GENERAL CONDITIONS

Please check your Insurance Certificate/Membership Certificate and make sure that all details are correct.

If any changes need to be made, please let Us know immediately.

Please familiarise yourself with your Policy and make sure that you are fully aware of the following issues:

- The coverage (both benefits and limitations),
- How the Policy is administered,
- How to use the Policy, including receiving Treatment and submitting Claims.

General conditions are listed below providing all the information you will need, from receiving Treatment to having any health care expenses settled.

MEDISKY INTERNATIONAL

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MEDISKY INTERNATIONAL

1. CONTRACT OBJECTIVES

Your MediSky International Plan is a Healthcare Plan, Insured by Inter Partner Assistance S.A. Oddział, hereafter referred to as "the Insurer" and reInsured by AXA PPP healthcare Limited. Some aspects of the administration of your Policy is also undertaken by AXA Global Healthcare (UK) Limited and/or AXA Life & Health Reinsurance Solutions (part of the AXA Group, one of the world's largest Insurance brands).

The Policy is subject to Polish law.

The General Terms and Conditions describe all benefits which are available in the frame of the selected programme, but the cover which will be provided to the Insured Person or Policyholder will be in accordance with the programme as shown in the Insurance Certificate/Membership Certificate issued to the Insured Person or the members and in the Table of Benefits. Any benefit which is not provided by the programme cannot be granted. We will pay charges for Pre-authorised, appropriate, Medically Necessary Conventional Treatment for eligible medical conditions subject to Reasonable and Customary charges authorised during the Period of Insurance.

Your Insurance Plan covers you up to the overall maximum level of annual coverage of € 50 000 where some parts of the coverage have their own separate limits as listed in the Table of Benefits less any chosen Deductible.

1.1. UNDERWRITING CHOICE

Your Policy is designed to cover Treatment of new medical conditions that begin after you and your Dependants join the Plan.

Your underwriting terms depends on the underwriting choices you joined on.

We rely on the information that has been provided to Us at the time of the Application to determine if We will accept the Application and if to apply any special terms on Your cover, such as personal medical exclusions or We may decide not to offer You cover.

If We find out that the information that was provided were incomplete, misleading, or false information of any kind at any time, We reserve the right to terminate the insurance from its inception date without refund of any premiums paid, and to require the Insured Persons to refund back to us any claims We have paid to You or on Your Insured Person's behalf.

If changes occur after the information was provided to Us (examples such as Insured person's state of health (including Dependants), occupation, or residential address, etc.), You must advise us in writing as soon as possible. We reserve the right to revise the terms of this insurance should that occur, or to terminate this insurance entirely.

1.1.1. Individual Plans

Full Medical Underwriting (FMU)

Under this underwriting option, you will be required to complete an application form and health declaration statement(s), declaring you and your Dependants medical history, which will be assessed by Our underwriter. All Pre-Existing Conditions or Treatment you and your Dependants have received or suffered from, or any signs and symptoms before your Insurance started under this Policy, will not be covered, unless you have declared this in the application form and health declaration statement(s) and We have agreed in writing to provide cover. Your Insurance Certificate/Membership Certificate will detail any medical exclusions and/or limitations endorsed on this Policy.

Continued Personal Medical Exclusions (CPME)

If you have an existing Policy, you can use CPME underwriting to transfer your private medical Insurance cover over to Us on the same individual underwriting terms that were applied by the previous Insurer, providing that continuous cover is maintained. However, any medical exclusions or restrictions that were imposed on your private medical Insurance cover by your previous Insurer will also continue under your cover with Us. **Please note:** if you are transferring on a CPME basis, We reserve the right to exclude additional symptoms or conditions according to the information provided in the health declaration statement(s).

For all individual Plans, the minimum attained age at entry for a Policyholder is 18 years old. In the case of an applicant being under the attained age of 18 years, a parent or guardian is required to sign the Application form and the parent or guardian shall be the Policyholder.

1.1.2. Group Plans

There is a possibility for a group Insurance Plan to be concluded by the Employer/company for their employees. This depends on Us accepting the Group application, Individual Group member application form and health declaration statement(s) completed by the Employees, if the underwriting terms are on FMU or CPME.

FMU/CPME underwriting is applicable for groups from 3 – 19 Employees.

If the underwriting terms are on Medical History Disregarded (MHD), We require a Group application and Group membership census. This applies if the Insured Person has joined the Plan as a member of a group or company scheme with 20 or more Employees, age up to 64 (sixty-four) Years old at the start date and the group or company has selected MHD underwriting terms. No Pre-Existing Conditions conditions will be excluded under the Plan when agreed by Us. The Plan will be subject to the General Terms, Conditions including exclusions and limitations in this Policy. For any applicant who is older than 64 (sixty-four) Years old at their date of application, We will require the applicant to submit an individual application form and health declaration statement for the underwriter's assessment.

For all application types based on the underwriting choice mentioned above, the Insured Person's eligibility depends on Us accepting his/her application and health declaration statement and the current Principal country of residence. We will advise the Policyholder/Insured Person if We are able to offer cover in that country.

If We accept the application and during the period of cover or at renewal the Insured Person's Principal country of residence changes, the Policyholder/Insured Person must contact Us immediately. We will advise if We can continue the cover, and this may result in an adjustment to the premiums due. In some instances, if We are unable to continue with the Policy when there are changes in the risks including the Principal country of residence, We will inform when the Policy/cover will be terminated.

2. BENEFITS AND SERVICES

2.1. COVERED PERSONS

The covered persons may be:

- Either:

2.1.1. The Insured Person

The Insured Person alone.

Newly Insured applicants are eligible to be included for cover under this Policy provided they are under age 69 (sixty-nine) at their date of acceptance, subject to completion of the appropriate individual application form and health declaration statement. For an applicant, under MHD underwriting, if the member is 65 (sixty-five) Years and above, We will require the applicant to similarly submit the individual application form and health declaration statement.

The Insured Person is not the contracting person and does not enter any agreement with Us, only the Policyholder can do this. The Policyholder and We have legal rights under this Policy and We send notices to the Policyholder which is the only entity We have contractual obligations to under the Policy.

For Individual policies, If none of the Insured Persons to be included on the plan are 18 or above at the date of application, the application will be subject to our acceptance, and their parent or legal guardian must apply for them. The parent or legal guardian will act as the Policyholder, the legal owner of the Policy and will be responsible for the policy administration, for understanding and acting according to the policy terms and conditions.

- Or:

2.1.2. The Insured Person (Policyholder) and the Dependants appointed hereinafter:

- Current Legal Spouse or civil partner or any person living permanently in a similar relationship with the Insured Person (Policyholder) irrespective of gender;
- Child, natural, step-child or legally adopted child if he/she is under age 18 and unmarried, dependent children aged 18 to 25 must be in continuous full-time education;
- Only one Spouse can be considered as a Dependant.

At the date of enrolment, the Policyholder and the Dependants acquire the status of Insured Person as soon as they are enrolled in the Insurance Plan. The coverage shall be terminated for the Dependants as soon as they no longer fulfil the afore-defined conditions and, in any case, at the same date as termination of the Policy for the Policyholder.

Our liability for any Claim from an Insured Person will cease immediately on the date of their lapsing of the Policy or when the Policy concluded for him is terminated.

Adding Dependents

If subsequently, the Main Member and/or Policyholder wish to add his newly married spouse, civil partner or newborn child to the Insurance Plan, the Main Member and/or Policyholder must complete an Application form and health declaration statement(s) for all Dependents including for newborn within the first 30 (thirty) days from birth. The cover will not start until the application has been accepted by Us for that Dependent and We have received premium payment.

Adding newborn children

Any newborn baby may be added to the parent's Policy by paying the applicable premium and enjoy cover commencing at the time of birth of the newborn provided:

- at least one parent has been covered on this Insurance Plan prior to the child's birth; and
- the child was not born as a result of assisted reproduction technologies or conception, not adopted or born to a surrogate or neither parent was under any fertility treatment; and • The Policyholder has completed the Application form and We have received this form before the child is 30 (thirty) days old; and
- the newborn child has been fully discharged from the Hospital; and
- the newborn is not a premature baby (i.e. where birth is prior to 37 (thirty-seven) weeks gestation).

If the newborn child does not meet any of the above criteria, We will ask for the child's medical history and require an Application form and health declaration statement to be submitted to Us for medical underwriting. We reserve the right to apply particular restrictions to the cover and may offer or decline cover for this newborn child until he has attained 3 months of age (cover can commence thereafter from the 91st day after birth upon our acceptance). If there are any changes to the information declared by the Main Member or Policyholder on the Application form and health declaration statement(s) after the Main Member or Policyholder signs it and before We accept the application, please let us know straight away.

Rights when the Policyholder dies

For individuals, in the case of the death of the Policyholder, the Spouse or civil partner (at least the age of 18 years old), who is the surviving dependent covered under the Policy will automatically become the (principal) Main Member, i.e. the Policyholder. The benefit under the existing Policy will terminate when any surviving Dependents are no longer eligible under this Policy or for which he has been issued his own separate Policy.

- Or:

2.1.3. Group Plan:

This section only applies to you if your Policy has been issued under a group Plan and your Employer has agreed to pay your premiums on your behalf for yourself and your Dependants if they are eligible for cover under this Policy.

The Policy and Insurance Plan is provided under an agreement with Your company, which selects the levels of benefits and programme included, sets out who can be covered, when cover begins, how it is renewed and how premiums are paid. Only the company is the Policyholder and has legal rights under the Insurance Plan. The Policyholder must ensure that the Insurance Plan is made available to You.

If you have taken this Policy as part of a Employer-Employee group or corporate business:

- you may be entitled to additional concessions and/or benefits to those recorded in this Policy, or
- you may have terms and conditions that are variations to the General Terms and Conditions of this document.

If this is the case, details of those concessions and/or benefits and/or variations to the terms of this Policy document will be recorded on the Policy schedule endorsement or renewal certificate (whichever is later). In the event there is a conflict between the concessions and/or benefits recorded on your Policy schedule endorsement or renewal certificate (whichever is later) and those recorded in the General Terms and Conditions, then the Policy schedule endorsement or renewal certificate (whichever is later) will prevail.

To be eligible for cover under this Policy, and unless otherwise accepted by Us in writing and shown in the Policy schedule, a member must be:

- an Employee of yours, aged from eighteen (18) and below sixty-nine (69), unless otherwise agreed by Us in writing, Actively at work on his/her Eligibility Date. Where an Employee is not Actively at work on his/her Eligibility Date, he/she will become eligible for coverage as soon as he/she becomes Actively at work.
- dependent(s) of the Employee, aged from fifteen (15) days and below sixty-nine (69), unless otherwise agreed by Us in writing, being able to perform all the Activities of daily living on the Employee's Eligibility Date, subject to the Employee being covered, are eligible for coverage under this Policy as determined and agreed with Us prior to Policy Commencement Date or Policy anniversary, whichever date is applicable.

For a Dependant who cannot perform all Activities of daily living on the Employee's Eligibility Date, he/she becomes eligible for coverage only when he/she can perform all Activities of daily living. The child(ren) who are eligible under this Policy cannot stay on the Policy after the Policy anniversary following his/her eighteen (18) birthday. However, his/her cover may be renewed up to the age of twenty-five (25) Years old provided he/she is unmarried, unemployed and is still a full time student.

If Your employer ends the company's healthcare plan with Us, Your/your dependents (where applicable) cover will automatically end.

2.2. CHANGING THE LEVEL OF PLAN

Subject to the Insurer's acceptance, the Policyholder can only apply to change the level of coverage at the Annual Renewal Date of the Policy and by informing the Insurer at least 2 (two) months before the renewal date. All individual or group Plan family members should be Insured on the same Insurance Plan.

2.3. SCHEDULE OF BENEFITS

The benefits consist of covering medical and Hospital costs incurred by the Insured Person (see Chapter 7 "Definitions"). The benefits are presented in the Table of Benefits (Annex 1) according to the Plan.

Medical care to be covered must be recognised by the local medical authorities and provided by authorised practitioners (in compliance with the laws, regulations or others relating to the practice of this profession in the country concerned).

Every time Our benefits will be limited to the costs that are Reasonable and Customary accepted. In case of all and any benefits in "Schedule of benefits", the Insurance protection covers exclusively benefits that are Medically Necessary.

The medical costs must have been incurred in the Area of coverage within the Period of Insurance (see Chapter 7 – Definitions).

The medical and Hospital services are covered as below and not exceeding Overall Maximum Limit:

2.3.1. Overall Maximum Limit

We will pay up to the overall limit shown in the Table of Benefits for each Period of Insurance per Insured Person unless otherwise specified in the policy schedule or Insurance certificate/membership certificate. Coverage for this limit does not extend beyond the Area of Coverage shown in Your Insurance Plan.

2.3.1.1. Ambulance Services

We will arrange and pay for the Insured Person's transport to the nearest suitable Hospital within the Limits stated for this service in the Table of Benefits, using the most appropriate means available, comprising local road ambulance or air ambulance, if appropriate, for emergency transport to or between Hospitals and when a medical practitioner says that it is Medically Necessary and that the Insured Person needs to have medical supervision while being transported. For Air ambulance services will require Our Pre-authorisation.

2.3.1.2. Hospitalisation costs

We will arrange and pay for the Medically Necessary Insured Person's In-Patient or Day-care admission to the Hospital and for the following Medical Expenses and services if it is Medically Necessary and only in the extent justified by Medically Necessary reasons:

- Accommodation in a standard, single-bedded private Hospital room (with bath or shower), meals, all Hospital medical facilities;
- Diagnostic procedures (including CT, MRI and PET scans), medical Treatment and services recommended by a Physician for In-Patient or Day-care admission including Physician's charges;
- Surgical appliances and prostheses (used by the Physician during the surgery and excludes providing or fitting external prostheses or appliances needed for any reason e.g. crutches, joint supports, etc.), subject to verification that such surgical appliances and prostheses implanted are U.S.A. FDA approved, used for its intended purpose and proven to be effective;
- Physiotherapy and Prescription Drugs;
- Surgical fees including Surgeon and Anaesthetist's charges;
- Intensive care unit accommodation;
- Operating Theatre;
- Medicines, drugs and dressings;
- If the Insured Person is a child aged under 16 (sixteen) who requires Hospitalisation, this benefit includes necessary overnight accommodation for 1 (one) parent in the same Hospital room, or when no such accommodation is available, for necessary bed at a hotel/motel near the Hospital up to € 50 each night. The stay at a hotel/motel near the Hospital is not applicable when In-Patient Treatment was in a Hospital within 50 km from his/her residential address. This benefit, accommodation for one parent is when the Insured Person is receiving an eligible In-Patient Treatment in the Hospital within the Area of coverage;
- Day-case surgery of a type formerly carried out on an In-Patient basis;
- During the 3 (three) months period immediately following the Insured Person's discharge from an In-Patient admission in a Hospital, post-Hospitalisation Treatment received on an Out-Patient basis provided the Insured Person remains under the control and supervision of the treating Physician or specialist consultant or such Treatment has been recommended by the Physician and for which Treatments are directly resultant from the Accident or Illness for which the Insured Person was Hospitalised.

2.3.1.3. In-Patient Cash benefit

We will pay an In-Patient Hospital Cash benefit when Treatment provided is free of charge for up to the maximum number of days specified in the Table of Benefits in any one Period of Insurance and on the condition that the selected Programme includes this benefit.

The minimum In-Patient stay is one night of stay.

If Your Policy has a Deductible, We will not take this off from the Hospitalisation cash benefit.

This benefit is not available if the cost of Treatment was funded by another party, such as another insurer.

2.3.1.4. In-Patient Rehabilitation

On the condition that the selected Programme includes this benefit, We, will pay up to the Limit stated for this benefit in the Table of Benefits for Treatment received during a Hospital stay or in a Rehabilitation center following your discharge from Hospital after an Insured Event.

We pay In-Patient Rehabilitation for as long as:

- it takes place in a hospital or unit that specialises in rehabilitation; and
- it follows an acute brain Injury, such as a stroke; and
- it is a part of Treatment that is covered by the Policy; and
- a Medical Practitioner/Physician who specialises in Rehabilitation is overseeing the Insured Person's Treatment; and
- we have agreed the costs before the Insured Person starts Rehabilitation; and
- the Treatment could not be carried out on an Out-Patient basis.

This benefit will not be paid unless Pre-authorisation has been provided by Us.

Note: We do not pay for Rehabilitation when the Treatment was given for Mental Health Disorders, psychiatric or psychological disorders.

2.3.1.5. Out-Patient care

On the condition that the selected Programme includes this benefit, We, will pay up to the limit stated for this benefit in the Table of Benefits for eligible Medically Necessary costs for Out-Patient services, including:

- Physicians fees (Out-Patient), Out-Patient Surgical Treatment, Prescribed Medicines
- Physiotherapy
- Laboratory, X-Ray fees, diagnostic tests
- Emergency Out-Patient Treatment
- Such consultations, Treatment or medical services takes place at the Physician's clinic or medical facility.
- Telemedicine consultation from an approved telehealth provider. One consultation per day.

2.4. SCHEDULE OF ADDITIONAL BENEFITS

The following Sections 2.4.1 to 2.4.4. are optional benefits, which the Policyholder may opt for added protection subject to additional premiums. Only those Insured Person(s) with these benefits are shown in their insurance certificate / membership certificate.

2.4.1 Cancer Treatment (chemotherapy and radiotherapy)

On the condition that your selected Programme includes this benefit, We will pay up to the Limit for this benefit defined in the Table of Benefits for In-Patient, Day-Patient, and Out-Patient Cancer Treatment, if the Treatment is considered by Us to be Medically Necessary, evidence-based active Cancer Treatment. This includes chemotherapy, radiotherapy, diagnostic tests/imaging, consultations, prescribed medicines, monitoring and follow-ups at a hospital or Specialist Cancer unit as part of an eligible In-Patient, Day-Patient and/or Out-Patient Cancer Treatment, under your Programme.

There is a limit of up to 120 days per In-Patient admission on this Policy.

This benefit is subject to a Waiting period of 12 (twelve) continuous months from the date this benefit is added to your selected Programme. This means that you cannot make a claim for this benefit until you have been covered for the full duration of the Waiting period after each Insured Person adds or upgrades the plan to include this benefit.

2.4.2. Organ and Tissue Transplant medical services.

On the condition that your selected Programme includes this benefit We will pay for Organ Transplant and Tissue Transplant up to the Limit for this benefit defined in the Table of Benefits. The human organ and tissue are from a relative or from a certified and verified source of donation.

This benefit requires Pre-authorisation and the transplant:

a. must be Medically Necessary and subject to Conventional Treatment;
b. the specific type and length of Treatment will be determined by the type of transplant and underlying medical condition; and
c. the transplant will be carried out in internationally accredited institutions by accredited surgeons in Poland and where the organ, tissue transplant is in accordance with World Health Organisation (WHO) guidelines.

This benefit is subject to a Waiting period of 12 (twelve) continuous months from the date this benefit is added to your selected Programme. This means that you cannot make a claim for this benefit until you have been covered for the full duration of the Waiting period after each Insured Person adds or upgrades the plan to include this benefit.

2.4.3. Routine Health Check and Vaccinations.

On the condition that your selected Programme includes this benefit We will pay up to the Limit for this benefit defined in the Table of Benefits for vaccinations required under the regulation of the country in which Treatment is being given, any Medically Necessary travel vaccinations and 1 (one) annual health check of the Insured Person consisting of the cost of examination of the Insured Person to have preventative health check for, valuable early detection of Illness or to ascertain the potential presence of Illness or disease, these may include, (but are not limited to):

- GP and Specialists consultations;
- Vital signs, including blood pressure, cholesterol, pulse, respiration, temperature;
- Cardiovascular and neurological system examinations;
- Breast/Ovarian/Colon/Prostate Cancers screening;
- Well Child examination,
- Routine Vaccinations provided up to 10 Years of age except travel vaccines.

This benefit is subject to a Waiting period of 12 (twelve) continuous months from the date this benefit is added to your selected Programme. This means that you cannot make a claim for this benefit until you have been covered for the full duration of the Waiting period after each Insured Person adds or upgrades the plan to include this benefit.

2.4.4. Dental Treatment.

On the condition that your selected Programme includes this benefit We will pay up to the Limit for this benefit defined in the Table of Benefits for preventative dental Treatment and routine dental care and Treatment limited to the following services:

- dental check-ups;
- cleanings, scaling and polishing;
- oral examinations and x-rays required prior to the performance of dental services;
- extractions; and
- amalgam restorations and fillings

Treatment must be provided by a dental practitioner.

This benefit is subject to a Waiting period of 6 (six) continuous months from the date this benefit is added to your selected Programme. This means that you cannot make a claim for this benefit until you have been covered for the full duration of the Waiting period after each Insured Person adds or upgrades the plan to include this benefit.

2.5. BENEFITS IN CASE OF DEATH

2.5.1 Lump sum in case of death from all causes

In case of death of an Insured Person due to an accident or Illness, a lump sum of € 5 000 is paid to the designated beneficiary (ies).

To give entitlement to benefits, any accident likely to result in the early payment of the lump sum must be declared within 6 (six) months from its occurrence date.

Unless the particular designation of beneficiary, the covered amount in the case of the Insured Person's death is attributed by order of preference:

- To the Spouse, not legally separated of the married Insured, or else, to the legal partner or a cohabitant (an extract of familial civil registration and marriage proof is required)
- Otherwise, to the children of the Insured born or unborn, equally between them, the share of the pre-deceased reverting to his own children or to his siblings if he has no children
- Otherwise, to the father and mother equally between them, the share of the pre-deceased reverting to the survivor
- Otherwise, to the heirs.

The Insured can modify the above order at any time and designate any natural or legal person of his choice by sending a registered letter to Us with a request for acknowledgement of receipt.

When the beneficiary is specifically named, the Insured must indicate the contact details of the beneficiary so that We can use them in the event of death. Where the personal designation lapses, the above standard designation shall apply.

The designation of a beneficiary becomes irrevocable by the acceptance of the beneficiary. Acceptance by authentic deed or private deed signed by the Insured Person and the beneficiary must be notified to the Insurer to take effect.

In the case of death of an Insured Person and one or more designated beneficiaries, during the same event without it being possible to determine the order of death or when the beneficiary, who died before the Insured Person, did not have time to accept the benefit of the payment, the Insured is assumed to have survived when determining the beneficiaries of the payment.

Please take note, when Death Benefit is paid to the designated beneficiary (ies), We would be discharged of all obligations and liabilities under this Policy and it will end Our legal responsibility on that payment.

2.6. SECOND MEDICAL OPINION

If an Insured Person's medical condition or diagnosis is serious and complex, we will help the Insured Person organise access to medical experts to obtain a second medical opinion and offer confidence in their healthcare choices of Treatment within Poland. Just contact us to request access to this service.

MEDISKY INTERNATIONAL

3. GENERAL CONDITIONS

3.1. EFFECTIVE DATE, DURATION AND RENEWAL DATE OF THE CONTRACT

The Insured's membership is stated in the Insurance Certificate/Membership Certificate, and mentions in particular:

- the Policy number,
- the effective dates (start and ending of the cover),
- the Dependants,
- the Plan,
- premiums to be paid for your cover.

The contract may also be terminated on the Insurer's initiative and the event of non-payment of the premium in accordance with the terms defined in Chapter 6 Article 6.2.

Cancellation rights for direct selling or distance selling

The Insurer, through MediSky, undertakes to send the main Insured Person information concerning their cancellation rights for direct selling or distance selling of the Policy.

Direct selling: The Insured Person has a right of cancellation in the case of direct sales at Home or in workplace, where the latter signs in this context a proposal for Insurance or a contract for purposes which do not fall within the scope of his commercial or professional activity. The Insured Person shall have 14 (fourteen) calendar days from the Date of Commencement of the contract to exercise his right to cancellation.

Distance selling: Distance selling provisions apply if the Policy is concluded via one or more distance selling techniques, particularly sold via correspondence or through the internet. A cancellation period of 14 (fourteen) calendar days applies in the case of distance selling from the date the Policy commences or from the date the Insured Person receives the Policy conditions and information.

The Date of Commencement of the Policy corresponds to the membership start date. This cancellation right shall not apply if the Policy is entirely executed by the two parties at the Insured Person's explicit request before the Insured Person exercises his/her cancellation right.

To exercise his/her cancellation right (direct or distance selling), the Insured Person must send the Insurer, via MediSky, ul. Karolkowa 28/201, 01-207 Warsaw, Poland, a letter by registered mail stating his/her desire to cancel his/her membership. The following template may be used:

"By this letter, I the undersigned ………… (full name and address) hereby cancel my Policy which I signed on ………in …………… (place of membership) and ask for reimbursement of the payment I made, corresponding to the sum of € …. [in euros]. (Date and signature)."

On condition that you have not already made a Claim and accept that you cannot make one later, the Insurer reimburses the premiums paid within 30 (thirty) calendar days from the date of notification is received. Membership is considered never to have existed and cover does not apply, from receipt by the Insurer of the cancellation letter sent via registered mail. After the period of 30 (thirty) days, the sum due accrues interest at the legal rate.

3.2. OBLIGATIONS OF THE INSURED PERSON

The Insured Person commits:

3.2.1. To provide the Insurer, through MediSky, with the following documents:

When applying for membership, an individual application form and health declaration statement is signed by the Insured Person.

Specific provision for the death benefit; the individual application form is completed with a medical questionnaire and health declaration statement. The Insurer reserves the right to make their acceptance conditional upon production of any additional information it deems necessary.

The Insured Person agrees to justify the statement(s) given to the Insurer at any time.

In the event of omission or misstatement by the Insured Person/Policyholder, the Insurer is entitled either to declare the contract null and void, or to continue applying it under new conditions which the Insurer shall set, or the Insurer may do one or more of the following:

- **Refuse to pay any Claims;**
- **Recover from the Insured Person and/or his Dependants any loss caused by the break of obligations;**
- **Refuse to renew the Policy.**

The Insurance cover shall enter into force once the agreed premium is paid and received by the Insurer.

The Insurer, through MediSky, commits to give to each Insured Person at the time of enrolment these General Conditions and inform the Insured Persons/Policyholder in writing of the modifications to be made, when appropriate, to their rights and obligations, in particular before any reduction in coverage, any change in the amount of premium or termination of the contract.

The Insured Person shall be liable in case of non-compliance with these obligations.

For Group Plan:

3.2.2. The Employer and/or the Employee/Insured member's obligations:

- The Policyholder shall designate a person (the 'group secretary' or 'administrator') to administer this Insurance Policy in accordance with its terms, and any guidance issued by the Insurer from time to time. The group secretary shall also notify the Insurer in writing of any change in the person designated. The group secretary to advise all Employees as soon as practicable if for any reason this Insurance Policy is terminated or should not be renewed, or this Insurance Policy should be terminated in accordance with the provisions of Chapter 3, Article 3.12. so that such Employees are made aware that all cover has ceased and that benefits will not be payable for Treatment costs incurred after the Termination Date.
- The Policyholder and/or the Employee/Insured member are responsible for ensuring that all data and information given to the Insurer is sufficiently true, accurate and complete.
- The Policyholder and/or the Employee/Insured member shall inform the Insurer in writing of any change in the address or contact details or other personal details.
- The Policyholder and/or the Employee/Insured member must inform the Insurer of any change in the country where the Employee/Insured member or Dependants normally live.
- The Policyholder and/or the Employee/Insured member shall remain responsible for his obligations under this Insurance Policy, even if the Policyholder and the Employee/Insured member may have delegated all or any part of those obligations to an intermediary or agent who shall be deemed to be the agent of the Policyholder and the Employee/Insured member.
- The Policyholder and the Employee/Insured member indemnify the Insurer from and against any costs, losses and expenses incurred by the Insurer resulting from the failure of the Policyholder and/or the Employee/Insured member, for any reason to discharge his obligations under this Insurance Policy.

3.3. ALTERATIONS

The conditions of this contract take into account the legislative and regulatory provisions in force on the contract's effective date. However, if these ones are amended during the contract period, the Insurer reserves the possibility to revise the contract, at the earliest from the effective date of the new provisions.

The Insurer may change the premium rates, benefits and terms and conditions of the Policy but any such changes will not apply until the Renewal date following the introduction of such changes. Any premium review is due to factors, such as the rising costs of medical treatment, as well as personal ones given by the changing of the Insured member's age band and for Groups when there are changes in the number of Employees to be included which shall affect membership.

Nevertheless, the Policyholder/Insured Person retains the possibility to request the termination of the contract without any notice period within 30 (thirty) days following the proposal of the Insurer.

This termination shall take effect from the first day of the following month after the termination request. The coverage and premium conditions are maintained on the existing basis until the Policy termination date.

3.4. SUBROGATION

The Insurer may be subrogated to the right of the person entitled to benefits in order to exercise any recourse proceedings against any liable third party. The Insurer waives its right of recourse proceedings against the Insured Person.

The Insurer or any person or company that the Insurer nominates, have subrogated rights of recovery on behalf of the Policyholder or any of his/her Dependants in the event of a Claim. This means that the Insurer will assume the rights of the Policyholder or any of his/her Dependants to recover any amount they are entitled to that the Insurer has already covered under this Policy. For example, the Insurer may recover amounts from someone who caused Injury or Illness, or from another Insurer or a state healthcare provider.

The Insurer may use external legal, or other advisers to help the Insurer to do this. The Policyholder must provide the Insurer with all documents, including medical records, and any reasonable assistance the Insurer may need to exercise these subrogated rights. The Policyholder must not do anything to prejudice these subrogated rights. The Insurer reserves the right to deduct from any Claims payment otherwise due to the Insured Person or his/her Dependants an amount that will be recovered from a third party or state healthcare provider.

3.5. INFORMATION – COMPLAINT – MEDIATION

For any information or complaints relating to the Policy which is the object of this prospectus, without prejudice to the Insured Person's right to bring legal proceedings to enforce execution of the Policy in the event of a dispute, he/she may contact the usual representative at MediSky under the following circumstances:

- Information and complaints regarding the Insurance admission conditions
- Information and complaints regarding payment of premiums
- Information and complaints in the event of a Claim

After receiving a complaint, MediSky will send the Policyholder, Insured Person or his/her Dependants, confirmation of receipt of the complaint within a maximum of 10 (ten) business days. The response will be sent to the Policyholder, Insured Person or his/her Dependants within the following 2 (two) months, unless exceptional circumstances arise.

If Insured Persons are not satisfied with MediSky's response, they can send a standard letter to: Quality Division Inter Partner Assistance Polska S.A. ul. Giełdowa 1, 01-211 Warszawa or email to: quality@axa-assistance.pl

In the event of disagreement with a decision by the Insurer and having exhausted all means of appeal offered by the Insurer, within a maximum of 60 (sixty) days of the day when the Complaint was received, the Policyholder, Insured Person or his/her Dependants may contact the consumers' Ombudsman (Powiatowy Rzecznik Konsumentów) within territorial jurisdiction.

3.6. DATA PROTECTION

The creation, modification, deletion or use of all automated processing of personal information related directly or indirectly to execution of the Policy, must be carried out in accordance with legal and regulatory provisions. According to the European General Data Protection Regulation 2016/679 of 27 April 2016 (the "GDPR") which entered into force on 25 May 2018, personal data collection is necessary for the management of the Insurance contract by the Insurer, its TPA, its service providers, its subcontractors or its reinsurers. The data processing is intended to issue, manage and execute Insurance contracts; the development of statistics and actuarial studies; the recourses, management of Claims and litigation; the implementation of the legal and regulatory provisions in force; the fight against money laundering, financing of terrorism and against fraud; operations related to customer management and business development. The recipients of these data are the duly authorised staff of the Insurer, its TPA, its service providers, its subcontractors or its respective reinsurers, social organizations or Insurance intermediaries.

The Insurer and MediSky undertake to take every relevant precaution to preserve the security of information and particularly to prevent it being deformed, damaged or communicated to unauthorised persons.

These personal data may be transferred to service providers or subcontractors established in countries outside the European Union. These transfers may only concern countries recognised by the European Commission as having an adequate level of protection for personal data, or recipients with appropriate safeguards. These data will be kept throughout the duration of the contract, until the expiry of both the limitation periods and the deadlines provided by the storage obligations.

The Insured Person has a right of access, rectification and erasure of his or her personal data. When consent is necessary for processing, he or she has the right to withdraw it. Under regulatory conditions, the Insured Person has the right to request the limitation of data processing or to oppose it.

The Insured Person also has the right to provide guidelines regarding the processing of personal data after his/her death. Any request for the exercise of his/her rights may be addressed to the Data Protection Officers via different means according to preferences.

AXA Assistance:

- e-mail: **iodo@axa-assistance.pl** or
- contact form under **www.axa-assistance.pl**

You may access the necessary information and queries from **https://www.axa-assistance.pl/iodo/**

MediSky International: **iod.medisky@dpag.pl**

3.7. REGULATORY INFORMATION AND GOVERNING LAW

Your Healthcare Plan is underwritten by Inter Partner Assistance S.A. Oddział Polska, an EU based Insurer.

Any dispute arising out of, or in connection with the Insurance contract shall be settled by the courts of the European Union that applies to your Policy. Polish Law will apply unless you and We agree otherwise.

If the country where you normally live changes to outside Poland it may not be possible for Us to continue to meet Our obligations under your Policy when you move. In these circumstances We may cancel your Policy from the date that you change the country where you normally live or on a specified date as agreed between Us and, you shall have a right to a pro-rata refund of the premium for any unused portion of your Policy.

3.8. SANCTION LIMITATION AND EXCLUSION CLAUSE

The Insurer shall not be deemed to provide cover and shall not be liable to pay any Claim or provide any benefit hereunder to the extent that the provision of such cover, payment of such Claim or provision of such benefit would expose that Insurer to any sanction, prohibition or restriction under United Nations resolutions, or the trade or economic sanctions, laws or regulations of the European Union, United Kingdom, United States of America or any other applicable law or regulation.

If you or a family member are directly or indirectly subject to economic sanctions, including sanctions against the country where you normally live, We reserve the right to do any of the following:

- immediately end cover (even if you have permission from a relevant authority to continue cover or pay premiums)
- stop paying Claims on your Policy (even if you have permission from a relevant authority to continue cover or pay premiums)
- cancel your Policy or remove a family member immediately without notice.

We will inform you if We do any of these.

If you know that you or a family member (or Employees, when this is a group Plan) are on a sanctions list, or subject to similar restrictions, you must let Us know within 7 (seven) days of finding this out.

3.9. OTHER INSURANCE

If there is any other private Insurance covering any of the benefits that are provided under the Policy for which a Claim is made, then the Insured Person/Policyholder must disclose this to the Insurer at the time of submitting the Claim. In these circumstances, the Insurer will not be liable to pay or contribute more than its proper rateable proportion.

If it transpires that the Insured Person/Policyholder has been paid for all or some of the Claim costs by another source or Insurance, the Insurer has the right to a refund of any settlement paid. The Insurer reserves the right to deduct such a refund from the Insured Person from any impending or future Claim settlements or to cancel his/her Policy from the inception date without a refund of premium.

Furthermore, if there is a reimbursement from a mandatory social security scheme, the Insurer will reimburse in addition to a mandatory social security scheme based on invoices and according to the benefits of the Plan.

3.10. ELIGIBILITY CONDITIONS

All individuals aged below 69 are eligible for this Insurance Plan if he/she resides in Poland.

These persons must, at the time of application for enrolment, fill out and sign an individual application form and health declaration statement for enrolment and a separate nomination of beneficiaries in case of death.

The Insurer reserves the right to subject their acceptances to the provision of any additional information that is deemed necessary.

The Insured Persons, as well as their Dependants when relevant, acquire the status of Insured Persons as soon as they are enrolled in Insurance.

Adding Dependants: The Insured may apply to include an eligible Dependant at any time during the Period of Insurance subject to the payment of the required premium. If the underwriting terms is based on FMU or CPME, the Policyholder must send an individual application and health declaration statement where applicable. The Policyholder must inform Us of all relevant and material facts. With Our agreement, We will inform when cover begins and will not backdate cover. The Dependants cover will match the cover provided to the existing individuals or members.

- Addition of a Spouse/legal partner is possible, provided that the application for these Dependants is made within 1 (one) month following the date of marriage/legal partnership.
- Addition of a new-born child to this contract from the date of birth provided that the Insurer receives a request of adding the new-born child within 30 (thirty) days of their date of birth; after this period, the Insurer will add the new-born child from the date We receive the written notification and not from their date of birth of a new-born.
- Addition of a new-born must meet the following eligibility criteria:
  - the new-born infant is born to a mother who has been covered under the Policy for the period of at least 12 (twelve) consecutive months prior to the date of birth of the new-born; and
  - the new-born infant was not born following any assisted conception pregnancy, from either parent's fertility Treatment, not due to multiple births, nor was adopted or carried by a surrogate, otherwise We may require separate underwriting.
  - a child not meeting the criteria mentioned above, must be added by submitting the application and health declaration statement, medical questionnaire and We may add, decline to provide cover or may offer cover including any terms We require.

3.11. EFFECTIVE DATE OF COVERAGE

Once the contract has come into effect, the coverage becomes effective for each individual who acquires the status of Insured Person on the following dates:

- Individual Person enrolled on the effective date of the individual Policy, from this date.
- Individual Person enrolled after the effective date of the individual Policy on the date the premium is paid, dateshown on the Insurance Certificate/Membership certificate.

The coverage for Dependants, as defined in Chapter 2, shall take effect at the same time as the coverage for the Insured Person or as soon as the persons concerned meets the required conditions.

For Group Plan, the enrolment is effective only when the Policyholder provides the Insurer with the nominative list of members and the staff categories to be covered, stating the Employees and the Dependants that should be covered. The Insurer has the right to refuse the enrolment. The Insurer may also require any other information that might be considered as necessary and is provided before the enrolment takes effect.

Cover is effective for each member of the covered category on the date the Insurer has received the nominative list mentioned above. Cover is effective for the Dependants on the same date as the Employee, or when they meet the requirements for cover whichever is the latest.

If an Employee is not Actively at work on the date he or she would otherwise be eligible for enrolment, then the enrolment date shall be deferred to the first working date of his/her active employment with the Policyholder. If a Dependant is incapacitated or confined to a Hospital on the date that he or she is eligible for cover under this Policy, the enrolment date shall be deferred to the date the Dependant has recovered and discharged from Hospital.

This Policy is issued on the basis that all Employees of the Policyholder are eligible for coverage under this Policy, are Actively at work at the location of business or at the location to which their business requires them to travel, on public holidays, normal annual leave, maternity leave, study leave, compassionate leave and/or other holidays, not due to Illness or Injury at the time they are enrolled into the Insurance Policy. The Insurer reserves the right to cancel or modify the terms of this Policy should We find that any Employee was not Actively at work at the time he/she was enrolled for benefits. Cover for the eligible Dependants must be Insured on the same Plan as the Employee subject to the agreed eligibility requirements.

When a new member becomes eligible or when removing your Dependants who may no longer be eligible for cover, you must write to Us within 30 (thirty) days, from the Eligibility Date of that member to apply for his/her cover or when they are no longer considered as Employees or Dependants. If the application is approved, We will then update your membership listing and issue an endorsement to this Policy accordingly. For any new member,We reserve the right to request any additional information as required and part of Our underwriting assessment procedures. We will inform You, if more information is required by Us.

For any new member,We reserve the right to request any additional information as required and part of Our underwriting assessment procedures. We will inform You, if more information is required by Us.

Only the Policyholder and the Insurer have legal rights under this Policy. No clause or term of this Policy will be enforceable by any other person or parties.

The individual or group Policy is a yearly renewable Policy.

Renewal

Before the end of each Policy Year, We will contact the Policyholder to tell them the terms the Policy will continue if the Policy is still available or in some situations We are unable to renew the Policy for a further period of insurance. We will renew the Policy on the new terms unless the Policyholder asks Us to make changes or tells Us they wish to cancel. We will collect your premium using the same payment method that you used for the previous Year.

Premium rates are not guaranteed and the premium payable at Policy anniversary shall be determined at each Policy anniversary based on the attained age of each member, the premium rates then in effect, and any other factors which may materially affect the risks Insured.

For Group plans: Your Employer must pay the premium when it is due. Any renewal notice We send to you or your Employer is for your information only and does not prejudice your Employer’s liability to pay the renewal premium on or before the Policy anniversary date. We will decide the premium amount at the start of each Policy Year and tell you how much it is. Your Employer can pay it in the way your Employer has agreed with Us. It is hereby agreed and declared that the total premium due must be paid and actually received in full by Us on or before the premium due date.

3.12. TERMINATION OR SUSPENSION OF COVERAGE

Except in the event of a reticence, omission or false declaration, the Insured Person may not be excluded from the Insurance against his/her will if he/she is part of the category of Insureds Person under the Plan.

In any event, cover ceases for each Insured Person:

- in the event of failure to pay the premiums under the terms and conditions;
- in the event of a false declaration;
- at the initiative of the Insured Person/Policyholder in the event of annual cancellation of its Policy;
- in the event of the death of the Insured Person;
- in the event of liquidation proceedings in relation to the Insurer;
- on the date the Insured Person reaches the legal age of retirement in the country in which he/she is employed;
- on the date the Insured Person is no longer employed by the Group/Company/Employer;
- in the event of a change of the Principal Country of Residence, where the country is outside of Poland;
- immediately following the maximum age allowable under this agreement,
- by unilateral termination by one of the contracting parties, with prior 20 (twenty) days written notification sent to the other party before termination. The restitution of the insurance premium is made according to the legal provisions and the applicability of the Policy conditions for the period following the unilateral termination, respectively pro-rata temporise except for cases when claims have been paid, reported or is outstanding;
- upon the withdrawal of the Insurer’s authorisation by the Authority;
- if the Policyholder/Insured Person/Dependents’ personal identification data is found in the Official Lists of individuals and legal entities suspected of committing financing terrorist acts, money laundering or on the list with persons with international sanctions. The Insurer shall have the right to terminate Insurance unilaterally by means of a registered letter addressed to the Policyholder in the event of such circumstances. The Policy shall cease to be valid at 0:00 am of the calendar day immediately following the date of dispatch of the letter sent by the Insurer informing the Policyholder of the termination of the Policy;
- if the Policyholder/Insured Person/Dependents refuses to give information or documents regarding their identification; or
- in case of force majeure according to the current laws.

The coverage for Dependants as defined in Chapter 2 is terminated (or suspended) at the same time as the principal Insured Person’s or Group Member’s (Employee) coverage.

The termination of the coverage results, both for the Insured Person (or Employee: under Group Plan) and his/her Dependants, on the cancellation of entitlement to benefits for all medical care provided after the termination date, even if they have started or have been

prescribed before this date.

4. EXCLUSIONS

4.1. EXCLUDED RISKS AND BENEFITS

The Insurer shall not pay any benefit to any Insured Person which arises or is caused by or associated with directly or indirectly by any one of the following:

1. Any expense, Treatment, medical or dental condition or procedure relating thereto not specifically stated in this Policy as being Insured or is excluded by endorsement;
2. Sums in excess of the Plan limits;
3. Any sum in excess of € 500 where We have not given prior approval;
4. Costs which would have been incurred if the Insured Event had not occurred;
5. Costs outside of Poland;
6. Costs relating to Palliative Treatment;
7. Complementary medicines, treatment or therapists; speech therapy;
8. Costs relating to the Deductible specified on the Insurance Certificate/Membership Certificate;
9. Any Claim involving fraud, misrepresentation or concealment or their consequences;
10. Any Claim arising from:
    - self-inflicted Injury (including suicide or attempted suicide) as a result of willful acts or gross negligence;
    - needless self-exposure to peril (except in an attempt to save human life) as a result of willful acts or gross negligence;
    - travel undertaken against medical advice.
11. Any Treatment, consultations, investigations, and charges related to drug and substance abuse (including alcohol) or any dependency or other addictive conditions and/or any conditions arising therefrom or as a result of;
12. Pregnancy, maternity, childbirth or complications of pregnancy,
13. Any Treatment, consultations, investigations, and charges arising from or connected with contraception, sterilisation (or its reversal), fertilisation, vasectomy, venereal disease, sexually transmitted infections, gender reassignment such as any surgical procedure, counselling and psychotherapy, sexual therapy, or any other form of sexual related conditions or dysfunction;
14. Any Treatment, consultations, investigations, and charges related to infertility or any form of assisted reproduction including establishing pregnancy and any subsequent complications;
15. Any Treatment, consultations, investigations, and charges undertaken solely to relieve the symptoms commonly associated with bodily changes, arising from any physiological or natural cause such as aging, menopause or puberty and which is not due to any underlying disease, Illness, or Injury;
16. Travel outside the Area of coverage specified on the Insurance Certificate/membership certificate;
17. Claims arising from birth injuries or defects, Hereditary conditions or congenital Illness or anomalies more than 60 days following birth according to the Plan; or Hereditary conditions or congenital Illness or anomalies in the case of children resulting from any fertlity Treatment or from any method of assisted conception or if adopted or through surrogacy;
18. Artificial heart implantation;
19. External Prosthesis and appliances, physical aids, devices, durable medical equipment;
20. Any costs arising after expiry of the current period of Insurance, unless this Policy has been renewed for a subsequent 12 months;
21. Care or medical Treatment which arises from human immunodeficiency virus Illness, including acquired immune deficiency syndrome (AIDS) or AIDS Related Complex (ARC) and any similar infections, Illnesses, injuries or medical conditions arising from these conditions, however caused;
22. Drugs and other medicines purchased without a Medical Practitioner/Physician's prescription; or routine or preventive medicines, vaccinations and check-ups unless included in the chosen Insurance Plan Table of Benefits;
23. Reconstructive Surgery except when We agree the cost of the treatment in writing beforehand and the Insured person's first reconstructive surgery is the result of an accident or surgery for a medical condition that was covered by this policy and provided the Insured person has been continuously covered on the policy since before the accident or surgery happened. Please note in the case of breast reconstructive surgery after a medically necessary mastectomy (provided the Cancer rider is available under the Insured Person's Plan), We will pay for the initial breast reconstruction only and shall exclude any other surgery or reconstruction of the other breast to produce a symmetrical appearance;
24. Any Treatment, consultations, investigations, and charges related to remedial surgery, cosmetic or aesthetic Treatment to enhance Your appearance or any part of the body, whether or not for medical or psychological purposes, and any of its associated costs consequent of such treatment; Any Treatment, consultations, investigations, and charges which relates to or is needed because of a previous cosmetic treatment or reconstructive surgery;

25. Any Treatment, consultations, investigations, and charges related to the removal of fat or other surplus body tissue and any consequences of such medical Treatment; obesity, or which is necessary because of obesity, weight loss, monitoring or control (such as slimming classes, aids, and drugs), bariatric surgery, or complications resulting from bariatric surgery, fitting of a gastric band, creating a gastric sleeve, or other treatment, eating disorders of any kind;
26. Surgery, procedure, any Treatment, consultations, investigations, and charges to correct short or long sightedness or any other vision or refraction defect (such as myopia, hyperopia, astigmatism), unless it was caused as a result of an Insured Person's Accident or Illness when occurring during the Period of Insurance; Treatment to correct astigmatism is covered, only if the astigmatism is due to the surgical replacement of the lenses of the eye arising from an Insured event. This exclusion will not apply to vision defects arising from keratoconus;
27. Any Treatment, consultations, investigations, and charges of sleep disorders, apnoea, insomnia, snoring, or any other sleep-related breathing problems; loss of hair, hair replacement; wigs or other temporary head covering unless we have agreed to pay under the Insured Person's additional Cancer benefit during Active Treatment of Cancer;
28. Medical Treatment performed by a Medical Practitioner, Physician or consultant or complementary therapist who is related to the Insured Person, unless previously approved by Us. By related, We mean the Insured Person's immediate family member, business associates, business partners, employer or his employee;
29. Any claims, consultation, and charges for cryopreservation, harvesting or storage of stem cells, sperm, ovum, or umbilical cord for future use; any stem cell treatment, transfer, or transplant including any related complications due to such procedure; implantation or reimplantation of living cells or living tissue, whether autologous or provided by a donor, other than for Tissue Transplants as defined in your Benefits table. Costs of removing living cells or living tissues from the insured person to implant or re-implant into another person and any related complication due to such a procedure;
30. Claims arising as a result of the Insured Person's participation in professional sports (which is as a result of training or taking part in any sport for which the Insured Person is paid or receives grant or sponsorship other than travel costs or if he is competing for prize money) or any hazardous/extreme sport or activity, i.e. such as: motor sports, aerial sports, scuba diving below 30 meters or where a PADI certificate is not held, any activity involving animals, speed competition, free climbing or mountaineering (with or without ropes) trekking above 2,500 meters, martial arts, bungee jumping, parachuting, base jumping, cliff diving, skiing off-piste and racing of any form (other than on foot). If a hazardous sport or activity is not specified in this list, the Insured Person must contact Us to ascertain if it is acceptable for Insurance before cover will apply;
31. Any Claim arising when the Insured Person is under military authority or is engaged in activities involving the use of firearms or physical combat or in an area of military conflict, except in connection with tourist trips made on a private basis during leave;
32. Any expenses relating to search and rescue operations to find an Insured Person in mountains, at sea, in the desert, in the jungle and similar remote locations including air/sea rescue charges for evacuation to shore from a vessel or from the sea;
33. Any accommodation, Treatments, consultations, investigations, and charges in a nursing home, hydro, spa, nature clinic, health farm and the like or a Hospital where the establishment concerned has, effectively, become the Insured Person's Home or permanent residence and/or the admission is arranged wholly or partly for domestic reasons or for the convenience of the Insured Person, or any nursing at home;
34. Rehabilitation unless it forms an integral part of medical Treatment received as an In-Patient and is under the control or supervision of a specialist and is undertaken in a recognised Rehabilitation unit;
35. Medical assessment, grading or any Treatment, consultations, investigations and charges related to neurological development, cognitive development, learning difficulties, speech delays, educational problems, development milestones, physical development, psychological development, hyperactivity, attention deficit disorder, autism, dyslexia, behavioural problems, or child development;
36. Any Treatment, consultations, investigations, and charges for mental or nervous disorders, Psychiatric Treatment and the costs of a psychotherapist, psychologist, family therapist or behaviour counsellor are excluded if not included on Your chosen Insurance Plan and as shown on Your Insurance /membership certificate;
37. Any Claim in any way caused or contributed to by the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent;
38. Any Claim whatsoever resulting from war, invasion, act of foreign enemy, hostilities (whether war be declared or not), act of terrorism, civil war, rebellion, revolution, insurrection, military or usurped power or taking part in civil commotion or riot of any kind. Exception: We will pay for each Insured Person per Insured Event provided that the Insured Person is an innocent bystander, and has not been an active participant, and has not acted recklessly or put themselves in danger by entering a known area of conflict; (For the purpose of this exclusion, an act of terrorism means an act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organisation(s) or government(s), committed for political, religious, ideological or similar purposes or reasons including the intention to influence any government and/or to put the public, or any section of the public, in fear).
39. Any expense which at the time of happening is covered by, or would, but for the existence of this Policy, be covered by any other existing private Insurance Policy. If there is any other cover in force which may pay in respect of the event for which the Insured Person is Claiming, the Insured Person must tell Us at the time he/she first contacts Us;
40. Any losses which are not covered by the terms and conditions of this Policy (examples of losses: We will not pay for loss of earnings due to being unable to work as a result of Illness or Injury).
41. Supplements or substances that are available naturally, such as oral vitamins, minerals and organic substances;
42. Artificial life maintenance for more than 60 (sixty) continuous days if your Insured Person is in a persistent vegetative state and only kept alive by medical intervention such as mechanical ventilation;
43. Chiropody and foot care even if a surgical podiatrist provides it, this includes things like gait analysis and orthotics;

44. Treatment of thread or superficial varicose veins, any recurrent varicose veins surgery or Treatment;
45. Pre-Existing Conditions and any related, associated or consequential medical conditions which were not disclosed to the Insurer before the Period of Insurance and which We have not agreed in writing to cover under this Policy. This exclusion applies only to FMU or CPME policies.
46. Treatment or drugs which have not been established as being effective, or which are Experimental and any off-label drugs or pioneering medical or surgical techniques and/or medical devices not approved by the relevant authorities, governmental medical regulatory boards; clinical trials for medicinal products which your Insured Person chooses to receive even though usual, customary and Conventional Treatment for the condition is available. However, We will pay if before the Treatment, it is established that the Treatment is recognised as appropriate by an authoritative medical body and We have agreed in writing with the Physician what the fees will be. For established Treatment, this means procedures and practices that have undergone appropriate clinical trial and assessment, sufficient evidence in published medical journals for specific purposes to be considered as proven safe and effective Treatment;
47. The use of a drug or any off-label drugs which has not been established as being effective or which is Experimental or within clinical trials. We will not consider individual case reports, studies of a small number of people or clinical trials which are not registered. The drugs must be licensed for use by the European Medicines Agency (EMA), if you are receiving treatment in Europe, by the Medicines and Healthcare Regulatory Agency (MHRA) if you are receiving treatment in the United Kingdom, or by the US Food and Drug Administration (FDA) if the Treatment is outside Europe and these drugs must be used within the terms of that licence for which they were approved for;
48. Robotic surgery except for prostatectomy, partial nephrectomy and pyeloplasty using the da vinci robot;
49. Any medical report fees, administration fees charged by the medical provider or Medical Practitioner, or any charges not directly related to medical necessary Treatment such as but not limited to completion or providing of claim forms;
50. CTGTP (Cell, Tissue, and Gene Therapy Products), ATMP's (Advanced Therapy Medicinal Products) or Regenerative medicine advanced therapy (RMAT) including any associated hospital, related procedures, tests, or specialists' costs;
51. Any Treatment, consultations, investigations, and charges related to genetic testing, genetic engineering; or for genetic screening to check whether:
    - if the Insured person has a Medical condition when the Insured person has no symptoms; or
    - if the Insured person has a genetic risk of developing a Medical condition in the future; or
    - if there is a genetic risk of the Insured person passing on a Medical condition; or
    - where the result of the genetic tests is not proven to change the course of an eligible Treatment. This might be because the course of Treatment for the Insured person's symptoms will be the same regardless of what Medical condition has caused them;
52. We do not cover costs where you are required to quarantine but have no medical need for treatment or care as an in-patient. This includes state mandated quarantine, even if it takes place in a hospital.
53. Any Treatment, consultations, investigations, and charges related to medical cannabis products or indications even for medical reasons when it is considered illegal in the jurisdiction where Treatment is being obtained and/or in the absence of demonstrable regulatory approval of the drug by the Medicines and Healthcare products Regulatory Agency (MHRA) if the Treatment is to be provided in the United Kingdom; or the European Medicines Agency (EMA) if the Treatment is to be provided in Europe, but outside of the United Kingdom; or the US Food and Drug Administration (FDA) if the treatment is to be provided outside Europe.

5. CLAIMS HANDLING AND ADMINISTRATION

5.1. PLAN ADMINISTRATOR

The Insurer has appointed MediSky International to act as the provider of certain third-party administration services in Europe including management of Claims and their administration, pre-authorisations (the "Services") in relation to the health Insurance plans designed by MediSky International and to be issued and underwritten by the Insurer.

5.2. GENERAL PROCESSES

For Claims enquiries, Policy questions and preauthorisation, requests Monday – Friday 9AM – 5.30PM

call +48 22 826 11 46 or email: customer-care@medisky.pl

Outside of MediSky working hours, the following number should only be used in case of emergencies: (+48) 573 923 263.

5.3. CLAIMS PROCEDURES

5.3.1. Exchange Rates

If we have to make a currency conversion, we will use the historic exchange rate listed by the National Bank of Poland applicable on the day of your Treatment for Out-patient and Day-patient treatment, and the day of your admission for In-patient treatment. We do not cover the losses you may incur due to fluctuations in exchange rates.

5.3.2. If we make a payment to you in error

If we transfer money to you in error or accidentally overpay you, you must return it to us immediately. If you become aware of an accidental payment or overpayment, you must let us know straight away so that we can arrange for the money to be returned to us.

5.3.3. For Claims Reimbursement

You shall be reimbursed for all eligible, Reasonable and Customary medical costs related to the benefi ts of the Insurance Plan. For reimbursement of your Medical Expenses, you must send Us the following documents:

- All related documents issued by your treating doctor – medical report or referral letter;
- Detailed invoice for the medical services;
- Receipt of payment;
- Fully completed Claim Form.

The Policyholder, the Insured Person or the beneficiary's right of claims under this Policy will be up to what is permissible under Civil code regulation from day they become aware of the occurrence of the insured incident. The Policyholder, the Insured Person or the beneficiary shall notify the Insurer in a timely manner (preferably not beyond 6 (six) months) when they are aware of an occurrence of the insured incident. Should the Policyholder, Insured person, beneficiary deliberately fail to disclose any matter relating to an insured incident or fail to disclose any material issue relating to the insured event to the Insurer which causes difficulty by the Insurer in the identification of the nature of the incident, cause, degree of loss, etc. in a timely manner, the Insurer is not liable to the claim payment for the portion that cannot be identified, with exception to the case where the Insurer had known or ought to have known such insured event through other means. This obligation does not include the delay caused by force majeure.

We work with international translators, so it is not mandatory that the Claims are submitted in English.

We will not accept copies, photocopies or duplicates of invoices for any Out-Patient Treatment above € 500 (five hundred euro) per invoice. You must retain the originals for 24 (twenty-four) months from the date of Treatment. During this period, We may ask to receive the originals, failing which the reimbursement paid may be challenged.

We may need You to ask for extra information to help Us process Your Claim, for example: medical reports or other information about Your condition. If this is the case, there will be a delay before We are able to make any Claim payment and these information must be provided to Us within 30 (thirty) days. Otherwise, the Claim will be automatically rejected until the details are provided.

We will pay for:

- Treatment and conditions included on your Plan while you are covered by your membership
- costs as described in your 'Table of benefits' as applicable on the date(s) of your Treatment
- Treatment which is clinically appropriate and suitable for you
- active Treatment of a disease, Illness or Injury that leads to your recovery, conservation of your condition or to restore you to your previous state of health
- costs for Treatment which you have received, but not deposits or advance payments for Treatment to be received in the future, or registration/administration fees charged by the provider of Treatment

- Reasonable and Customary costs. This means that the costs charged by your Treatment provider should not be more than they would normally charge and be representative of charges by other Treatment providers in the same area**
- Treatment and conditions included on your plan while you are covered by your Membership after deducting any annual Deductible for each claim. For Plans with annual Deductible, the Insured Person is responsible for the annual Deductible before We will begin to pay any benefit under the policy. If the Insured Person's eligible claim is less than the annual Deductible, the Insured Person should still submit the claim to Us so We can count the benefits due towards each Insured Person's annual Deductible. Once benefits due exceed the chosen Deductible, benefit payments will begin.

In cases where published Insurance industry standard guidelines exist, the Insurer may refer to industry standard guidelines when assessing and paying Claims. Charges in excess of Insurance Industry published standard guidelines or in excess of Reasonable and Customary costs may not be paid.

We will not pay for Treatment which in Our reasonable opinion is inappropriate based on established clinical and medical practice, and We are entitled to conduct a review of your Treatment, when it is reasonable for Us to do so.

**We will use guidelines published by a government health department or official medical body in the country where you are having treatment or using a service to decide if charges are within the usual and customary range. We may also use anonymised claims data or data from our local partners as a benchmark when we pay or assess claims.

5.4. PRE-AUTHORISATION AND PAYMENT CARDS

The Insured Person must contact us at least:

- 5 (five) working days before any In Patient Treatment takes place,
- 48 (forty-eight) office hours before any Out-Patient Treatment.

In order to obtain Our pre-authorisation for Treatment of any kind which are likely to exceed € 500 (five hundred €) on completion of Treatment, otherwise, We, may not pay the Claim. This sum includes In-Patient, Day-care and Out-Patient Treatment, as well as transportation and ancillary costs. For Us to be able to verify eligibility of Your Pre-authorisation request, We will always ask You to advise Us of: onset date and symptoms, estimated costs, chosen provider, type of medical service required, type of medical speciality and other information where applicable.

If the Treatment scheduled is eligible for cover, We can confirm the level of benefit applicable to the medical provider/s and authorise Treatment, subject to the terms and conditions stated under the present General Conditions document. When the Claim is subsequently fully validated, We, will arrange for In-Patient costs to be settled directly to the medical provider/s, for as long as the medical provider accepts.

To view a list of providers with whom direct billing can be arranged for hospitalisations, go to:
https://select.axaglobalhealthcare.com/s/?expId=AXA_MSL_1434

For In-Patient and Day-Patient Treatment at other Hospitals or medical facilities, there are some Hospitals or medical facilities who we would not pay for Treatment charges. This may be because they do not meet our billing criteria, or because We no longer choose to recognise them. You should check if We will pay the facility or Hospital before you have your Treatment. We may decline your claims and would not reimburse you for Treatment you pay for yourself with one of these providers.

It is important to note that if We authorise Treatment which ultimately transpires to have been related to a condition excluded by the Policy, for example, Treatment for an undeclared and unaccepted Pre-existing Medical Condition, the Insured Person will be responsible for all costs, including those settled by Us. In such cases, the Insured Person must repay Us all costs We have paid.

The Insured Person must make no admission of liability, offer, promise or payment without Our prior consent.

In case of an emergency, if the Insured Person is physically prevented from contacting Us immediately, the Insured Person or someone designated by him/her must contact Us within 48 (forty-eight) hours.

In respect of any other costs, the Insured Person will be required to reimburse to Us, within 1 (one) month of Our request to the Insured Person, any costs or expenses We have paid out on the Insured Person's behalf which are not covered under the Policy.

As often as We require, the Insured Person shall submit to medical examination at Our expense. In the event of the death of an Insured Person We shall be entitled to have an autopsy carried out at Our expense (where this is not forbidden by local law). The Insured Person must supply Us with a written statement substantiating their Claim, together with (at his/her own expense) all original invoices, certificates, information, evidence and receipts that We require.

Where you receive Treatment as an Out-Patient, and where costs are below € 500 (five hundred €) and do not require pre-authorisation, the costs must be paid for in full by you at the time of receiving the Treatment. You must then submit a Claim to Us for reimbursement. Please ensure that a Claim form is fully completed by the Insured Person and the treating Physician. Submit this with the detailed receipts and all other information supporting your Claim, including but not limited to x-rays, test results, medical reports etc. , within 6 (six) months from the Treatment date.

5.4.1. Payment cards

The member should activate their payment card as soon as this is received from MediSky. Failure to do so may reduce the possibility to use the card when needed, especially in case of emergencies.

Payment cards allow to pay the costs of the medical services directly to the medical provider of your choice. The cardholder needs to inform MediSky by phone **(+48 22 826 11 46)** or at e-mail address: **customer-care@medisky.pl** at least 48 (forty eight) hours before the medical appointment. Payment cards can only be used for the provision of medical services by a registered medical practitioner/physician.

In maximum 48 (forty-eight) hours from the date of receiving Treatment, MediSky should receive from the customer all relevant documents (e.g. medical report, invoice etc.).

5.5. MEDICAL EXAMINATION

We reserve the right to have the health status of the Insured Person and the medical care provided checked. We may request, if necessary, any document, examination or medical act to assess the benefits.

5.6. FALSE DECLARATION

Declarations made by Insured Persons/Policyholder to MediSky and to the Insurer serve as a basis for the cover. Independently of causes of nullity, the cover granted to the Insured Person by the Insurer shall be null and void in cases of concealment or wilful misrepresentation by the Insured Person/Policyholder, when the reluctance of misrepresentation changes the subject of risk or decreases in the opinion of the Insurer, even though the risk omitted or distorted by the Insured Person was immaterial to the Claim.

The premiums paid remain earned by the Insurer who is entitled to the payment of all premiums due, as damages.

6. PREMIUMS

6.1. PREMIUMS RATES AND CALCULATION BASIS

Insurance premium shall be calculated upon the assessment of the risk and its amount depends on the Plan, the country of Residence and age of the Insured. The premiums amount, net of taxes, are set out on the Insurance Certificate/Membership Certificate issued to the Insured Person.

The premiums may be revised according to the provisions of this Agreement. The rates may be revised annually according to the technical results of the Policy. However, the revision of the rates is effective at the contract anniversary date.

When a new rate for premiums is established by the Insurer, MediSky is required to inform the Insured Person/Policyholder, three (3) months before their entry into force.

In case of disagreement, the Insured Person or Policyholder (for Group Plan, the Employer) may request the termination of his/her membership certificate by registered mail within two (2) months from the notification made by MediSky.

6.2. PREMIUMS PAYMENT

Premiums are payable annually, semi-annually, quarterly, or monthly in advance by the Insured Person or, in the case of a Group Plan, by the Policyholder (Employer). All applicable taxes, statutory charges, and transaction-related fees including but not limited to bank charges and currency conversion differences shall be added to the premium amount and are the sole responsibility of the Insured Person or Policyholder (Employer), in accordance with applicable laws and regulations.

The Insurer shall not be liable for any shortfall in premium collection resulting from such deductions or fluctuations. It is the responsibility of the payer to ensure that the full net premium amount, inclusive of all applicable charges, is received by the Insurer.

Should the Insured Person/Policyholder/Employer fail to pay all premiums within the month following their due date, the coverage is suspended for THIRTY (30) days after issuance by the Insurer of a registered letter stating the formal notice of suspension of cover. During this 30 (thirty) day period, the Insurer will not accept any Claims for Treatment incurred on or after the premium due date until the Insured Person/Policyholder/or Employer has paid the premium due. This also applies to Treatment that the Insurer may have already pre-authorised. If, beyond that period, the Insured Person/Policyholder/or Employer has not made the requested payment, the Policy may be terminated without any further formality within TEN (10) following days. Once We have cancelled your Plan, your Policyholder or Employer will have to reapply for cover and you will have to complete a new application form, which will be subject to medical underwriting.

The premiums are paid in € = Euro.

Insurance premium shall be calculated upon the assessment of the risk and the amount depends on the chosen Insurance Plan, the ages of the Insured Person, Deductible, and any optional Insurance Plans. The premium, net of taxes, are set out on the Insurance / membership certificate issued to the Insured Person.

The premiums may be revised annually according to the provisions of this General Terms, Conditions and according to the technical results of the portfolio. However, the revision of the premiums is effective at the Policy Annual Renewal Date.

7. DEFINITIONS

The following definitions apply to benefits included in your Plan and to some other commonly used terms. The benefits you are covered for are listed in your Table of Benefits. Wherever the following words/phrases appear in your contract documents, they will always be defined as follows.

Accident refers to a sudden, unexpected, unforeseen and involuntary external event resulting in identifiable physical Bodily Injury occurring to an Insured Person while his/her Insurance Plan is in force.

Advanced therapies refers to complex set of advanced therapies, including gene therapies and CAR-T treatment for cancer. They are known by different names across the world, for example Advanced therapy medicinal products (ATMPs), Cellular and gene therapy products (CGTPs) of Regenerative medicine advanced therapy (RMAT).

Note: We do not cover any type of ATMPs/ CGTPs/ RMATs including their associated hospital or specialist costs as this is under the list of exclusions.

Annual Renewal Date the day after the expiry date as shown on the Insurance Certificate/Membership Certificate.

Ambulance Services means the necessary medical transportation to or from the nearest suitable Hospital.

Area of coverage means Poland.

Benefits Plan the schedule detailing those benefits applicable to the Plan you have selected, and which should be read in conjunction with the Insurance Certificate/Membership Certificate.

Bodily Injury means physical damage or harm caused to the body as a result of an accident.

Cancer malignant tumour, tissues, or cells, characterised by the uncontrolled growth and spread of malignant cells and invasion of tissue.

Cancer Treatment refers to Medically Necessary Treatment intended to shrink, stabilise or slow the spread of Cancer or related to the diagnosis of Cancer received as an In-Patient, Day-care patient or ambulatory/Out-Patient including but not limited to radiotherapy, chemotherapy or target therapy unless such Treatment has been specifically excluded under the terms of the Policy. This benefit covers eligible expenses from the point of diagnosis to pre- and post-hospitalisation, planning, carrying out Cancer Treatment as prescribed by an oncologist which includes tests, scans, imaging, consultations, Prescribed Medicines, monitoring and follow-up at a Hospital or specialist Cancer unit and excludes Treatment that is provided solely to relieve symptoms. We reserve the right to request the Insured Person to obtain eligible prescribed pharmacy items from designated network pharmacy where applicable and when authorised by Us, failing which the Insured Person may not obtain full reimbursement for the Claim. Once the Medically Necessary Cancer Treatment has completed and the Insured Person is in complete remission, any consultation, medicines, monitoring or follow-ups will be paid under the ambulatory/Out-Patient benefit as long as the member remains an Insured Person under this Policy and on condition that the selected programme includes this benefit.

Claim means your request for payment of benefits under the Policy concluded on the basis of MediSky Healthcare Plan programme.

Commencement Date means the date on which the Insurance protection becomes effective, as specified on the Insurance Certificate/ Membership Certificate, not earlier than the date of payment of Insurance premium.

Conventional Treatment refers to Treatment that:

- is established as best medical practice in the country where the Treatment is taking place; and
- is clinically appropriate in terms of necessity, type, frequency, extent, duration, and the facility where the Treatment is provided; and
- has been proven to be effective and safe for the Treatment of Your Insured Person's medical condition through high quality clinical trial evidence and through substantive peer reviewed clinical evidence in published authoritative medical journals.

Conventional Treatment does not cost more than an equivalent Treatment that delivers similar therapeutic or diagnostic outcome. It must not be provided or used primarily for the convenience or financial or other advantage of You or Your Medical Practitioner or health professional.

If the Treatment is a drug, the drug must have been established as being effective and must be licensed for use by either:

- the Medicines and Healthcare products Regulatory Agency (MHRA) if the Treatment is to be provided in the United Kingdom; or
- the European Medicines Agency (EMA) if the Treatment is to be provided in Europe, but outside of the United Kingdom; or
- the US Food and Drug Administration (FDA) if the Treatment is to be provided outside Europe.

The drug must be used within the terms of its licence and dosage for which it is approved.

Conventional Treatment will also apply to the use of related medical equipment or consumables.

Chronic Condition means a disease, Illness or Injury that has one or more of the following characteristics:

- it needs ongoing or long-term monitoring through consultations, examinations, check-ups and/or tests
- it needs ongoing or long-term control or relief of symptoms
- it requires Your rehabilitation or for You to be specially trained to cope with it
- it continues indefinitely
- it has no known cure
- it comes back or is likely to come back

Deductible means the annual amount each Insured Person must pay for each Period of Insurance before the Policy will pay certain benefits. Deductible amounts are set out in the Insurance Certificate/ Membership Certificate. Deductible is applied to all benefits.

Date of Entry means the date cover on MediSky Healthcare Plan first starts.

Day-care means Treatment provided in a Hospital where an Insured Person is admitted but it is not Medically Necessary to stay in the Hospital for one or more nights.

Dependant means as indicated on the Application or Insurance Certificate/Membership Certificate the Insured Person's legal Spouse (or partner of the same or opposite sex who, at the time of the Insured Event, has been living with the Insured Person for more than six continuous months) who is not legally separated from him/her, and the Insured Person's child, including illegitimate children (step-child, foster child or legally adopted child) aged under 19 on the date when the Insured Person has been granted an Insurance protection on the basis of the Healthcare Plan programme for the first time or at any subsequent Renewal of the Policy (or up to 25 Years old if it is evidenced that such child is continuing in full-time education, unmarried, unemployed) and is financially dependent on the Insured Person for support.

Diagnose means the determination by a qualified medical practitioner of which disease or condition explains a person's symptoms and signs.

Emergency Out-Patient Treatment means Treatment Medically Necessary as a result of an Accident or sudden Illness, received in a Casualty/Emergency room within 48 (forty-eight) hours of the accident or onset of the Illness, but which does not require admission to Hospital as an In-Patient or Day-care patient.

Emergency Treatment means Treatment that commences within 24 hours of an Illness or Accident happened causing direct threat to health and requiring urgent medical attention.

Experimental refers to Treatment modality or medication in Our reasonable opinion whose efficacy and safety are yet to be established and lack the authoritative evidence-based clinical studies. These are also Treatment modalities or medicines which are not generally accepted by the medical community as proven to be effective or recognised by the professional medical organisations as conforming to accepted medical practice. This definition also includes equipment used for purposes other than those defined under their license or which is undergoing study, research, or testing.

Full cover refers to the amount of the claim that will be fully paid by Us in accordance with the terms and conditions of this Policy and within the Insured Person's overall maximum benefit stated in the Table of Benefit.

Hereditary and congenital conditions refer to Hereditary or congenital abnormality, deformity, disease, Illness or Injury present at birth arising during the antenatal stages of pregnancy or caused during childbirth. Cover for Hereditary and congenital conditions are limited to In-Patient Treatment only and as specified in the Table of Benefits.

Hospital means any establishment which is licensed as a medical or surgical Hospital in the country where it operates and where the patient is permanently supervised by a medical practitioner. The following establishments are not considered hospitals: rest and nursing homes, spas, cure-centres and health resorts.

Illness means any sickness, disease, disorder or alteration in the Insured Person's medical condition marked by a pathological deviation from the normal health state diagnosed by a Physician.

Insurance Certificate/membership certificate special conditions forming part of the Insured Person's Policy, stating the names of the Insured Persons, the Area of coverage, the Period of Insurance, the level of coverage and any optional extensions selected, and any special provisions which apply to the Policy.

Insured Person refers to the main Insured Person and his/her Dependants (for Group Plan refers to Employees and his/her Dependants, if agreed) as stated on the Insurance Certificate/Membership Certificate, issued to the Insured Person or Policyholder or Employer to whom an Insurance protection has been granted, the basis of the Policy concluded in the frame of MediSky Healthcare Plan for the purpose of obtaining Insurance protection for itself or itself and its Dependants.

Insurer the Insurance company that provides the Insurance cover Inter Partner Assistance Oddział - Polska S.A. ul. Giełdowa 1, 01-211 Warszawa.

Injury: physical damage or harm caused to the body as a result of an accident.

Individual Benefit Limit the maximum amount that We will cover for selected benefits.

In-Patient means Treatment provided in a Hospital where an Insured Person is admitted and, out of medical necessity, occupies a bed for one or more nights but not exceeding 12 months in total for any one Insured Event.

In-Patient Cash Benefit benefit means a daily cash benefit that is paid by Us, if You have received Treatment in a Hospital, You have stayed overnight and you have not received any charges from the Hospital.

Insured Event means an Accident or Illness or in case the selected Insurance option covers also benefits stated in Agreement – also death of Insured Person, occurred during the Period of Insurance within the Area of cover which entitles the Insured Person to receive benefits under the Policy concluded in the frame of the Healthcare Plan programme.

Insurance Plan benefits as detailed on the Insurance Certificate/Membership Certificate.

Lifetime refers to the period in which the Insured Person is alive and remains as an Insured Person under the terms of this Policy. We will pay the maximum limit shown in the Table of Benefits for eligible benefits in aggregate during the lifetime of the Insured Person.

Limitation Period is the period beyond which a party's rights may no longer be invoked.

Medical Advisor means the Medical Practitioner We choose to advise on Claims under the Policy concluded on the basis of MediSky Healthcare Plan programme.

Medical Expenses means expenses incurred for Treatment following an Accident or Illness as a result of an Insured Event.

Medically Necessary means the appropriate provision of diagnostics or Treatments to Diagnose, or treat an Illness, Injury, condition, disease or its symptoms and that meet accepted standards of medicine for a medically appropriate duration that is approved by Us and Our medical advisors as the most cost effective, appropriate Conventional Treatment and not of an Experimental, investigative, research or preventive nature.

MediSky International sp. z o.o. with its registered seat in Warsaw, Karolkowa 28/201 street, entered into a registry of entrepreneurs of the National Court Register kept by the District Court of the capital city of Warsaw in Warsaw, XII Commercial Division of the National Court Register under KRS no 0000628122, NIP 5252669863 – the Insurance agent, entered into the registry of Insurance agents under the number 11232800/A.

MediSky is the Plan administrator of the Policy.

New-born Care costs of Treatment of an acute medical condition for a new-born baby up to 30 (thirty) days after the date of birth provided that the new-born is added to the Plan within 30 days of birth and premium paid. In circumstances where We require details of the new-born baby's medical history before the baby is added to the Plan, We reserve the right to apply specific restrictions to the cover We will offer. We do not pay for New-born Care benefits for babies born as a result of Assisted Reproduction Technologies or Conception, born to surrogate or who have been adopted as these children can join after 90 days and once We have completed the underwriting.

Organ Transplant means medical Treatment incurred in respect of kidney, heart, heart-lung, liver, pancreas transplants, and does NOT include the implantation of an artificial heart. In the circumstances where the Organ Transplant is required because of a Hereditary or Congenital anomaly, the cover shall be limited under the benefit provisions – Hereditary and Congenital anomalies, if applicable under the Insured Person's Plan.

Out-Patient means medical Treatment provided to the Insured Person or recommended by a Physician when it is not Medically Necessary for an Insured Person to be admitted as an In-Patient or Day-care patient in a Hospital or any other facility for medical care.

Overall Maximum Limit the maximum We will pay for all benefits in total, per Insured Person, per contract Year.

Period of Insurance means the period specified on the Insurance Certificate/Membership Certificate for which the appropriate premium has been paid.

Physician means a legally licensed medical practitioner who is a doctor recognized by the law of the country where Treatment covered under the Policy is provided and who, by rendering such Treatment is practicing within the scope of his/her license and training.

Physiotherapy means Treatment recommended by a Physician for medical reasons following an Insured incident and provided by a licensed Physiotherapist.

Physiotherapist means a practitioner who must be fully trained and legally qualified and permitted to practice by the relevant authorities in the country where the Treatment is received.

Policyholder means a natural or moral person or a legal entity having no legal personality who is a party to the Policy concluded for the benefit of Insured Persons as well as a natural person who concluded the Policy to obtain an Insurance protection for itself or for itself and its Dependants.

Policy/Plan means a document confirming the conclusion of insurance contract between the Policyholder and Us. The full terms of Your Policy/Plan are set out in the latest versions of:

- any Application form We ask You to fill in
- Insurance/membership certificate
- this General Terms and Conditions
- electronic membership card.

Policy Limits means the financial limits of Our liabilities towards Insured Persons' for specific benefits applicable per Insured Event, per Year of Insurance, or lifetime, indicated in the Table of Benefits. Lifetime refers to maximum aggregate limit for the whole of the Insured Person's membership on the Plan/Policy.

Plan, level of benefits (as detailed on the Insurance Certificate/Membership Certificate).

Pre-existing Conditions, any condition or Illness:

- which had existed or was in existence prior to the original Commencement Date of this Policy or reinstatement or Plan Upgrade (whichever is later), or
- for which the Insured Person has experienced symptoms or displaying signs of (even if the Insured Person has not consulted a medical practitioner) on or prior to the original Commencement Date of this Policy or date of the application for this Policy or specific benefits, or
- where diagnostic tests showed the pathological existence of the condition or Illness on or prior to the original Commencement Date of this Policy or the date of the application for this Policy or specific benefits.

Prescribed Medicines refers to medication whose sale and use is legally subject to prescription by a Physician. Products which can be bought without a medical prescription are not included in this definition and are not eligible for reimbursement.

Principal Country of Residence means the country where the Insured Person lives and has his/her primary and/or secondary Home(s) for most part of the Policy Year, as stated on the Application Form and specified on the Insurance Certificate/Membership Certificate.

Proton beam therapy, this is subject to the availability and benefits limits (where applicable) shown in the Table of Benefits for your Insured Person's Plan, We will pay for Treatment:

We have Pre-athuthorised that are Medically Necessary, limited to the following eligible cancers:

- malignant solid Cancers in Insured Persons' aged 21 and under
- central nervous system (brain and spinal cord) Cancer
- chordomas or chondrosarcomas (types of spine Cancer) in the base of the skull or cervical spine (neck bones) which have not spread (metastasised)
- high naso-ethmoid, frontal and sphenoid tumours with base of skull involvement
- adenoid cystic carcinoma with perineural invasion
- esthesioneuroblastoma
- Cancer of the iris, ciliary body, or choroid parts of the eye (uveal melanoma) which has not spread (metastasised)
- conjunctival melanoma
- choroidal haemangioma

We do not pay for accelerated charged particle therapies other than the limited cover for Proton Beam Therapy in the circumstances stated above.

Prosthesis refers to an external prosthetic body part which is required following an accident or surgery for a covered medical condition and needed as part of the Treatment. We will pay for the initial prosthetic device and will not pay for replacements.

Rehabilitation means Treatment(s) designed to facilitate recovery from Injury, Illness, or disease (excluding mental Illness or disorders) so as to regain maximum self-sufficiency, form and function in as near normal manner as possible.

Reasonable and customary refers to the Medically Necessary fees or expenses incurred for Treatment, medical care, services and/or supplies which shall be considered by Us or by Our Medical Advisors to be Reasonable and Customary to the extent that they do not exceed the usual level of charges for similar medical Treatment, services and/or supplies in the country where these were incurred and includes fees or charges that would not have been incurred if no Insurance had existed.

The expenses paid for these medical services or Treatment which We or Our medical team considers Reasonable And Customary and which could not have reasonably been avoided without negatively affecting the Insured's medical condition. These expenses must not be more that the general level of charges of other medical care providers with similar standing in the locality, for giving like or comparable Treatment, services or supplies to individuals of the same gender, of comparable age, for a similar disease, Illness or Injury.

We normally calculate what is reasonable and customary (R&C) based on the average negotiated cost of the Treatment within the network applicable to your Policy in the country in which Treatment is received. Where no network or no negotiated cost exists in a network Hospital, or the Treatment is not available in a network Hospital, We will base that calculation on a combination of Our global experience, substantiated by statistical information from government health departments and information collected from independent medical specialists and surgeons practicing in the country or area where Treatment is received.

For the avoidance of doubt when comparing Treatment, We will also consider the complexity of the procedure, and the standard of the medical facility where the Treatment is received. If your Treatment requires more than one specialist or surgeon present at the same operative (surgical) session, We shall review the medical necessity in the management of such surgical problem or medical condition in terms of the different trained skills and complexity of the services provided as an identification to cover the total services. No additional benefits or cost is payable for surgical assistants. In the event of any differences in opinions between Our Medical Advisors or Physicians and your Physician, Our Medical Advisors or Physician's opinion shall prevail.

Renewal of the Policy means conclusion of Policies on the basis of MediSky Healthcare Plan for the second and following Insurance Periods as well as granting Insurance protection for the second and following Insurance Periods.

Routine Vaccinations means vaccinations provided up to 10 Years of age and may include Diphtheria, Hepatitis A & B, Measles, Mumps, Pertussis, Polio, Rubella, Tetanus, varicella, Haemophilus Influenza B, Rotavirus, Meningococcus and Pneumococcal Conjugate.

Spouse is the person married to the Insured Person or Employee or group member, who is not separated or divorced according to a judgement with the status of res judicata. This is a legally registered union between two people of different or same gender. in this Policy, a civil partner is treated as a Spouse.

Subrogation, Our right to act as your substitute to pursue any rights you may have against a third party who is liable for a Claim paid by Us under the Policy.

Table of Benefits means the document attached to the Policy, stating inter alia the benefits provided under the respective programmes and financial limits for these benefits.

Tissue Transplant means medical Treatment incurred in respect of bone marrow and cornea transplants. In the circumstances where the Tissue Transplant is required because of a Hereditary or Congenital anomaly, the cover shall be limited under the benefit provisions – Hereditary and Congenital anomalies, if applicable under the Insured Person's Plan.

Replacement tissue means biomaterial available for the repair or replacement of biological tissues.

Treatment means any Medically Necessary surgical procedure or medical intervention which is required to cure an Injury or Illness or to provide relief of a Chronic Condition.

Waiting period is a period of time commencing on the start date of the contract or the date when an Insured Person is included under the Plan or when the Insured Person has applied for a specific Benefit Plan during which the Insured Person is not entitled for particular benefits.

We or Us/Our means the Insurer.

Year means the 12 months from the Policy start date or last renewal date.

You/ Your means the Insured Person, the Main Member and/or Your Dependents.

Additional Definition applicable for Group Plan:

Actively at work refers to an Employee who is at work on the Policy Commencement Date and performing every duty of his/her present occupation on a customary and fulltime basis. An Employee shall also be deemed Actively at work if he/she is on annual leave and is not absent from work due to Illness, Injury, or other form of disability. If an Employee is not actively at work on the Policy Commencement Date, he/she will not be covered.

Activities of daily living refer to a Dependant partner or Dependant child(ren) (who is eligible for cover under the group scheme) aged at least three (3) Years old and who can perform all the following activities:

- Dressing: The ability to put on, take off, secure, and unfasten all garments and as appropriate, any braces, artificial limbs, or other surgical appliances;
- Feeding: The ability to feed one's self once food has been prepared and made available;
- Mobility: The ability to move indoors from room to room on level surfaces;
- Toileting: The ability to use the lavatory or otherwise manage bowel and bladder functions to maintain a satisfactory level of personal hygiene;
- Transferring: the ability to move from a bed to an upright chair or wheelchair and vice versa;
- Washing: The ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means.

Eligibility date means the date or period stated in your Policy schedule and/or endorsement on which a member becomes eligible for cover under this Policy.

Employee means a full-time member who is in direct employment with the Employer and is Actively at work on the date he/she is eligible for cover under this Policy and accepted by the Insurer as members under the Plan or any other category of alternative members as set in the current group membership listing (as amended throughout the course of the Year).

Employer means the legal entity that employs the Employee and that is responsible for the payment of premiums under this Policy.

Group Policy anniversary date The date the premiums for the group are reviewed. The first group anniversary date will be twelve (12) months after the start date of the group scheme and at each twelve (12)-months period thereafter. For, interpreting your Policy, all references to Policy anniversary will be defined to mean the group anniversary date.

The limits are applied per Insurance Year unless otherwise mentioned in the current General Terms and Conditions.

The limits are applied within your Overall Maximum Limit per Insurance Year unless otherwise mentioned in current Insurance conditions or in the Insurance Policy. Benefits marked with * are Optional benefit riders which the Policyholder must apply and additional premiums paid.

INSURANCE PLANS	SUNRISE HOME	TERMS AND DEFINITIONS
Area of coverage	Freedom of choice and access to any clinic/ Hospital within Poland	
OVERALL MAXIMUM LIMIT	€ 250 000	
In-Patient (emergency/programmed)	Full cover	We will pay for hospital room and board costs for a standard single en-suite room including general nursing care.
Rehabilitation (pre-authorisation)	€ 2 000 (after a surgery)	We will pay for In-Patient rehabilitation costs for a combination of therapies such as physical, occupational and speech therapy for Rehabilitation for as long as: • it follows an acute brain Injury, such as a stroke or accident; and • it is a part of Treatment that is covered by • the Policy; and • a Medical Practitioner/Physician who specialises in Rehabilitation is overseeing the Insured Person's Treatment; and • We have agreed the costs before the Insured Person starts Rehabilitation; and • the Treatment could not be carried out on an Out-Patient basis.
Advanced imaging (MRI, CT, PET)	Full cover (In-Patient + Out-Patient)	We will pay for the costs of CT, MRI or PET scan (or combination of these scans) when recommended by Your Specialist
Cancer Treatment (surgery, hospitalization, ambulatory, medicines, Treatments, therapies)	Full cover	This benefit requires Pre-authorisation. We will pay for fees specifically related to active Cancer Treatment and this includes chemotherapy, radiotherapy, oncology, diagnostic tests, and prescribed medicines. Cancer Treatment is subject to a limit of up to 120 days per In-Patient admission.
Transplant medical services	Full cover (In-Patient) € 25 000 (Out-patient)	This benefit is subject to Pre-authorisation. This refers to the Treatment for and in relation to life-sustaining for the case of transplant of human organs for the following transplants: kidney, heart, heart-lung, liver, pancreas transplants approved by our Medical Advisor in respect of the Insured Person as the recipient of the organ. The transplant will be carried out in internationally accredited institutions by accredited surgeons and where the organ procurement is in accordance with World Health Organisation (WHO) guidelines. Costs associated for the donor, the search or and the procurement are excluded. The specific type and length of treatment will be determined by the type of transplant and underlying medical condition.
Prostheses (surgical implants)	Full cover	We will pay for internal prosthesis/medical implants needed as part of treatment. These must be approved by US Food and Drug Administration (FDA) and are used for their intended purpose and proven to be effective Treatment.
Hereditary and congenital conditions	Full cover in the first 60 days after birth (In-Patient)	We will pay for the In-Patient/Day-Patient treatment of Hereditary and congenital conditions, subject to Pre-authorisation. After the specific period, the new born will be subject to underwriting.
Cash-benefit (public system In-Patient - in the country where you pay the taxes)	€ 100/night (maximum 10 nights/Year)	We will pay a cash benefit for each night You spend in a hospital where You are not charged for Your admission (i.e.: at a public hospital or treatment is free of charge).
Out-patient surgery	Full cover	We will pay for the costs of a surgical procedure performed as an Out-Patient under a local anaesthesia.

MEDISKY INTERNATIONAL

INSURANCE PLANS	SUNRISE HOME	TERMS AND DEFINITIONS
Out-Patient consultations (includes Telemedicine consultation – only 1 (one) consultation per day from an approved telehealth provider) (recommended with presumptive diagnosis) **Prescribed Medicines** (prescribed by Your medical practitioner to treat an eligible medical condition and includes prescribed medicines following a Telemedicine consultation)	€ 1 000	
Laboratory analysis, X-rays, diagnostic tests	€ 2 000	
Physiotherapy	Up to 12 sessions only, Up to maximum € 1 000 in aggregate, per period of cover	
Emergency Out-Patient room	Full cover	
Routine health check and vaccinations	€ 100 Prevention (after 1 year Waiting period)	
Type of ambulances covered: • road ambulance • air ambulance, if appropriate. **Reasons when transport by ambulance is covered:** • for emergency transport to or between hospitals; or • when a medical practitioner says that it is medically essential and when you need to have medical supervision while being transported	Full cover	
Lump sum in case of death	€ 5 000	
Second Medical Opinion Service	Included	
MediSky Assistance	Customer Care Department (9:00 – 17:30, Mo-Fr)	