exocrine cells and goblet cells in intestines, method: IIF
- Coxsackie antibodies
- Chlamydia pneumoniae IgA antibodies
- Chlamydia pneumoniae IgG antibodies
- Chlamydia pneumoniae IgM antibodies
- Antibodies to Castle's intrinsic factor and anti-parietal cell antibodies (APCA), method: IIF
- Antibodies to double-stranded / native DNA – dsDNA (nDNA)
- Endomysium IgA antibodies – EmA IgA
- Endomysium IgG antibodies – EmA IgG
- Endomysium IgG, IgA antibodies – EmA
- Anti-gliadin IgG and IgA (AGA) antibodies (total), method: IIF
- IgA anti-gliadin antibodies – AGA
- IgG anti-gliadin antibodies – AGA
- Anti-nuclear and anti-cytoplasmatic antibodies (ANA1), screening, method: IIF
- Antibodies to myocardial cells (HMA)
- Anti-parietal cell antibodies (APCA), method: IIF
- Anti-smooth muscle antibodies (ASMA)
- Anti-mitochondrial antibodies (AMA)
- Anti-mitochondrial antibodies (AMA) type M2
- Yersinia enterocolitica antibodies – IgG
- Yersinia enterocolitica antibodies – IgG, IgM, IgA (total)
- Yersinia enterocolitica antibodies – IgM
- Liver panel antibodies – (anti-LKM, anti-LSP, anti-SLA), method: IIF
- Full liver panel antibodies (ANA2, AMA, ASMA, anti-LKM, anti-LSP, anti-SLA), method: IIF, DID
- Antibodies to acetylcholine receptors (AChR-Ab)
- Antibodies to TSH receptors (TRAb)
- Anti-nuclear (including histone, Ku, rib-P-Protein) antibodies (ANA3), method: Western blot
- Anti-nuclear and anti-cytoplasmatic antibodies (ANA2), method: IIF, DID
- Pertussis – IgA
- Pertussis – IgG
- Pertussis – IgM
- Listeriosis – qualitative
- Parvovirus B19 – IgG and IgM
- PCR HSV – herpes, qualitative
- Pneumocystosis IgG – quantitative
- Pneumocystosis IgM – quantitative
- Toxoplasmosis – IgG avidity test
- Toxocariasis IgG (semi-quantitative)
- Mumps – IgG
- Mumps – IgM
- SLE – semi-quantitative
- Syphilis serology – FTA – ABS confirmatory test
- Antibodies to ds DNA method: IIF

- Bile duct antibodies, method: IIF
- Anti-liver cytosol antibodies Type 1 (anti-LC1), method: Western blot
- Anti-reticulin antibodies (ARA) IgA, method: IIF
- Anti-reticulin antibodies (ARA) IgG, method: IIF
- Anti-reticulin antibodies (ARA) IgA and IgG (total), method: IIF
- Anti-phosphatidylserine IgG antibodies
- Anti-phosphatidylserine IgM antibodies
- Antibodies to ovary antigen, method: IIF
- Antibodies against striated muscles, method: IIF
- Anti-glomerular basement membrane (GBM) antibodies and anti-alveolar basement membrane (ABM) antibodies, method: IIF
- Intestinal panel (antibodies to pancreatic exocrine cells and goblet cells in intestines, ASCA, ANCA), method: IIF
- Anti-Saccharomyces cerevisiae antibodies (ASCA) IgG, method: IIF
- Antibodies to pemphigus and pemphigoid, method: IIF
- Hemochromatosis, method: PCR
- Antibodies to Ascaris lumbricoides, IgG
- Anti-endomysial, anti-reticulin and anti-gliadin antibodies, IgA+IgG
- Anti-endomysial, anti-reticulin and anti-gliadin antibodies, IgG
- Anti-endomysial and anti-reticulin IgA antibodies
- Anti-endomysial and anti-reticulin IgG antibodies
- EBV, method: Quantitative PCR
- EBV, method: Qualitative PCR
- Mycoplasma pneumoniae, method: Qualitative PCR
- Ureaplasma urealyticum, method: Qualitative PCR
- Tick-borne encephalitis IgM antibodies
- Trichinosis, IgG
- Toxoplasma gondii, method: Qualitative PCR
- Glutamic acid decarboxylase (anti-GAD) antibodies
- Tyrosine phosphatase (IA2) antibodies

Urine tests with taking test samples (urine):

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

Bacteriological tests with taking smear (the service does not include tests performed using molecular biology techniques):

- Urine culture
- Faeces – general culture
- Throat/tonsil swab aerobic
- Oral swab – aerobic culture
- ear swab anaerobic culture
- ear swab aerobic culture

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- eye swab aerobic culture
- nasal swab
- Nasal swab – aerobic culture
- Nasopharyngeal swab – anaerobic culture
- Nasopharyngeal swab – aerobic culture
- Rectal swabs and vaginal swabs towards the HEM pad. GBS
- Vaginal swab – anaerobic culture
- Vaginal swab – aerobic culture
- Culture for GC (GNC) vaginal swab
- Wound swab
- Wound swab – anaerobic culture
- Stool culture for SS
- Vaginal microbiological test (vaginal biocenosis)
- Semen — aerobic culture
- Sputum culture
- Endocervical swab
- Endocervical smear – anaerobic culture
- Endocervical smear for GC
- Stool culture for pathogenic E. Coli, in children up to 2 years
- Stool culture for Yersinia enterocolitica
- Urethral swab
- Urethral swab – anaerobic culture
- Culture of human milk from left breast – aerobic
- Culture of human milk from right breast – aerobic
- Abscess content culture
- Abscess content – anaerobic culture
- Urethral swab for GC (GNC) culture
- Left ear seton – aerobic culture
- Right ear seton – aerobic culture
- Breast discharge – aerobic culture
- Foreskin swab – aerobic culture
- Furuncle swab
- Gingival swab – aerobic culture
- Tongue swab – aerobic culture
- Laryngeal swab – aerobic culture
- Laryngeal swab for Pneumocystis carinii
- Anal swab – aerobic culture
- Anal swab culture for SS
- Ulceration swab – aerobic culture
- Umbilical swab – aerobic culture
- Penile swab – aerobic culture
- Vulvar swab – aerobic culture
- Skin lesion swab – aerobic culture
- Chlamydia pneumoniae antigen, method: IIF swab
- Chlamydia pneumoniae antigen, method: IIF swab – other material
- Chlamydia pneumoniae antigen, method: IIF – throat swab
- Chlamydia pneumoniae PCR swab
- Chlamydia trachomatis antigen, method: IIF swab – other material
- Chlamydia trachomatis antigen, method: IIF – urethral swab
- Chlamydia trachomatis antigen, method: IIF – endocervical swab
- Chlamydia trachomatis, method: PCR – qualitative method (vaginal swab, urethral swab or urine)
- Eosilophils in nasal swab
- Mycoplasma hominis and Ureaplasma urealiticum urethral swab
- Mycoplasma hominis and Ureaplasma urealiticum endocervical swab
- Synovial fluid – cytology
- Synovial fluid – general analysis
- Liquid from sinuses – aerobic culture
- Pinworms – anal swab

Faecal tests with taking test samples:

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

Cytology tests with taking test samples:

- Standard* Pap smear
- Standard* nasal mucosa cytological test

Mycological tests with taking smear (the service does not include tests performed using molecular biology techniques):

- Mycological examination – toenail fungal culture
- Mycological examination – fingernail fungal culture
- Mycological examination – hair fungal culture
- Mycological examination – skin fungal culture
- Mycological examination – skin scraping fungal culture
- Stool culture for yeast-like fungi
- Urine culture for yeast-like fungi
- Sputum culture for yeast-like fungi
- abscess content culture for yeast-like fungi

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- Secretion culture for yeast-like fungi
- Swab culture for yeast-like fungi
- Urethral swab culture for yeast-like fungi
- Pharyngeal swab culture for yeast-like fungi
- Endocervical swab culture for yeast-like fungi
- Nasal swab culture for yeast-like fungi
- Nasopharyngeal swab – culture for yeast-like fungi
- Eye swab culture for yeast-like fungi
- Vaginal swab culture for yeast-like fungi
- Wound smear culture for yeast-like fungi
- Ear swab culture for yeast-like fungi
- Oral swab – culture for yeast-like fungi
- Mycological examination – hand epidermis fungal culture – scrapings
- Mycological examination – foot epidermis fungal culture – scrapings
- Mycological examination – fungal culture – scalp – scraping
- Semen culture for yeast-like fungi
- Under the foreskin swab – culture for yeast-like fungi
- Gingival swab – aerobic culture for yeast-like fungi
- Tongue swab culture for yeast-like fungi
- Laryngeal swab culture for yeast-like fungi
- Anal area swab – culture for fungi
- Ulceration swab – culture for fungi
- Penile swab culture for yeast-like fungi
- Vulvar swab – culture for yeast-like fungi
- Skin lesion swab – culture for fungi

Toxicological tests with taking test samples (blood):

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

Quick strip tests with taking test samples (blood):

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

Diagnostic imaging:

ECG examinations:

- Resting ECG
- Stress test
- Exercise ECG using a cycloergometer
- Setting up a standard * EKG Holder (per 24 h) in the office
- Mounting a 12-channel Holter ECG device
- Opening Holder RR (per 24 h) in the office

X-ray (medium conforming with the standard applicable in a given clinic):

- Cranial X-ray orbits
- X-ray of orbits + lateral (2 views)
- Cranial X-ray PA + lateral
- Cranial X-ray PA + lateral + base
- Cranial X-ray, base
- Cranial X-ray, semi-axial by Orley
- Cranial X-ray, sella turcica
- Cranial X-ray, tangential
- Cranial X-ray, cranial nerve canals
- Splanchnocranium X-ray
- Abdominal X-ray, other
- Abdominal X-ray, supine
- Abdominal X-ray, erect
- Chest X-ray
- Chest X-ray – X-ray tomography
- Chest X-ray + lateral
- Chest X-ray, lateral with barite
- Chest X-ray, other
- Chest X-ray PA + lateral with barium
- X-ray of chest, thyroid, trachea
- Sacrococcygeal X-ray
- Lateral nasal X-ray
- Lower leg X-ray, AP + lateral
- Lower leg X-ray, AP + bilateral lateral
- Upper leg and lower leg X-ray
- Femoral bone X-ray, AP + left lateral
- Femoral bone X-ray, AP + right, lateral
- Shoulder X-ray, axial
- Shoulder X-ray, bilateral axial
- Shoulder X-ray, AP + lateral
- Shoulder X-ray: AP + bilateral – comparative image
- Shoulder X-ray, AP
- Shoulder X-ray, AP, both – comparative image
- Forearm X-ray, AP + lateral
- Bilateral forearm X-ray, AP + lateral
- Elbow/forearm X-ray, AP + lateral
- Elbow/forearm X-ray, AP + lateral, bilateral

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- X-ray of temporal bones, transorbital
- X-ray of temporal bones by Schuller/Stevers
- Temporal bone pyramid X-ray, transorbital
- Hand X-ray, lateral
- Hand X-ray, PA
- Hand X-ray PA, bilateral
- Finger(s) X-ray, PA + lateral/oblique
- Finger(s) X-ray, PA + lateral/oblique bilateral
- Scaphoid X-ray
- Foot X-ray, AP + lateral/oblique
- Foot X-ray, AP + lateral/oblique
- Foot X-ray, AP + lateral/oblique bilateral
- Foot X-ray, AP + lateral/oblique bilateral
- Foot X-ray, AP (comparative)
- Metatarsal X-ray
- Toe(s) X-ray, AP + lateral/oblique
- Heel X-ray + axial
- Heel X-ray, lateral
- Lumbar X-ray: AP + lateral
- X-ray of lumbar spine, AP + lateral + oblique
- X-ray of lumbar spine, lateral
- X-ray of lumbosacral spine, oblique
- X-ray of lumbosacral spine AP + lateral
- Lumbar 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
- Cervical X-ray
- Cervical X-ray, AP + lateral
- Cervical X-ray, lateral
- Cervical X-ray, lateral + oblique (3 views)
- Cervical X-ray, oblique views
- Cervical functional X-ray
- Spinal X-ray AP, erect (scoliosis)
- Spinal X-ray AP, erect + lateral (scoliosis)
- Scapular X-ray
- Pelvic and hip joint X-ray
- X-ray of sternum, AP
- X-ray sternum / chest lateral
- Mandibular X-ray
- Paranasal sinus X-ray
- Rib X-ray (unilateral), 2 oblique views
- Wrist X-ray, lateral
- X-ray of both wrists, lateral
- Wrist X-ray, PA + lateral
- Wrist X-ray, PA + bilateral lateral
- Hand X-ray, PA + oblique
- Hand X-ray, PA + oblique, bilateral
- Wrist/hand X-ray, PA + lateral/oblique left
- Wrist/hand X-ray, PA + lateral/oblique right
- Wrist/hand X-ray, PA + lateral/oblique bilateral
- Wrist/hand X-ray, PA + lateral/oblique bilateral
- X-ray of both patellae axial
- Bilateral patellar X-ray, axial in 2 positions
- Bilateral patellar X-ray, axial in 3 positions
- X-ray of sacroiliac joints – PA
- X-ray of sacroiliac joints – oblique
- Hip joint X-ray, AP
- Bilateral hip joint X-ray, AP
- Hip joint X-ray, axial
- Knee joint X-ray, AP + lateral
- Knee joint X-ray, AP + bilateral lateral
- Bilateral knee joint X-ray — AP + lateral
- Knee joint X-ray, lateral
- Elbow joint X-ray
- Ankle joint X-ray, AP + lateral
- Ankle joint X-ray, AP + lateral bilateral
- Temporomandibular joint functional X-ray
- Urography (with standard contrast agents)
- X-ray of nasopharynx
- Shoulder X-ray (transthoracic)
- Shoulder X-ray, AP + axial
- Clavicular X-ray
- Large intestine X-ray – rectal enema (with standard contrast agents)
- Chest X-ray – X-ray tomography
- Larynx X-ray – tomography
- X-ray, small intestine passage (with standard contrast agents)
- Esophagus, stomach and duodenum X-ray (with standard contrast agents)
- X-ray teleradiogram – digital cephalometry

Ultrasound examinations:

- Abdominal ultrasound
- Urinary tract ultrasound
- Breast ultrasound
- Thyroid ultrasound
- Transabdominal prostate ultrasound
- Transvaginal gynaecological ultrasound
- Transabdominal gynaecological ultrasound
- Testicular ultrasound
- Salivary gland ultrasound
- Transrectal prostate ultrasound
- Ultrasound / Doppler ultrasound of carotid arteries and vertebral arteries
- Ultrasound / Doppler ultrasound of lower limb arteries
- Ultrasound/Doppler ultrasound of upper limb arteries
- Ultrasound/Doppler ultrasound of lower limb veins
- Ultrasound/Doppler ultrasound of upper limb veins
- Ultrasound / Doppler ultrasound of the abdominal aorta and angiography of pelvic arteries
- Ultrasound/Doppler ultrasound of hepatic vessels (assessment of hepatic portal circulation)

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- Ultrasound/Doppler ultrasound of renal arteries
- Ultrasound/Doppler ultrasound of intracranial arteries
- Hip joint ultrasound
- Hip joint ultrasound + orthopaedic consultation (under 1 year of age)
- Hip joint ultrasound
- Knee joint ultrasound
- Elbow joint ultrasound
- Ankle joint ultrasound
- Shoulder joint ultrasound
- Subcutaneous tissue ultrasound (lipomas, fibromas, etc.)
- Post-traumatic muscle haematoma ultrasound
- Lymph node ultrasound
- Laryngeal ultrasound
- Wrist ultrasound
- Ultrasound of ligaments, muscles, small joints
- Metatarsal ultrasound
- Plantar aponeurosis ultrasound
- Finger and metacarpophalangeal joint ultrasound
- Achilles tendon ultrasound
- Urinary tract ultrasound + TRUS
- Trans-fontanelle ultrasound
- Echocardiography — cardiac ultrasound
- Ultrasonography of the eyeballs and orbitals
- Obstetric ultrasound – extended examination (4 D)
- Ultrasound of pleura
- Echocardiography – cardiac ultrasound (foetal)

Endoscopic examinations with endoscopic biopsy specimen sampling:

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

Magnetic resonance imaging with standard contrast agents:

- Magnetic resonance imaging (MRI) of the head
- MR — magnetic resonance head Angio
- MR – magnetic resonance of the head + Angio
- MR – magnetic resonance of the head and the hypophysis
- MR – magnetic resonance of the facial skeleton
- MR – magnetic resonance of the abdominal cavity
- Magnetic resonance imaging of the small pelvis
- MR – magnetic resonance of the bone pelvis
- MR – magnetic resonance of the abdominal cavity and small pelvis
- MR – magnetic resonance of the chest
- MR – magnetic resonance of the lumbar spine
- Magnetic resonance imaging of the thoracic spine (Th)
- Magnetic resonance imaging of the cervical spine (C)
- MR — low-field magnetic resonance
- Magnetic Resonance Imaging (MRI)
- MR – magnetic resonance of the pituitary gland
- Magnetic resonance imaging of the shoulder joint
- Magnetic resonance imaging of the elbow joint
- Magnetic resonance imaging of the knee joint
- Magnetic resonance imaging of the wrist
- Magnetic resonance imaging of the ankle joint
- Magnetic resonance imaging of the hip joint
- MR – magnetic resonance of sacroiliac joints
- MR — magnetic resonance of the foot
- Magnetic resonance imaging of the lower leg
- Magnetic resonance imaging of the thigh
- Magnetic resonance of forearm
- Magnetic resonance imaging of the arm
- Magnetic resonance imaging of the neck
- MR – magnetic resonance – arteriography of lower limb arteries
- MR – magnetic resonance – heart examination with quantitative assessment of systolic function, vitality, perfusion at rest and vitality assessment
- MR – magnetic resonance – Cholangiography MR
- MR – magnetic resonance – mammography MR
- MR – magnetic resonance – heart morphological examination with quantitative assessment of systolic function and vitality assessment
- MR – magnetic resonance – heart examination with quantitative assessment of systolic function
- MR – magnetic resonance – heart examination with quantitative assessment of blood flow
- MR – high-field magnetic resonance, angiography of the great vessels of the chest
- MR – magnetic resonance – renal arteriography
- MR – magnetic resonance – abdominal cavity and cholangiography
- MR – magnetic resonance – carpal arthrography
- Magnetic Resonance Imaging of the adrenal glands

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- Magnetic resonance imaging of the foetus
- Magnetic resonance imaging of the joint with colour chart
- MR – magnetic resonance – shoulder joint – arthrography
- MR – magnetic resonance – knee arthrography
- MR – magnetic resonance – elbow joint
- MR – magnetic resonance – ankle arthrography
- Magnetic resonance imaging - Urography

Computer tomography with standard contrast agents:

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

EEG examinations:

- Standard* EEG
- Standard* EEG (children)

EMG examinations:

- EMG – electromyography – carpal tunnel syndrome

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

Electroneurographic examinations:

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

Scintigraphy examinations:

- Scintigraphy – bones
- Scintigraphy – kidneys (Renoscintigraphy)
- Scintigraphy – heart – exercise
- Scintigraphy – heart – at rest
- Scintigraphy – thyroid gland

Other diagnostic tests and examinations:

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

Note:
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 services 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, CT, MRI and ultrasound diagnostic imaging includes a 2D image with no additional options (including extended genetic ultrasound).

* Standard – commonly available and commonly used in Poland

Allergy tests

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

— Allergologist consultation – qualification for tests

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— **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

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

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

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

- Specific IgE testing: Acarus siro D70 (in dust)
- Specific IgE testing: Alternaria tenuis M6
- Specific IgE testing: Amoxicillin C204
- Specific IgE testing: Aspergillus fumigatus M3
- Specific IgE testing: Ribwort plantain W9
- Specific IgE testing: Banana F92
- Specific IgE testing: Egg white F1
- Specific IgE testing: Silver Birch T3
- Specific IgE testing: Mugwort W6
- Specific IgE testing: Candida albicans M5
- Specific IgE testing: Onion F48
- Specific IgE testing: Chironomus plumosus 173
- Weeds – blend: mugwort (W6), stinging nettle (W20), European goldenrod (W12), ribwort plantain (W9), Chenopodium album (W10)
- Specific IgE testing: Cladosporium herbarum M2
- Specific IgE testing: Chocolate F105
- Specific IgE testing: Cod F3
- Specific IgE testing: Brewer's yeast F403
- Trees – blend: alder (T2), birch (T3), hazel (T4), oak (T7), willow (T12)
- Specific IgE testing: Beans F15
- FP5 – food blend (paediatric): cod (F3), egg white (F1), peanut (F13), cow's milk (F2), soy (F14), wheat flour (F4)
- Specific IgE testing: Ascaris lumbricoides P1
- Specific IgE testing: Gluten (gliadin) F79
- GP4 – late grass blend: sweet vernal grass (G1), perennial rye grass (G5), timothy grass (G6), common reed grass (G7), rye (G12), Yorkshire fog (G13)
- Specific IgE testing: Pea F12
- Specific IgE testing: Pear F94
- Specific IgE testing: Buckwheat F11
- Specific IgE testing: Turkey F284
- Specific IgE testing: Apple F49
- Specific IgE testing: Wasp venom SP.I3
- Specific IgE testing: Bee venom I1
- Specific IgE testing: European hornet venom I5
- Specific IgE testing: Lamb F88
- Specific IgE testing: Whole egg F245
- Specific IgE testing: Barley F6
- Specific IgE testing: Cocoa F93
- Specific IgE testing: Cockroach, German cockroach I6
- Specific IgE testing: Coffee F221
- Specific IgE testing: Casein F78
- Specific IgE testing: Kiwi F84
- Specific IgE testing: Mosquito I71
- Specific IgE testing: Chenopodium album W10
- Specific IgE testing: Dill 277
- Specific IgE testing: Meadow fescue G4
- Specific IgE testing: Cocksfoot G3
- Specific IgE testing: Sweetcorn F8
- Specific IgE testing: Chicken F83
- Specific IgE testing: Dust – blend
- Specific IgE testing: Latex K82
- Specific IgE testing: Lepidoglyphus destructor D71
- Specific IgE testing: Corylus avellana T4
- Specific IgE testing: Carrot F31
- Specific IgE – epidermis blend EP1: dog (E5), cat (E1), horse (E3), cow (E4)
- Specific IgE – mould blend MP1: Alternaria tenuis (M6), Penicillium notatum (M1), Cladosporium herbarum (M2), Aspergillus fumigatus (M3), Candida albicans (M5)
- Specific IgE testing: Cow's milk – Beta-lactoglobulin F77
- Specific IgE testing: Cow's milk F2
- Specific IgE testing: Cow's milk – Alpha-lactalbumin F76
- Specific IgE testing: Mucor racemosus M4
- Specific IgE testing: Mustard F89
- Specific IgE testing: Hamster epidermis E84
- Specific IgE testing: Rabbit epidermis E82
- Specific IgE testing: Sheep epidermis E81
- Specific IgE testing: Guinea pig epidermis E6
- Specific IgE testing: Pigeon faeces E7

- Specific IgE testing: Cucumber F244
- Specific IgE testing: Alder T2
- Specific IgE testing: Hazelnut F17
- Specific IgE testing: Walnut F256
- Specific IgE testing: Peanut F13
- Specific IgE testing: Oats F7
- Specific IgE testing: Respiratory allergen panel
- Specific IgE testing: Mixed panel
- Specific IgE testing: Food panel
- Specific IgE testing: Penicillium notatum M1
- Specific IgE testing: Black pepper F280
- Feather blend EP71: duck feathers (E86), goose feathers (E70), hen feathers, turkey feathers
- Specific IgE testing: Feathers (goose) E70
- Specific IgE testing: Parsley F86
- Specific IgE testing: Duck feathers E86
- Specific IgE testing: Canary feathers E201
- Specific IgE testing: Budgerigar feathers E78
- Specific IgE testing: Orange F33
- Specific IgE testing: Tomato F25
- Specific IgE testing: Wheat F4
- Specific IgE testing: Rye pollen G12
- Specific IgE testing: Dermatophagoides pteronyssinus D1
- Specific IgE testing: Dermatophagoides farinae D2
- Specific IgE testing: Rice F9
- Specific IgE testing: Celery F85
- Specific IgE testing: Cheddar cheese F81
- Specific IgE testing: Horse hair E3
- Specific IgE testing: Cat hair E1
- Specific IgE testing: Dog hair E2
- Specific IgE testing: Soybean F14
- Specific IgE testing: Poplar T14
- Specific IgE testing: Grasses – blend GP1 (orchard grass G3, meadow fescue G4, perennial rye grass G5, timothy grass G6, Kentucky bluegrass G8)
- Specific IgE testing: Strawberry F44
- Specific IgE testing: Tuna F40
- Specific IgE testing: Timothy grass G6
- Specific IgE testing: Tyrophagus putrescentiae
- Specific IgE testing: Pork F26
- Specific IgE testing: Willow T12
- Specific IgE testing: Beef F27
- Specific IgE testing: Potato F35
- Specific IgE testing: Egg yolk F75
- Specific IgE testing: Rye F5
- Specific IgE testing: blend FP2 – fish, crustacean, seafood: cod (F3), shrimp (F24), salmon (F41), mussel (F37), tuna (F40)

Note:
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 services resulting from the scope extensions shall not be covered by the scope of the package.

Pregnancy care

This service includes monitoring of physiological pregnancy by a Physician in Medical Facilities indicated by the Insurer in accordance with the standards of the Operator and consists of active health counseling in the field of physiology of pregnancy and childbirth
can be provided in the fields of:

- Gynaecologist consultation – pregnancy care
- Fasting glucose
- Glucose 75 g, 1-hour glucose challenge test
- Glucose 75 g, 2-hour glucose challenge test
- Blood group (AB0), Rh factor and antibody screening
- Free estriol
- HBs Ab/antibodies
- HBs Ag/antigen
- HCV Ab/antibodies
- HIV-1/HIV-2
- Urine – general analysis
- Blood count + platelet count + automated smear
- Immune antibody screening / alloantibodies (replaces anti-Rh /-/ antibodies)
- Rubella IgG
- Rubella IgM
- Basic syphilis serology (VDRL or USR or anti-TP)
- Standard* Pap smear
- Toxoplasma IgG
- Toxoplasma IgM
- Total Beta-hCG
- Rectal swabs and vaginal swabs towards the HEM pad. GBS
- Vaginal smear for GC
- Endocervical smear for GC (GNC) culture
- Obstetric ultrasound

- Transvaginal obstetric ultrasound
- Transabdominal gynaecological ultrasound
- Transvaginal gynaecological ultrasound

Note:
The service does not cover molecular biology tests and ultrasound examinations include only a 2D image with no extended genetic ultrasound. The tests within the above scope are performed on the basis of a personal maternity record issued to the Insured by a Medical Facility specified by the Insurer. 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 Insured's pregnancy and medical indications for test and examinations not included in the above scheme and the scope of the agreement.

* Standard – commonly available and commonly used in Poland

Preventive health check

Preventive health check – option I is an annual (available once during the Insurance Period) health check, depending on the age and sex of the Insured, including an extended range of examinations and consultations for the Insured over 18 years of age.

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

The scope of the check for Women includes:

— Internist consultation – medical history

— Gynaecological consultation

— Cardiological consultation

— Ophthalmological consultation

— Dermatological consultation with standard* dermatoscopy

— Laboratory tests:
- Urine – general analysis
- Faecal occult blood (FOB)
- Blood count + platelet count + automated smear
- ESR
- GPT/ALT transaminase
- TSH/hTSH
- Creatinine
- Uric acid
- Free T4
- HBs Ag / antigen
- HCV Ab / antibodies
- Standard* Pap smear
- Lipid profile (CHOL, HDL, LDL, TG)
- Fasting glucose

— Imaging examinations:
- Breast ultrasound or mammography – for women, depending on Physician's referral
- PA-chest X-ray – if medical indications exist
- Abdominal ultrasound
- Thyroid ultrasound
- Transabdominal gynaecological ultrasound or transvaginal gynaecological ultrasound

— Functional examinations:
- Echocardiography – cardiac ultrasound
- Resting ECG

— Internist consultation – closing consultation

The scope of the check for Men includes:

— Internist consultation – medical history

— Cardiological consultation

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- Urological consultation
- Ophthalmological consultation
- Dermatological consultation with standard* dermatoscopy
- Laboratory tests:
  - Urine – general analysis
  - Faecal occult blood (FOB)
  - Blood count + platelet count + automated smear
  - ESR
  - GPT/ALT transaminase
  - PSA panel (PSA, FPSA, FPSA / PSA index)
  - TSH/hTSH
  - Creatinine
  - Uric acid
  - Free T4
  - HBs Ag / antigen
  - HCV Ab / antibodies
  - Lipid profile (CHOL, HDL, LDL, TG)
  - Fasting glucose
- Imaging examinations:
  - PA-chest X-ray – if medical indications exist
  - Transrectal prostate ultrasound
  - Thyroid ultrasound
  - Testicular ultrasound
  - Abdominal ultrasound
- Functional examinations:
  - Resting ECG
  - Echocardiography – cardiac ultrasound
- Internist consultation — closing consultation

Note:
The service is available in Medical Facilities indicated by the Insurer. To agree on the review, this fact should be reported using the form available on the website https://www.luxmed.pl/strona¬glowna/kontakt/infolinia.html

* Standard – commonly available and commonly used in Poland

Post-COVID-19 health review

The post-COVID-19 health review is an annual (available 1 time in the insurance period) review covering the scope of examinations and consultations, dedicated to those persons over 18 who have experienced or suspect a coronavirus SARS-CoV-2.
The health check starts with an internist visit when medical history is taken and referrals for examinations (according to the indications) are issued. The health check concludes with an internist consultation, during which the Insured obtains information on their health status and further recommendations. In the case of medical indications, the Insured is referred to additional diagnostic tests which are carried out outside the scope of the health inspection after recovering from COVID-19.

The health check includes:

- Internist telephone consultation – first visit
- Laboratory tests
  - blood count + platelet count + automated smear
  - blood test for COVID-19 IgG antibodies
  - CRP, quantitative
  - NT pro BNP
  - D-dimers
  - Sodium (Na)
  - Potassium (K)
  - Creatinine
  - GPT / ALT transaminase
  - Urinalysis
- Functional examinations
  - Resting ECG
- Imaging examinations
  - Chest X-ray if indicated due to respiratory system condition

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— Internist consultation — closing visit.

Note:
The service is available in Medical Facilities indicated by the Insurer. To agree on a review, this must be reported using the form available at https://www.luxmed.pl/strona¬glowna/kontakt/infolinia.html

Sports Medicine Programme

The Sports Medicine Program is intended for the Insured from the age of 6 years, from the age of 8 years or from the age of 18 years which results from the content of this scope. Services covered by Sports Medicine Programme are performed in selected healthcare centres indicated by insurer and described on the website www.luxmed.pl/program-medycyny-sportowej-placowki. The scope of services which are available under Sports Medicine Programme in the selected healthcare centres, which are mentioned above and indicated by Insurer, may vary depending on location.

The programme includes:

Doctor consultations in sports medicine — from the age of 6 years

The service includes unlimited no-referral access to doctor consultations within the scope of the following specialisations:

- sports medicine specialist
- PTMS-certified specialist

Note:
Consultations in sports medicine which are provided by a sports medicine doctor or/and PTMS-certified (Polish Society of Sports Medicine) specialist are related to sports medicine in the scope of: sports medical examinations which are preformed to identify indications and contraindications to playing sport and increased physical activity, health balance of professional athletes, amateur athletes and physically active persons, prevention of trauma resulting from playing sport, specification of a preliminary diagnostic and therapeutic process, disturbances of post-work out regeneration, certificates for sports schools, sports camps. Consultations in sports medicine do not include sports judicial decisions.

Sports judicial decisions — from the age of 6 years

The service shall include unlimited access without referring to sporting jurisprudence in the field of preliminary, periodic and follow-up examinations for disciplines: motor sports, fingerprinting, judo, stocks, MMA, jujitsu, boxing, taekwondo, kickboxing and other martial arts, lifting loads, other disciplines (e.g. group sports such as football, volleyball).
Depending on your sports disciplines and type of examination (preliminary, periodic, follow-up), the following consultations and diagnostic tests are performed every 6 months:

— Doctor consultations in the scope of the following specializations:
- laryngology (for Scuba diving)
- neurology (for taekwondo, boxing, MMA, jujitsu, other martial arts)
- sports medicine specialist and judicial decisions

— Laboratory tests:
- Blood tests with sample (blood) collection:
    - blood count + platelet count + automated smear
    - Glucose / fasting glucose
- Urinalysis with sample (urine) collection:
    - Urine – general analysis

— Functional examinations:
- ECG at rest
- Spirometry (regarding scuba diving)

— Nursing procedures:
- Blood pressure measurement
- Eye-test (near-sighted and far-sighted with Snellen charts)

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- Anthropometric measurements
- Dental examinations

The judicial examinations are carried out in accordance with the standards of the Operator's sporting judicial tests developed on the basis of the current guidelines of the Central Sports Medicine Centre and in cooperation with the Polish Society of Sports Medicine. The scope of research depends on the sport disciplines practised and the duration of the research, in accordance with the guidelines contained in the Regulation of the Minister of Health of 22 July 2016 on the qualifications of physicians authorised to issue medical certificates to the players on their health condition and on the scope and frequency of required medical examinations necessary to obtain such certificates. The decision is issued by a Physician specialising in sports medicine, and if the Insured is under the age of 23, it may also be issued by a doctor certified by the Polish Society of Sports Medicine (PTMS). In the event of a change in the legal provisions concerning the case law of sports-related benefits within the above scope, including the scope of examinations, may be changed as a result of their adaptation to the generally applicable provisions of law.

Note:
An athlete participating in a sports competition arranged by entities pursuing activity in terms of sports activity in accordance with Article 37, Chapter 7 of the Act on Sport dated 25.06.2010 is subject to the general specialist examinations and diagnostic examinations to the extent necessary for the issuance of a medical opinion on the health condition enabling to safely participate in a sports competition, and in particular to participate in training or sports competitions. A sports medicine Physician having regard to the individual state of health of the Insured, in order to issue a medical certificate, may order additional tests outside the scope of benefits described above.

Functional Movement Screen — from the age of 8 years

The service includes unlimited no-referral access to movement quality assessment by a certified physiotherapist, which includes examination of joint mobility, neuromuscular control, local and global stability and quality of proper motor patterns. The assessment is performed in compliance with LUXMED standards for FMS tests.

Cardio Sport Programme — Basic Cardiology Diagnostics — from the age of 18 years

The service includes unlimited no-referral access to the following tests and examinations under the Cardio Sport Programme. The programme is dedicated to active people and enables to perform a preliminary assessment of the risk of heart problems within basic diagnostics.

The following diagnostic tests are performed under the programme:

— Body composition analysis

— Laboratory tests:

- Blood tests with sample (blood) collection:
  - Blood count + platelet count + automated smear
  - Fasting glucose
  - Creatinine
  - Lipid profile
- Functional examinations:
  - ECG at rest
  - Cardio Sport exercise ECG with discussion of the results obtained, recommendations for the future and a certificate of the Physician performing the examination.

Note:
The programme does not assess all predispositions to sport associated with increased level of exertion and intensity. A Cardio Sport exercise ECG is performed when a Physician assessing the Insured’s resting ECG confirms a lack of medical contraindications for the performance of the examination. The programme is completed with a certificate of no cardiology contraindications for amateur sports activity of increased effort. The certificate issued is not an opinion issued within sports medicine examinations.

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Physiotherapy

As part of the Physiotherapy service, the Insured may have unrestricted access to **physiotherapist consultations**. The service includes: a medical history interview, a functional examination, the physical therapist's advice and procedures necessary to make a diagnosis, adopting an appropriate therapeutic decision and determining the mode of rehabilitation.
The service only includes rehabilitation of the locomotor system and it is provided for the following indications (qualification criteria), i.e. it applies to the Insureds with:

- orthopaedic traumas
- osteoarthritis
- occupational disorders related to the locomotor system (confirmed by a relevant medical certificate)
- neurological pain syndromes
- with muscle tone disorders (refers to neurokinesiological rehabilitation for children up to 18 years of age)
- with postural defects (refers to postural defects rehabilitation for children up to 18 years of age)

The procedures are provided on the basis of referrals from physical therapists or Physicians (specialists in the field of orthopaedics, neurology, neurosurgery, rheumatology, rehabilitation medicine, balneology) from an outpatient Medical Facility indicated by the Insurer, specifying the scope and type of rehabilitation procedures, and includes physiotherapy services available at outpatient Medical Facilities indicated by the Insurer. **The service is unlimited and covers performance of a total of 5 rehabilitation services (neurokinesilogy or postural defects)** in a 12-month Insurance Period.
Physiotherapy covers the following range of physiotherapy and kinesitherapy procedures:

- Physical therapy – electrical stimulation of muscle of the lower limb
- Physical therapy – electrical stimulation of muscle of the upper limb
- Physical therapy – phonophoresis lumbar spine
- Physical therapy – phonophoresis thoracic spine
- Physical therapy – phonophoresis cervical spine
- Physical therapy – phonophoresis wrist
- Physical therapy – phonophoresis lower leg
- Physical therapy – phonophoresis forearm
- Physical therapy – phonophoresis arm
- Physical therapy – phonophoresis hand
- Physical therapy – phonophoresis shoulder joint
- Physical therapy – phonophoresis hip joint
- Physical therapy – phonophoresis knee joint
- Physical therapy – phonophoresis elbow joint
- Physical therapy – phonophoresis ankle joint
- Physical therapy – phonophoresis foot
- Physical therapy – phonophoresis upper leg
- Physical therapy – galvanisation lumbar spine
- Physical therapy – galvanisation thoracic spine
- Physical therapy – galvanisation cervical spine
- Physical therapy – galvanisation wrist
- Physical therapy – galvanisation lower leg
- Physical therapy – galvanisation forearm
- Physical therapy – galvanisation arm
- Physical therapy – galvanisation hand
- Physical therapy – galvanisation shoulder joint
- Physical therapy – galvanisation hip joint
- Physical therapy – galvanisation knee joint
- Physical therapy – galvanisation elbow joint
- Physical therapy – galvanisation ankle joint
- Physical therapy – galvanisation foot
- Physical therapy – galvanisation upper leg
- Physical therapy – ionophoresis lumbar spine
- Physical therapy – ionophoresis thoracic spine
- Physical therapy – ionophoresis cervical spine
- Physical therapy – ionophoresis wrist
- Physical therapy – ionophoresis lower leg
- Physical therapy – ionophoresis forearm
- Physical therapy – ionophoresis arm
- Physical therapy – ionophoresis hand
- Physical therapy – ionophoresis shoulder joint
- Physical therapy – ionophoresis hip joint
- Physical therapy – ionophoresis knee joint
- Physical therapy – ionophoresis elbow joint
- Physical therapy – ionophoresis ankle joint
- Physical therapy – ionophoresis foot
- Physical therapy – ionophoresis upper leg
- Physical therapy – local cryotherapy lumbar spine
- Physical therapy – local cryotherapy thoracic spine
- Physical therapy – local cryotherapy cervical spine

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- Physical therapy – local cryotherapy wrist
- Physical therapy – local cryotherapy lower leg
- Physical therapy – local cryotherapy forearm
- Physical therapy – local cryotherapy arm
- Physical therapy – local cryotherapy hand
- Physical therapy – local cryotherapy shoulder joint
- Physical therapy – local cryotherapy hip joint
- Physical therapy – local cryotherapy knee joint
- Physical therapy – local cryotherapy elbow joint
- Physical therapy – local cryotherapy ankle joint
- Physical therapy – local cryotherapy foot
- Physical therapy – local cryotherapy upper leg
- Physical therapy – low-energy laser therapy lumbar spine
- Physical therapy – low-energy laser therapy thoracic spine
- Physical therapy – low-energy laser therapy cervical spine
- Physical therapy – low energy laser wrist
- Physical therapy – low ¬ energy laser lower leg
- Physical therapy – low energy laser forearm
- Physical therapy – low energy laser arm
- Physical therapy – low energy laser hand
- Physical therapy – low energy shoulder joint laser
- Physical therapy– low energy laser hip joint
- Physical therapy- low energy laser knee joint
- Physical therapy – low energy laser elbow joint
- Physical therapy– low energy laser secondary joint
- Physical therapy – low energy laser foot
- Physical therapy – low energy laser thigh
- Physical therapy – magnetic field lumbar spine
- Physical therapy – magnetic field thoracic spine
- Physical therapy – magnetic field cervical spine
- Physical therapy – magnetic field wrist
- Physical therapy – magnetic field lower leg
- Physical therapy – magnetic field forearm
- Physical therapy – magnetic field arm
- Physical therapy – magnetic field hand
- Physical therapy – magnetic field shoulder joint
- Physical therapy – magnetic field hip joint
- Physical therapy – magnetic field knee joint
- Physical therapy – magnetic field elbow joint
- Physical therapy – magnetic field ankle joint
- Physical therapy – magnetic field foot
- Physical therapy – magnetic field upper leg
- Physical therapy – diadynamic currents lumbar spine
- Physical therapy – diadynamic currents thoracic spine
- Physical therapy – diadynamic currents cervical spine
- Physical therapy – diadynamic currents wrist
- Physical therapy – diadynamic currents lower leg
- Physical therapy – diadynamic currents forearm
- Physical therapy – diadynamic currents arm
- Physical therapy – diadynamic currents hand
- Physical therapy – diadynamic currents shoulder joint
- Physical therapy – diadynamic currents hip joint
- Physical therapy – diadynamic currents knee joint
- Physical therapy – diadynamic currents elbow joint
- Physical therapy – diadynamic currents ankle joint
- Physical therapy – diadynamic currents foot
- Physical therapy – diadynamic currents upper leg
- Physical therapy – interferential currents lumbar spine
- Physical therapy – interferential currents thoracic spine
- Physical therapy – interferential currents cervical spine
- Physical therapy – interferential currents wrist
- Physical therapy – interferential currents lower leg
- Physical therapy – interferential currents forearm
- Physical therapy – interferential currents arm
- Physical therapy – interferential currents hand
- Physical therapy – interferential currents shoulder joint
- Physical therapy – interferential currents hip joint
- Physical therapy – interferential currents knee joint
- Physical therapy – interferential currents elbow joint
- Physical therapy – interferential currents ankle joint
- Physical therapy – interferential currents foot
- Physical therapy – interferential currents upper leg
- Physical therapy – TENS currents lumbar spine
- Physical therapy – TENS currents thoracic spine
- Physical therapy – TENS currents cervical spine
- Physical therapy – TENS currents wrist
- Physical therapy – TENS currents lower leg

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- Physical therapy – TENS currents forearm
- Physical therapy – TENS currents arm
- Physical therapy – TENS currents hand
- Physical therapy – TENS currents shoulder joint
- Physical therapy – TENS currents hip joint
- Physical therapy – TENS currents knee joint
- Physical therapy – TENS currents elbow joint
- Physical therapy – TENS currents ankle joint
- Physical therapy – TENS currents foot
- Physical therapy – TENS currents upper leg
- Physical therapy – ultrasound lumbar spine
- Physical therapy – ultrasound thoracic spine
- Physical therapy – ultrasound cervical spine
- Physical therapy — ultrasound wrist
- Physical therapy – ultrasound lower leg
- Physical therapy – ultrasound forearm
- Physical therapy – ultrasound arm
- Physical therapy – ultrasound hand
- Physical therapy – ultrasound shoulder joint
- Physical therapy – ultrasound hip joint
- Physical therapy – ultrasound knee joint
- Physical therapy – ultrasound elbow joint
- Physical therapy – ultrasound ankle joint
- Physical therapy – ultrasound foot
- Physical therapy – ultrasound upper leg
- Physical therapy – ultrasound therapy (in water)
- Physical therapy – Trabert's current lumbar spine
- Physical therapy – Trabert's current thoracic spine
- Physical therapy – Trabert's current cervical spine
- Physical therapy – Trabert's current wrist
- Physical therapy – Trabert's current lower leg
- Physical therapy – Trabert's current forearm
- Physical therapy – Trabert's current arm
- Physical therapy – Trabert's current hand
- Physical therapy – Trabert's current shoulder joint
- Physical therapy – Trabert's current hip joint
- Physical therapy – Trabert's current knee joint
- Physical therapy – Trabert's current elbow joint
- Physical therapy – Trabert's current ankle joint
- Physical therapy – Trabert's current foot
- Physical therapy – Trabert's current upper leg
- Kinesitherapy – instructional exercises lumbar spine
- Kinesitherapy – instructional exercises thoracic spine
- Kinesitherapy – instructional exercises cervical spine
- Kinesitherapy – instructional exercises wrist
- Kinesitherapy – instructional exercises shank
- Kinesitherapy – instructional exercises forearm
- Kinesitherapy – instructional exercises arm
- Kinesitherapy – instructional exercises hand
- Kinesitherapy – instructional exercises shoulder joint
- Kinesitherapy – instructional exercises hip joint
- Kinesitherapy – instructional exercises knee joint
- Kinesitherapy – instructional exercises elbow joint
- Kinesitherapy – instructional exercises ankle joint
- Kinesitherapy – instructional exercises foot
- Kinesitherapy – instructional exercises thigh
- Kinesitherapy – function-improving exercises lumbar spine
- Kinesitherapy – function-improving exercises thoracic spine
- Kinesitherapy – function-improving exercises cervical spine
- Kinesitherapy – function-improving exercises wrist
- Kinesitherapy – function-improving exercises shank
- Kinesitherapy – function-improving exercises forearm
- Kinesitherapy – function-improving exercises arm
- Kinesitherapy – function-improving exercises hand
- Kinesitherapy – function-improving exercises shoulder joint
- Kinesitherapy – function-improving exercises hip joint
- Kinesitherapy – function-improving exercises knee joint
- Kinesitherapy – function-improving exercises elbow joint
- Kinesitherapy – function-improving exercises ankle joint
- Kinesitherapy – function-improving exercises foot
- Kinesitherapy – function-improving exercises thigh
- Kinesitherapy – individual therapy lumbar spine
- Kinesitherapy – individual therapy thoracic spine
- Kinesitherapy – individual therapy cervical spine
- Kinesitherapy – individual therapy wrist
- Kinesitherapy – individual therapy lower leg
- Kinesitherapy – individual therapy forearm
- Kinesitherapy – individual therapy arm

- Kinesitherapy – individual therapy hand
- Kinesitherapy – individual therapy shoulder joint
- Kinesitherapy – individual therapy hip joint
- Kinesitherapy – individual therapy knee joint
- Kinesitherapy – individual therapy elbow joint
- Kinesitherapy – individual therapy ankle joint
- Kinesitherapy – individual therapy foot
- Kinesitherapy – individual therapy upper leg
- Kinesitherapy – lumbar spine traction
- Kinesitherapy – cervical spine traction
- Myorelaxation therapy – Therapeutic spinal massage
- Individual therapy using neurokinesiology / neurophysiology methods for children
- Kinesitherapy – exercises improving postural defects in children

Note:
The insurance does not cover the costs of physiotherapy in the case of: congenital malformations and their consequences, postural defects, perinatal traumas, chronic connective tissue diseases and their consequences, demyelinating diseases and their consequences, physiotherapy after: surgical procedures not performed as part of LUX MED Group Health Insurance for Companies, coronary events, neurological and cerebrovascular events, physiotherapy with highly specialist methods (mechanical and neurophysiological methods, osteopathic techniques), as well as diagnostic services and functional training, fitness and corrective gymnastics services. The scope of services does not include aseptic necrosis physiotherapy, physiotherapy of scars/keloid scars or post-burn conditions, or visceral manipulation – internal organ therapy.

Respiratory therapy

The offer provides the Insureds, without referring, with a total of three sessions with a physiotherapist during a 12-month medical insurance period indicated by the Insurer, with regard to respiratory therapy.
The offer applies to Insureds above 18 years of age based on the following indications (qualification criteria):

- lung damage and resulting problems with respiratory fitness (oxygen saturation at rest < 94%),
- condition following cardiac injury or history of inflammation such as myocarditis or pericarditis during the period of compensated circulation,
- anxiety, depression, sleep disturbances,
- muscle or joint aches,
- chronic fatigue,
- chronic respiratory diseases (e.g. asthma, COPD, cystic fibrosis).

Note:
The service includes advice from physiotherapist with basic procedures necessary to diagnose and make an appropriate therapeutic decision, including initiation of respiratory therapy. The therapy makes use of breathing techniques and positions for reducing breathlessness, helping effective coughing, and includes general exercise. Contraindications to respiratory therapy are: signs of circulatory failure and advanced respiratory failure; chronic diseases during exacerbation; acute diseases; neoplasms; pulmonary tuberculosis; bronchial asthma requiring hospitalisation; bronchiectasis with profuse secretion and inflammation; conditions associated with haemoptysis and recent haemorrhages. During the treatment, the Insured's health status is monitored. In the event of a threat to the Insured's health, the physiotherapist has the right to refuse to perform the service.

Dentistry

Dental standby duty

The scope of dental Standby duty, depending on the Medical Facility, includes coverage or reimbursement of the cost of dental services listed below up to the maximum amount, i.e. **PLN 350** in each 12-month Insurance Term performed by dentists:

- Emergency tooth pulp devitalisation in a deciduous tooth with cavity dressing
- Emergency tooth pulp devitalisation with cavity dressing
- Emergency dental abscess incision, including drainage
- Emergency periapical abscess decompression

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

Note:
Dental standby duty services are provided exclusively in the event of a sudden onset of an illness or if an accident occurs outside of normal office hours of LUX MED's Medical Facilities. A precondition for obtaining dental standby duty services shall be for the Insured to notify the need to attend a dental standby duty 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 services at a medical facility indicated by LUX MED, 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 services 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 entitled for the reimbursement for whom the services were provided (at least their name, surname and 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. *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 the names 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.*

If, following the service cost reimbursement under the 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 invoices or receipts for services performed for third parties are submitted 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.

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

The amount reimbursed shall be transferred by the Insurer to the bank account number indicated in the Application within 30 days from the date of delivery of the Application. If, within the period specified above, the examination of all the circumstances necessary to establish liability of the Insurer of the amount of to be reimbursed proves impossible, the payment shall be made within 14 days from the day on which, with the observance of due diligence, the examination of these circumstances was possible.

The Reimbursement Application is included in the Appendix to the Group Health Insurance Agreement for Companies and is available at www.luxmed.pl/ubezpieczenia.

Preventive dental care

Dental prophylaxis is a dental examination that involves oral health screening of teeth by a Physician specialising in conservative dentistry and oral hygiene procedures performed by a dental hygienist once during a 12-month Insurance Term at outpatient Medical Facilities indicated by the Insurer 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

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- Instructions on oral hygiene
- Tooth polishing
- Periodontal scaling – complementary
- Periodontal scaling from 1 dental arch
- Periodontal scaling from all teeth
- Deposit removal — sandblasting
- Prophylactic fissure sealing – 1 tooth
- Individual fluoride treatment, topical

Anaesthesia

The service is performed by dentists at outpatient Medical Facilities indicated by the Insurer and covers the following services:
and includes the following services:

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

Conservative dentistry

The service is performed by dentists at outpatient Medical Facilities indicated by the Insurer and includes the following services:

- Specialist consultation – conservative dentistry
- 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
- Restoration of damaged incisal angle with regular light-cured material
- Glass ionomer filling
- Examination of tooth vitality
- Circumpulpar pin inlay
- Cosmetic covering of enamel hypoplasia – composite veneer
- Cosmetic covering of discoloured dentine in anterior teeth – composite veneer
- Treatment of changes of the oral mucosa
- Medicinal dressing on a permanent tooth
- Periodontal pocket irrigation
- Periodontal pocket irrigation and drug application
- Cauterisation of interdental papilla

Paedodontics

The service is performed by dentists at outpatient Medical Facilities indicated by the Insurer and includes the following services, including materials:

- Paedodontic consultation
- 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
- Adaptation visit (children) – dentistry
- Medicinal dressing on a deciduous tooth
- Dentine impregnation – per tooth
- Amputation of devitalised deciduous tooth pulp
- Endodontic treatment of a deciduous tooth
- Treatment of pulp necrosis in a deciduous tooth
- Vital pulp extirpation
  Vital pulp amputation in a tooth with unformed root
- Tooth pulp devitalisation in a deciduous tooth with cavity dressing

Dental surgery

The service is performed by dentists at outpatient Medical Facilities indicated by the Insurer and includes the following services:

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

In addition, the Insured is entitled to a **15% discount** on the following services:

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

Endodontics

The service is performed by dentists at outpatient Medical Facilities indicated by the Insurer and covers the following services:
and includes the following services:

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- Specialist consultation – conservative dentistry
- Tooth pulp devitalisation with cavity dressing
- Chemical and mechanical root canal preparation
- Root canal opening
- Root canal filling
- Crown-root inlay removal

In addition, the Insured is entitled to a **15% discount** on the following services:

- Removal of a fractured tool from the canal under a surgical microscope
- Crown-root inlay removal under a surgical microscope
- 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
- 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 a molar under a surgical microscope stage I
- Endodontal treatment of a molar under a surgical microscope stage II
- Tissue expert assessment in a procedure microscope
- Interventional appointment during endodontic treatment

Prosthodontics

The service is performed by dentists at outpatient Medical Facilities indicated by the Insurer and includes the following services:

- Specialist prosthetic consultation

In addition, the Insured is entitled to a **15% discount** on the following services:

- Full denture with metal palate
- Malocclusion correction
- Models for diagnostic or planning purposes of the doctor
- Crown-root inlay cast metal
- Crown-root inlay cast metal combined
- Crown-root inlay made of gold
- Crown-root inlay made of gold combined
- Crown-root inlay made of gold Metal, ceramic, glass fibre – standard
- Provisional crown using indirect method
- All-metal cast crown
- All-gold cast crown, premolar
- Porcelain crown on metal without margin
- Porcelain crown on gold, premolar
- Porcelain veneer
- Composite crown ONLAY INLAY OVERLAY
- Galvanised telescopic crown, gold
- Latch / bolt / retainer point in frame denture
- Replacement of Rhein inlay – 1 element
- Partial denture supporting 1–4 missing teeth
- Full maxillary denture
- Full mandibular denture
- Frame denture with latches without latch cost
- Frame denture
- Overdenture on gold latch
- Denture repair – 1 element
- Direct denture lining
- Indirect denture lining
- Removal of a prosthetic crown – 1 element
- Partial denture supporting 5-8 missing teeth
- Partial denture supporting more than 8 teeth
- Porcelain crown on gold, molar
- Porcelain crown on gold anterior teeth
- All-gold cast crown, molar
- All-gold cast crown, anterior tooth
- Porcelain crown ONLAY INLAY OVERLAY
- Cementation of a prosthetic crown
- Cementation of a bridge
- Partial denture – 1 point
- Occlusion alignment using articulator
- Functional impression using individual tray
- All-ceramic crown-root inlay
- Crown-root inlay cast metal Stage I
- Crown-root inlay cast metal Stage II
- Crown-root inlay cast metal combined Stage I
- Crown-root inlay cast metal combined Stage II
- Crown-root inlay made of gold Stage I
- Crown-root inlay made of gold Stage II
- Crown-root inlay made of gold combined Stage I
- Crown-root inlay made of gold combined Stage II
- All-metal cast crown Stage I
- All-metal cast crown Stage II
- All-gold cast crown, premolar Stage I
- All-gold cast crown, premolar Stage II

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- All-gold cast crown, molar Stage I
- All-gold cast crown, molar Stage II
- All-gold cast crown, anterior tooth Stage I
- All-gold cast crown, anterior tooth Stage II
- Porcelain crown on metal without margin, Stage I
- Porcelain crown on metal without margin, Stage II
- Porcelain crown on galvanised metal Stage I
- Porcelain crown on galvanised metal Stage II
- Porcelain crown on gold premolar tooth Stage I
- Porcelain crown on gold premolar tooth Stage II
- Porcelain crown on gold molar tooth Stage I
- Porcelain crown on gold molar tooth Stage II
- Porcelain crown on gold, anterior tooth Stage I
- Porcelain crown on gold, anterior tooth Stage II
- Porcelain veneer Stage I
- Porcelain veneer Stage II
- Porcelain crown ONLAY INLAY OVERLAY Stage I
- Porcelain crown ONLAY INLAY OVERLAY Stage II
- Galvanised telescopic crown, gold Stage I
- Galvanised telescopic crown, gold Stage II
- Latch / bolt / retainer point in frame denture Stage I
- Latch / bolt / retainer point in frame denture Stage II
- 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 Stage I
- Partial denture supporting 5–8 missing teeth Stage II
- Partial denture supporting more than 8 teeth Stage I
- Partial denture supporting more than 8 teeth Stage II
- Full maxillary denture Stage I
- Full maxillary denture Stage II
- Full mandibular denture Stage I
- Full mandibular denture Stage II
- Frame denture with latches without latch cost Stage I
- Frame denture with latches without latch cost Stage II
- Frame denture Stage I
- Frame denture Stage II
- WAX UP
- WAX UP INTERDENT
- All-ceramic crown-root inlay Stage I
- All-ceramic crown-root inlay Stage II
- Adhesive bridge – 1 point
- 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
- Rhein latch – 1 element
- Bredent latch – 1 element
- 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
- Metal telescopic crown
- Metal telescopic crown Stage I
- Metal telescopic crown Stage II
- Porcelain veneer posterior
- Porcelain veneer posterior Stage I
- Porcelain veneer posterior Stage II
- Overdenture on gold latch Stage I
- Overdenture on gold latch Stage II
- Gradia gingival mask
- Gradia gingival mask Stage I
- Gradia gingival mask Stage II
- Wax teeth control and correction
- Frame denture metal control and correction
- Splint denture
- Metal crown ONLAY INLAY OVERLAY
- Gold crown inlay
- Spherical inlays
- Protective splint sport
- Protective splint sport colour
- Silver-palladium crown-root inlay
- Silver-palladium crown-root inlay Stage I
- Silver-palladium crown-root inlay Stage II
- Silver-palladium crown-root inlay combined
- Silver-palladium crown-root inlay combined Stage I
- Silver-palladium crown-root inlay combined Stage II
- Models for diagnostic or planning purposes – doctor
- Reinforcement of a denture with an arch
- Reinforcement of a denture with a steel mesh
- Reinforcement of a denture with a gold-plated mesh
- Overdenture on telescopic crowns Stage I
- Overdenture on telescopic crowns Stage II
- ASC bracket
- Face-bow examination and placement in articulator
- Acrylic microdenture
- 1 arch MOCK UP
- 1 point MOCK UP
- Visualisation of prosthodontic treatment on a model
- Teflon replacement
- All-composite crown
- Composite crown on glass fibre
- All-porcelain crown on zirconia
- All-porcelain crown on zirconia Stage I
- All-porcelain crown on zirconia Stage II
- All-ceramic crown
- All-ceramic crown
- All-ceramic crown

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- Maryland missing tooth restoration – acrylic
- Maryland missing tooth restoration – composite

Orthodontics

The service is performed by dentists at outpatient Medical Facilities indicated by the Insurer and includes the following services:

- Orthodontist consultation

In addition, the Insured is entitled to a **15% discount** on the following services:

- Wide-arch braces Bi-helix, Quad – helix
- Block braces with modification
- Derichsweiler apparatus
- Removable braces
- Fixed braces – closed metal 1 arch
- Stochfisch braces
- One brace of metal, transparent braces
- One brace of metal, fixed braces
- Lip-bumper
- Braces repair, arch wire replacement
- Braces repair, 1 screw replacement
- Braces repair, 2 screws replacement
- Braces repair, plate breakage
- Braces repair, addition of a wire element
- Nance plate
- Vestibular plate
- Chin cap
- Palatal expander
- NiTi palatal expander
- Retainer 1
- Retainer 2
- Retainer 3
- Orthodontist consultation in the course of treatment with removable braces
- Orthodontist consultation in the course of treatment with fixed braces
- Headgear
- Removal of fixed braces
- Visit with a chin cap
- Visit with cusp grinding
- Occlusal analysis and treatment plan development
- Block braces
- One wire arch of fixed braces porcelain brackets
- One wire arch of fixed metal braces
- Orthodontist's consultation with an impression
- Braces repair replacement of 1 element
- Braces repair replacement of 2 elements
- Braces repair replacement of 3 elements
- Visit with a vestibular plate
- Follow-up visit in the course of treatment with removable braces
- Follow-up visit in the course of treatment with fixed braces x 1
- Replacement of a metal bracket
- Replacement of a porcelain bracket
- 1/3 segment arch
- 1/2 segment arch
- Follow-up visit – fixed braces, metal brackets
- Follow-up visit – fixed braces, crystal brackets
- One wire arch of fixed braces crystal brackets
- One wire arch of fixed braces metal brackets
- Removable braces – Schwarz plate
- Fixed braces – aesthetic brackets 1 arch
- Hyrax braces
- Pendulum braces
- Fixed braces – aesthetic brackets part of arch 1
- Fixed braces – aesthetic brackets part of arch 2
- Wide-arch braces Bi-helix, Quad – helix Stage I
- Wide-arch braces Bi-helix, Quad – helix Stage II
- Block braces Stage I
- Block braces Stage II
- Removable braces – Schwarz plate Stage I
- Removable braces – Schwarz plate Stage II
- Hyrax braces Stage I
- Hyrax braces Stage II
- 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 with metal brackets Stage I
- One wire arch of fixed braces with metal brackets Stage II
- Braces repair
- Pendulum braces Stage I
- Pendulum braces Stage II
- Nance braces
- Retention control
- Stripping – 1 tooth
- Acrylic bite splint
- Headgear application
- Retention plate
- Retention arch application – maxilla
- Retention arch application – mandible
- Removal of retention arch
- Fixed braces – metal, non-ligature brackets 1 arch
- Fixed braces – aesthetic, non-ligature brackets 1 arch
- TWIN-BLOCK braces
- TWIN-BLOCK braces Stage I
- TWIN-BLOCK braces Stage II
- Follow-up visit – fixed braces, porcelain brackets
- Hass braces
- Space maintainer
- Clear aligner impression

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- Clear aligner follow-up
- Braces repair, 1 arch wire replacement ceramic brackets
- Braces repair, 2 arch wires replacement ceramic brackets
- Braces repair, 1 arch wire replacement metal brackets
- Braces repair, 2 arch wires replacement metal brackets
- Additional orthodontic element 1
- Additional orthodontic element 2
- Additional orthodontic element 3
- Replacement of an aesthetic bracket
- Vestibular plate – infant trainer
- Fixed braces – aesthetic, non-ligature Damon brackets 1 arch
- Fixed braces – metal, non-ligature Damon brackets 1 arch
- Follow-up visit in the course of treatment with fixed braces with non-ligature Damon brackets – 1 arch
- 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
- Multi-P braces
- Multifunctional braces Molar rotator
- Expander braces
- TWIN-BLOCK braces with a screw – modified
- TWIN-BLOCK braces with a screw – modified Stage I
- TWIN-BLOCK braces with a screw – modified Stage II
- Herbst hinge
- Herbst hinge Stage I
- Herbst hinge Stage II
- Carriere Distalizer
- Guray / OBC wedging
- Fragmentary fixed braces
- Fixed braces – 2D lingual brackets 1 arch
- Replacement of a 2D lingual metal bracket
- Follow-up visit – fixed braces, 2D lingual brackets
- Braces repair, 1 arch wire replacement 2D lingual brackets
- Braces repair, 2 arch wires replacement 2D lingual brackets
- MALU appliance
- Wide-arch braces – palatal arch
- Wide-arch braces – tongue arch
- Fixed metal braces 2x4
- Orthodontic acrylic splint
- Class II corrector
- One wire arch of fixed braces individual lingual brackets
- One wire arch of fixed braces individual lingual brackets Stage I
- Wire arch replacement individual lingual brackets
- Replacement of an individual lingual bracket
- One wire arch of fixed braces individual lingual brackets Stage II
- System Benefit braces Stage I
- System Benefit braces Stage II
- Flexible orthodontic appliance
- Tooth separation procedure
- Follow-up visit in the course of treatment with fixed partial braces
- Attachment of a metal bracket
- Attachment of a crystal bracket
- Retention arch application
- Fixed aesthetic braces 2x4
- Fixed aesthetic braces 2x4 Stage I
- Fixed aesthetic braces 2x4 Stage II
- One wire arch of fixed braces nickel-free brackets
- One wire arch of fixed braces nickel-free brackets Stage I
- One wire arch of fixed braces nickel-free brackets Stage II
- Retainer arch 1 tooth
- Orthognathic treatment planning
- Plate denture for children
- Plate denture for children Stage I
- Plate denture for children Stage II
- Retainer arch 6 teeth
- Models for diagnostic or planning purposes of the orthodontist

Biological dentistry

The service is performed by dentists at outpatient Medical Facilities indicated by the Insurer and covers the following services:

In addition, the Insured is entitled to a **15% discount** on the following services:

- Saliva-Check Buffer (GC) test
- Streptococcus mutans saliva concentration using Saliva-Check Mutans (GC)
- Tri Plaque ID Gel (GC) control
- 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
- Tooth decay infiltration – ICON (DMG)
- Minimally invasive tooth decay treatment using glass hybrid technology – EQUIA FORTE
- Application of bioactive dentin substitute – Biodentine (Septodont)
- Bioreconstruction of lost tooth tissue using ACTIVA (Pulpdent)
- Restoration of lost tooth tissue using BPA-free Gaenial
- Local application of MI VARNISH (GC) releasing bioavailable calcium, phosphate and fluoride
- Sustaining therapy Maintenance treatment using bioavailable calcium, phosphate and fluoride – GC MI Paste Plus
- Enamel remineralisation with a Tooth Mousse preparation

Periodontology

The service is performed by dentists at outpatient Medical Facilities indicated by the Insurer and includes the following services:

- Specialist periodontal consultation

In addition, the Insured is entitled to a **15% discount** on the following services:

- Treatment of oral mucosa lesions – ozonotherapy – doctor
- Simple curettage within 1/4 of dental arch
- Open curettage within 1 tooth
- Teeth immobilisation with wire ligature – tooth
- Immobilisation of the rail tooth of composite – 1 tooth
- Immobilisation of the rail 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
- Periodontol Tunnelling
- Preparation of a written plan and costs of periodontal treatment
- Regular curettage within 1 tooth
- Root planning 1/2 arch
- 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)

Implantology

The service is performed by dentists at outpatient Medical Facilities indicated by the Insurer and includes the following services:

- Specialist implantological consultation

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In addition, the Insured is entitled to a **10% discount** on the following services:

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

Treatment of functional disorders of the masticatory apparatus

The service is performed by dentists at outpatient Medical Facilities indicated by the Insurer and covers the following services:

In addition, the Insured is entitled to a **10% discount** on the following services:

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

Aesthetic dentistry

The service is performed by dentists at outpatient Medical Facilities indicated by the Insurer and covers the following services:

In addition, the Insured is entitled to a **10% discount** on the following services:

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

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- Teeth whitening using external method – supplemental set – dental hygienist
- Teeth whitening Beyond lamp 1 dental arch
- Teeth whitening Beyond lamp 2 dental arches
- Whitening of group of teeth using external method – 1 dental arch using LED lamp

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

The service includes provision of the following services in outpatient medical clinics indicated by insurer, based on a referral from a dentist from these facilities, and includes the following services:

- Single tooth X-ray
- Panoramic X-ray

Guarantee

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

Note:
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).

The service does not cover services provided under general anaesthesia.

House calls

The service is provided by an emergency doctor at the place of residence of the Insured, if the place of residence is within the current territorial scope of the home visits. Home visits shall be carried out only in medically justified cases, which prevent the Insured from arriving at an outpatient medical facility indicated by the Insurer, excluding any state of imminent danger to life. The reasons making it impossible for the Insured to report to the Medical Facility do not include either inconvenient access to the clinic or obtaining a prescription or a medical certificate for leave.
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 at the Medical Facilities indicated by the Insurer. In the case of a home visit, it is impossible to freely choose the Physician. A house call request is accepted or refused by a medical dispatcher (indicated by the Insurer) based on the information provided.
The current territorial scope of the home visits is described at www.luxmed.pl. In cities where home visits are not provided, the Insured will be reimbursed. Details of the reimbursement can be found on the above website. Reimbursement shall be considered reasonable only upon prior qualification of the Insured for a home visit by the dispatcher.

Ambulance team intervention in the workplace

The service 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 made by a medical dispatcher (indicated by the Insurer) after a conversation with the Insured or witness of the event.
Depending on the situation, the service 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 Insured'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 service is not an alternative to the services provided under the National Emergency Medical Service System. The service is not limited.

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Ambulance team intervention in the place indicated

The service is available to the Insured exclusively for sudden onsets of illnesses and accidents. A sudden onset of an illness covered by the service 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 service 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 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 service is not an alternative to the services provided under the National Emergency Medical Service System. The service is not limited.

Nursing care away from medical centers

The service is offered when the Insured is unable to arrive at a Medical Facility indicated by the Insurer due to their medical condition, based on recommendation of a Physician from the facility. Reasons preventing the Insured from going to the facility shall not include the convenient arrival at the facility. the Service shall be performed by a nurse (a limit of up to **10 nurse visits** in the 12-month insurance period) at the place of residence of the Insured and shall include procedures not requiring the presence of a doctor, in the following scope:

- nursing service (injection)
- drawing blood for analysis
- dressing change
- establishing an EKG Holder (24 h) at the Insured's home
- insertion / replacement of Foley catheter

The service includes: traditional gauze or cotton wool wound dressings, bandages, cannulae, syringes, cotton swabs, adhesive strips, needles, disinfection agents used for the above procedures. Nursing services are available every day, from 8 am to 8 pm. within the administrative boundaries of cities and their surrounding areas, where there are Medical Facilities indicated by the Insurer for the service – a detailed territorial coverage is described on www.luxmed.pl. The services shall be provided only in the planned mode and shall be reported to the dispatcher at least 24 hours before their execution.

Medical transport

The service 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:

- necessity to ensure continuity of treatment,
- the need for treatment at a specialised facility.

The service 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 service. 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 will be transported and the consent from the destination (confirmation of receipt). In justified cases, the Insurer may request additional information concerning the conditions of transport and limitations resulting from the health condition of the Insured. The service 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 service is a separate service from the transport carried out within the hospital module in the LUX MED Group Insurance Agreement.

Second Medical Opinion

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

Each report covered by the above scope is comprehensively analysed by the best medical specialists in the world, selected based on a patented medical analytical process. A recognised medical specialist reviews the diagnosis or treatment plan suggested by the treating doctor of the Insured, and then presents his/her detailed recommendations. As part of the process of a second medical opinion, medical records, the results of imaging studies and specimens for histopathological examination are collected. A specialist Physician performs a detailed review of all the data, and then prepares a comprehensive report that confirms the earlier diagnosis and treatment, or recommends its change in the form of a report, with a translation into Polish. As part of the service, the Insured may also obtain from the specialist answers to basic questions about the particular condition via e-mail, without presenting a full medical records, but only on the basis of a detailed phone interview.
In addition, the Insured is entitled to receive, in the form of a report, a proposal of three specialists from outside of Poland, with the best competence for further treatment, as well as to be provided help in the organisation of consultations with the selected medical specialist. The service includes assistance outside of Poland (but not the costs) in arrangement of appointments with doctors, handling of therapy-related tasks, hospital admission arrangement, visits, hotel accommodation, transport and insured service, medical care monitoring, medical care quality control, handling and correctness of payments charged and negotiation of favourable discounts on health services.

Medical case consultation

The service includes the arrangement of medical case consultation for the Insured in Poland, consisting of prominent Polish doctors. This service is available only for complicated medical cases and its purpose (if possible) will be to determine further diagnostic and therapeutic management of the Insured. The fees of consultation participants are covered by the Insured with a **30% discount**.

Oncological Preventive Health Care Programme

The Oncological Preventive Health Care Programme is a preventive health check directed towards early detection of the most frequent malignant neoplasms. The Cancer Prevention Programme is intended exclusively for Employees (Main Insured) aged 18 to 70.

The programme includes:

Preventive examinations

The service includes conducting a medical interview **1 time** in the 12-month insurance period, issuing referrals for tests in accordance with medical indications and current recommendations of scientific societies, taking into account age, gender, family interview and individual oncological risk factors, as well as an internist closing consultation where the Employee obtains recommendations for the future concerning his/her health condition, including recommendations on how to reduce the risk of malignant neoplasm.

The scope of individual prevention covers:

— Internist consultation – medical history

— Dermatological consultation with standard* dermatoscopy

— Referral laboratory tests:

- Blood count + platelet count + automated smear
- PSA panel (PSA, FPSA, FPSA / PSA index)
- Standard* Pap smear

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- Referral imaging and endoscopic tests:
  - Abdominal ultrasound
  - Breast ultrasound
  - Classic mammography (RTG)
  - Transvaginal gynaecological ultrasound
  - CT – chest computed tomography (low-dose protocol)
  - Colonoscopy with local anesthesia
- Internist consultation – programme closing consultation

Note:
The service is available at selected Medical Facilities specified by the Insurer and described at www.luxmed.pl/program-profilaktyki-onkologicznej-LUXMED-placowki

Coordination of diagnostics
The service shall include the support of the oncological coordinator in the case of suspected presence of a malignant neoplasm confirmed by physicians of medical facilities indicated by the Insurer in the scope of:

- advising on:
  - methods of obtaining a diagnosis and oncological treatment card (DiLO) entitling to the so-called rapid path of oncological diagnostics
    and possible publicly funded treatments (NFZ),
  - selection of publicly funded specialised oncology centres (NFZ) suitable for the diagnosis and treatment of individual malignant neoplasms,
- assistance in arranging a first visit to a publicly ¬ funded specialist oncological diagnostics facility recommended by the Insurer (NFZ),
- organisation and issuance of an Oncological Opinion, i.e. issuance by an oncologist indicated by the Insurer, of a medical opinion on the basis of medical documentation presented by the Employee, confirming the diagnosis of a malignant neoplasm. The Insurer shall ensure that up to one oncological opinion is issued for the diagnosis of one neoplastic disease.

Note:
The Employee shall be entitled to an Oncological Opinion within 30 days after the confirmation of diagnosis of a malignant neoplasm before the commencement of treatment and shall be carried out within 10 business days from the date of submission of the application for an oncological opinion, provided that the application for an oncological opinion is submitted within 20 days from the date of confirmation of diagnosis of a malignant neoplasm. If the Employee started treatment before submitting the application for an oncological opinion or the Employee has expired or the DiLO card has been closed – in such cases, the Employee shall not be entitled to an Oncological Opinion.

The coordination of diagnostics shall be available to the Employee also within 3 months after termination, expiration of the Insurance Agreement or removal of the Employee from the List of Insureds (Insurance Agreement), provided that the suspicion of a malignant neoplasm confirmed by physicians of medical facilities indicated by the Insurer occurred before termination, expiration of the Insurance Agreement or removal of the Employee from the List of Insureds (Insurance Agreement).

Education
The service shall include carrying out at the registered office of the Policyholder the number of educational days in the 12-month insurance period previously agreed with the Insurer, consisting of:

- preventive seminar,
- individual preventive consultations of the oncological nurse.

Note:
The educational day is provided each time for a group of up to 300 Employees.

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* Standard – commonly available and commonly used in Poland

HARMONIA in Business: a Prevention Programme

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 Insureds 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 Policyholder 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.

The Programme includes:

Analysis

In this Module, once in the 12-month Insurance Period, an anonymous survey is conducted among all the Main Insureds 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 Insureds via a dedicated link provided to the Insuring Party.
The Prevention Survey is designed to investigate the well-being of the Main Insureds 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 Insureds 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 Policyholder 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.

Education

In this Module, once in the 12-month Insurance Period, one (1) educational day is held at the Policyholder'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 Insureds 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.

Note:
Every group consisting of 100 Main Insureds signed up for the Programme is entitled to one educational day. Every subsequent prevention seminar extending beyond the scope of the Programme is performed on the basis of an additional order for a separate remuneration in the amount of PLN 2,600 (in words: two thousand six hundred zlotys).
The seminar may be performed remotely in the form of a webinar. The Insurer will inform the Policyholder of the link location and its availability dates.

Psychotherapy

This module provides the Main Insured 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 service is available at selected Medical Facilities specified by the Insurer and described at https://harmonia.luxmed.pl/harmonia-w-biznesie-program-profilaktyczny-wykaz-placowek/

Notes:
Sessions with a psychotherapist as part of the service 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 used is made by the psychotherapist upon reviewing the Patient's medical condition, problems and expectations. The psychotherapist 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 services will be provided on the basis of a facility's price list.

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.

Notes:
The services in the form of a 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.

VIP Patient's Personal Caretaker

Each Insured is assigned a VIP Patient Personal Caretaker. The Caretaker is in constant contact by phone with the Insured, organises medical examinations and consultations in selected outpatient medical facilities indicated by the Insurer.

Package availability Option – Silver

Service consisting in ensuring improved access to Specialist Physicians — the availability time for the Silver Option is higher than 70%. Under the option, the Insured shall be entitled to Reimbursement of the costs of benefits under the terms and conditions set forth below.
The Insurer shall reimburse the costs incurred by the Insured in the amount of 70% of the unit price provided during the Reimbursement Period at a Medical Facility other than the one indicated by the Insurer, of the Outpatient Service to which the Insured is entitled under the Agreement and the Scope of Insurance held, up to the Reimbursement Limit of PLN 650 per Insured per quarter.

Package availability Option – Gold

Service consisting in ensuring improved access to Specialist Physicians – the availability time for the Gold Option is higher than 80%.
Under the option, the Insured shall be entitled to reimbursement of the costs of benefits under the terms and conditions set forth below.
The Insurer will reimburse the costs incurred by the Insured in the amount of 90% of the unit price performed during the Reimbursement Period in a Medical Facility other than indicated by the Insurer, of the Outpatient Benefit to which the Insured is entitled under the Agreement and the Scope of Insurance held, up to the Reimbursement Limit of PLN 650 per Insured per quarter.

Package availability Option – Platinum

Service consisting in ensuring improved access to specialists' physicians – the availability time for the Platinum Option is higher than 90%. Under the Option, the Insured shall be entitled to reimbursement of the costs of benefits under the terms and conditions set forth below.

The Insurer will reimburse the costs incurred by the Insured in the amount of 100% of the unit price performed during the Reimbursement Period in a Medical Facility other than indicated by the Insurer, of the Outpatient Services to which the Insured is entitled under the Agreement and the Scope of Insurance held, up to the Reimbursement Limit of PLN 650 per Insured per quarter.

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

The Insured is entitled to a **10% discount** on medical services offered by Medical Facilities indicated by the Insurer – this applies to LUX MED and Medycyna Rodzinna [Family Medicine] facilities listed on www.luxmed.pl. The discount is calculated from the prices applicable at the aforementioned facilities. Discounts cannot be combined.

10% discount on medical procedures provided at PROFEMED

Each Insured is entitled to a **10% discount** on all medical services provided at the PROFEMED facility. For information on the services provided, visit www.profemed.pl. The discount is calculated from the prices applicable at the aforementioned facilities. Discounts may not be combined.

10% discount on medical procedures provided in the LUX MED Hospital

The Insured is entitled to a **10% discount** on all medical procedures provided at the LUX MED Hospital indicated by the Insurer. The discount is calculated from the price list available at the aforementioned facilities. Discounts cannot be combined.

10% discount on medical procedures provided in the Carolina Medical Center Hospital

The Insured is entitled to a **10% discount** on all medical procedures offered by Sport Medica SA at Carolina Medical Center (detailed information about the facility is available on www.carolina.pl). The discount is calculated from the price list available at the above-mentioned facility. The discount does not include prices of such medical materials as lightweight casts, implants, orthotics, stabilisers, orthopaedic fixations, sutures of meniscus, and prices of drugs for intra-articular and intravenous injections. Discounts cannot be combined.

Appendix no. 2 to the General Terms and Conditions of LUX MED Group Insurance – OWU [GTC] CODE G/001/2023/C

Scope of benefits:	Orthopaedic Care	Orthopaedic Care Plus	Full Care
Hospital services:			
Hospitalisation	**Orthopaedics (based on referral to a hospital)**	**Scheduled Orthopaedic**	✓
Psychological consultations			✓
Obstetrics and neonatal services			✓
Medical care prior to hospitalisation	**As regards Orthopaedics**	**As regards Scheduled Orthopaedics**	✓
Medical care after Hospitalisation	**As regards Orthopaedics**	**As regards Scheduled Orthopaedics**	✓
Rehabilitation	**As regards Orthopaedics**	**As regards Scheduled Orthopaedics**	✓
Emergency care including:		✓	✓
Hospital Health Check		✓	✓
Hospital Care Coordination	**As regards Orthopaedics**	✓	✓

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THE SCOPE OF BENEFITS UNDER THE LUX MED HOSPITAL INSURANCE, FOR THE MAIN INSURED, PARTNER AND ADULT CHILD.

SECTION I: HOSPITAL SERVICE

Module: LUX MED Orthopaedic Care Hospital Insurance

§1 Hospitalisation

Hospitalisation caused by accident (with a referral to an operation or procedure resulting from a trauma occurring during the insurance coverage period of Orthopaedic Care and performed within 30 days of its occurrence). 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:

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. hospitalisation with the aim of planned use of pharmacology therapy of chronic diseases;
        IV. diagnostics and treatment of the consequences of strokes;
        V. 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.

3. **General surgery**
    a. includes general surgery procedures;
    b. it does not include:
        I. surgical obesity treatment;
        II. thoracic surgery (i.e. thoracosurgery).

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.

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.

9. **Spinal neurosurgery**
    a. includes neurosurgery procedures of intervertebral discs;
    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;

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IV. procedures involving the spinal cord and nerve roots.

10. **Oncology**
   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.

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 Cardiology, 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. High-Risk Pregnancy care;

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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.

PART 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 pregnancy care.

§2 Medical care after Hospitalisation

1. Care after Hospitalisation includes 3 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.
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 physiotherapy in accordance with the recommendations of medical or physiotherapeutic personnel after orthopaedic procedures for up to 6 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 10 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 6 weeks after the procedure.
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).
4. Rehabilitation is provided only in relation to the Service provided under the Insurance Agreement.

PART 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.

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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:

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.

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6. We may deviate or limit the scope of the Hospital Health Check in cases of medical contraindications to certain examinations.

PART 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.

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.
   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/001/2023/C

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

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SECTION I: HOSPITAL SERVICE

Module: LUX MED Orthopedic Care Hospital Insurance

§1 Hospitalisation

Hospitalisation caused by an Accident (with a referral to an operation or procedure resulting from a trauma occurring during the insurance coverage period of the Orthopaedic Care and performed within 30 days of its occurrence). 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.

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.

§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:

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. Hospitalisation with the aim of planned use of pharmacology therapy of chronic diseases;
   IV. diagnostics and treatment of the consequences of strokes;
   V. 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.

3. **Paediatric surgery**
   a. includes general surgery procedures;
   b. it does not include:
      I. surgical obesity treatment;
      II. thoracic surgery (i.e. thoracosurgery).

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.

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.

   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

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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. terms
   d. determining the date of a surgery or procedure;
   e. 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 pregnancy care.

§2 Medical care after Hospitalisation

1. Care after Hospitalisation includes 3 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.

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 covers the necessary procedures in the field of physical therapy and physiotherapy in accordance with the recommendations of medical or physiotherapeutic personnel after orthopaedic procedures beginning within 2 weeks from the date of orthopaedic surgery and lasting for up to 6 weeks from its beginning;

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 ours.

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).

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:

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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.

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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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 (02-676) at ul. Postępu 21C (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.

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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.

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Wysokość kapitału zakładowego: 4,800,000.00 euro

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 (02-676) at ul. Postępu 21C (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

<table>
<tr><td></td><td colspan="2">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.</td></tr>
<tr><td rowspan="7">What is the purpose of processing of personal data?</td><td colspan="2">We process personal data as an insurance entity and the purpose of this processing is the insurance risk 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</td></tr>
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	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.
To whom we transfer your personal data?	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, • 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

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	protection regulations.
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