

HEALTH INSURANCE PROGRAMS

Effective from 1 August 2021

HEALTH INSURANCE RULES No. 010

Addendum No. 1 to

I. This Addendum defines the scope and nature of the Insurance Coverage, Insurable Events, Uninsurable Events, other terms and requirements under the Health Insurance Programs offered by the Insurer.

II. The Addendum is the integral part of the Insurance Rules.

III. In case of controversy or incompliance in provisions of the Addendum and the Insurance Rules, the provisions and requirements provided for in the Addendum shall prevail.

1. AMBULATORY TREATMENT AND DIAGNOSTICS

1.1. The Insurable Event shall be deemed to be the following Medically Reasonable Health Care Services provided to the Insured due to a Health Disorder (an acute disease, a chronic disease exacerbation or an injury) and its follow-up/monitoring in the Health Care Institution and the associated costs.

1.2. Reimbursable health care services:

1.2.1. Consultation with a family doctor or medical specialist, including remote healthcare services; home visits by family doctors;

1.2.2. The examinations and tests performed by a doctor, which are periodically required at a specified (prescribed by a doctor) time interval in order to regularly monitor the health condition of the Insured who suffers from a specific chronic disease or takes specific pharmaceuticals;

1.2.3. Consultations of a psychiatrist, psychiatrist-psychotherapist, medical psychologist, medical psychologist-psychotherapist and psychotherapeutic treatment performed by the said medical specialists, but not more than 12 (twelve) visits during 1 (one) year of the Insurance Period;

1.2.4. Diagnostic tests prescribed by a doctor:

(a) Laboratory tests: clinical, biochemical cytological-histological, immunoenzymatic, microbiological-bacteriological;

b) Instrumental tests: clinical physiological, X-ray, ultrasound, endoscopic, computed tomography, nuclear magnetic resonance and other imaging tests;

1.2.5. Day surgery/day stationary services;

IMPORTANT CLAUSE: these costs in full or in part shall be reimbursed only if:

a) They are not partially reimbursed from the CHIF budget; and

b) The Insurer is informed about the necessity to provide Day Surgery/Day Stationary services by a written notice or via e-mail sd@compensalife.lt prior to starting treatment and gives its prior written consent thereto. The Insured is responsible for obtaining the consent of the Insurer..

1.2.6. Ambulatory surgery services;

1.2.7. Nursing services.

1.3. Non-reimbursable expenses for:

1.3.1. Termination of pregnancy; Health Disorders that occur or exacerbate due to termination of pregnancy for medical indications; pregnancy diagnostics, pregnancy care; childbirth and postnatal care; Health Disorders caused by pregnancy or childbirth (e.g., gynecological, endocrine, breast, neurological, urological, etc. pathologies); pregnancy prevention services;

1.3.2. Reparative and aesthetic surgical treatment; procedures and surgery performed for cosmetological, reparative and/or aesthetic purposes; dermatological treatment, including but not limited to phototherapy, photodynamic therapy, pulsed light therapy, laser aesthetic procedures (pigmentation, redness, dilated blood vessels, acne, stretch marks, scars, etc.); hair removal procedures; hair loss treatment; treatment with botulinum toxin injections; laser treatment of nail fungus;

1.3.3. Diagnosis and treatment of AIDS, HIV, syphilis, gonorrhea, trichomoniasis, chlamydia, ureaplasmosis, human papillomavirus, herpes genital and other sexually transmitted diseases;

1.3.4. Diagnosis and treatment of infertility/inability to get pregnant, potency disorders; artificial insemination procedures;

1.3.5. surgical treatment of overweight/obesity;

1.3.6. Vision correction; organ transplantation surgery, acquisition of endoprosthesis and joint replacement surgery;

1.3.7. Bone marrow transplants; hemodialysis procedures;

1.3.8. Stem cell or autologous therapy;

1.3.9. Long-term nursing/care and supportive care services;

1.3.10. Treatment of benign tumours, warts, moles;

1.3.11. Diagnosis and treatment of varicose veins in the legs;

1.3.12. Consultations of a dentist or an oral cavity and orthognatic surgeon and examinations or treatment prescribed by them;

1.3.13. Medical accessories used for day surgery/day stationery services, which are not reimbursed by the CHIF;

1.3.14. Alternative medicine services;

1.3.15. Sports medicine doctor's services.

2. STATIONARY TREATMENT

2.1. The Insurable Event shall be deemed to be the following Health Care Services provided to the Insured due to his Health Disorder, the elimination of which required therapeutic and/or surgical profile stationary treatment in the stationary Health Care Institution, where the Insured is provided with care for more than 48 hours.

2.2. Reimbursable health care services:

2.2.1. If the Additional Services in Public Hospitals sub-type of the Health Insurance Program is chosen – a single or double paid ward in public hospitals;

2.2.2. If the Stationary Treatment in State Hospitals sub-type of the Health Insurance Program is chosen – diagnostic services provided to the Insured during stationary treatment in public hospitals; purchased medical aids, Pharmaceuticals, paid wards;

2.2.3. If the Stationary Treatment in Private Hospitals sub-type of the Health Insurance Program is chosen – diagnostic services provided to the Insured during stationary treatment in private hospitals; additional services including medical aids, purchase of Pharmaceuticals and paid wards;

2.3. Non-reimbursable expenses for:

2.3.1.1.3.1. Termination of pregnancy; Health Disorders that occur or exacerbate due to termination of pregnancy for medical indications; pregnancy diagnostics, pregnancy care; childbirth and postnatal care; Health Disorders caused by pregnancy or childbirth (e.g., gynecological, endocrine, breast, neurological, urological, etc. pathologies);

2.3.2. Oral, maxillofacial surgery services in the stationary Health Care Institution;

2.3.3. Endoprosthesis acquisition and joint endoprosthesis surgery; organ transplant surgery; bone marrow transplants; reparative and aesthetic surgical treatment; surgical treatment of overweight/obesity;

2.3.4. Stationary rehabilitation services; mental illness/psychiatric treatment services; long-term nursing/care and supportive care services.

3. PRENATAL CARE, CHILDBIRTH AND POSTNATAL CARE

3.1. The Insurable Event shall be deemed to be the following Health Care Services provided to the Insured due to pregnancy, childbirth and respective complications during the prenatal, child-birth and postnatal period and associated costs.

3.2. Reimbursable health care services:

3.2.1. Pregnancy diagnosis, pregnancy care services (i.e. periodic visits; monitoring of normal or high-risk pregnancy) provided in accordance with the requirements of applicable law on health examinations of pregnant women;

3.2.2. Fetal diagnosis, prenatal examinations, consultation with a geneticist doctor and prescribed treatment;

3.2.3. Diagnosis and treatment of health disorders identified during visits of a pregnant woman; diagnosis and treatment of health disorders that have worsened during pregnancy and complications of pregnancy (e.g., gynecological, endocrine, breast, neurological, urological, etc. pathologies);

3.2.4. Diagnosis and treatment of health disorders that developed or worsened during childbirth, after giving birth and/or breastfeeding;

3.2.5. Prenatal, child-birth and postnatal services provided to the Insured, paid wards after childbirth in stationary Health Care Institutions.

4. DENTAL SERVICES

4.1. The Insurable Event shall be deemed to be the following Health Care Services provided to the Insured due to a Health Disorder in connection with the treatment and prevention of dental, oral and maxillofacial diseases and associated costs.

4.2. Reimbursable health care services:

4.2.1. Oral care specialist consultations, oral hygiene assessment, dental hard and soft plaque removal, fluorine application services;

4.2.2. Consultation with a dentist or oral cavity and maxillofacial surgeon; general dental endodontic, orthodontic, periodontal, surgical dental diseases, orthognathic treatment services;

restoration services for dental hard tissue defects with fillings, inlays, overlays and laminates; dental radiological examination, analgesia, tooth extraction services, including dental day surgery, bone replacement or artificial bone services; treatment by teeth protectors (e.g., orthodontic, relaxation, bruxism);

4.2.3. Dental prosthetics with dentures, implants services.

4.3. Non-reimbursable expenses for:

4.3.1. Teeth whitening, including whitening by teeth protectors.

5. PHARMACEUTICALS AND MEDICAL AIDS

5.1. The Insurable Event shall be deemed to be the purchase of Pharmaceuticals prescribed for the Insured due to the Health Disorder according to a doctor's prescription or medical document confirming the relevant prescription in Pharmacies, Health Care Institutions and/or the purchase or rental of Medical Aids in Pharmacies, Orthopedic Aids Stores and associated costs.

5.2. Reimbursable health care services:

5.2.1. Pharmaceuticals and Medical Aids reimbursable from the CHIF budget. If the Pharmaceutical purchased are not fully reimbursed from the CHIF budget, the balance of the full amount shall be reimbursed, unless otherwise provided in the Contract;

5.2.2. Pharmaceuticals and Medical Aids not reimbursed from the CHIF budget shall be reimbursed as provided for in the Contract;

5.2.3. Pharmaceuticals and Medical Aids used during Day Surgery/Day Stationary and/or Ambulatory Surgery shall be reimbursed as provided for in the Contract.

5.3. Non-reimbursable expenses for:

5.3.1. Pharmaceuticals for addiction diseases, potency disorders, weight loss; sex hormones and pharmaceuticals for the reproductive system; contraceptives;

5.3.2. Vitamin and mineral supplements with ATC code A11 or A12 no matter how they are bought in Pharmacies: with or without the doctor's prescription;

5.3.3. Thermometers, hygiene aids, appliances for hygiene, testers, heaters, scales and blood pressure measuring apparatus and other functional diagnostic appliances and/or instruments;

5.3.4. Compensatory technical aids (wheelchairs, functional beds);

5.3.5. Purchase or rental of wellness/rehabilitation aids;

5.3.6. Herbal, animal or homeopathic preparations; preparations and articles having various functions without an ATC code.

6. VITAMINS, OVER-THE-COUNTER PHARMACEUTICALS

6.1. The Insurable Event shall be deemed to be the purchase of vitamins, food supplements, prescription and over-the-counter Pharmaceuticals for the treatment or prevention of the Insured's Health Disorder in Pharmacies and associated costs.

6.2. Reimbursable health care services:

6.2.1. Vitamins, mineral supplements, food supplements, homeopathic and medicinal preparations of herbal or animal origin, multi-functional preparations and preparations that do not have the assigned ATC code;

6.2.2. Over-the-counter Pharmaceuticals without the doctor's prescription.

6.2.3. Vitamins and mineral supplements with ATC code A11 or A12.

6.3. Non-reimbursable expenses for:

6.3.1. Pharmaceuticals for addiction diseases, potency disorders, weight loss; sex hormones and pharmaceuticals for the reproductive system; contraceptives;

7. OPTICS

7.1. The Insurable Event shall be deemed to be the following Health Care Services provided to the Insured due to the Health Disorder related to his vision and associated costs.

7.2. Reimbursable health care services:

7.2.1. Consultancy on the choice of optical aids with an ophthalmologist or optometrist;

7.2.2. Prescription glasses lenses, prescription glasses frames, contact lenses and contact lens maintenance aids prescribed by an ophthalmologist or optometrist, which are necessary for the correction of the existing visual disorder provided that they are purchased in specialized opticians;

7.2.3. Vision correction and/or vision preservation surgery,

disposable instruments and accessories used during this surgery;

7.2.4. Prescription glasses and lens manufacturing service;

7.2.5. Purchase of VDU spectacles, dioptric sunglasses.

7.3. Non-reimbursable expenses for:

7.3.1. Glasses maintenance aids and accessories (e.g., spectacle cases, cleaners, wipes, etc.);

7.3.2. sunglasses;

7.3.3. Purchase of artificial tears; supplements; medical preparations.

8. PREVENTIVE AND PERIODICAL HEALTH EXAMINATIONS AND ANALYSES:

8.1. The Insurable Event shall be deemed to be the following Health Care Services provided to the Insured in the Health Care Institution with regard to Health Disorders seeking to avoid them or pre-assess the Insured's health condition and associated costs.

8.2. Reimbursable health care services:

8.2.1. The tests prescribed to the Insured by a doctor or chosen at the request of the Insured and consultations of doctors;

8.2.2. Preventive health examination; medical examinations for issuance of certificates; health examinations of employees to determine fitness for work;

8.2.3. Diagnosis of genetically inherited, congenital diseases;

8.2.4. Sports medicine doctor's consultations.

8.2.5. Diagnosis of AIDS, HIV, syphilis, gonorrhea, trichomoniasis, chlamydia, ureaplasmosis, human papillomavirus, herpes genital and other sexually transmitted diseases;

8.2.6. Examinations and consultations not related to the Health

Disorder made at the request of the Insured provided that the results of the performed examinations do not exceed the normal limits;

8.2.7. Laboratory testing of vitamins;

8.2.8. Diagnostic tests for chronic diseases;

8.2.9. Diagnosis of infertility/inability to get pregnant, potency disorders, contraception consultations;

8.2.10. Diagnostic tests for leg vein varicose.

8.3. Non-reimbursable expenses for:

8.3.1. Pregnancy diagnostics and care; diagnosis of health disorders that occurred or worsened due to pregnancy and/or pregnancy termination due to medical indications; diagnosis of health disorders caused by childbirth and breastfeeding;

8.3.2. Alternative medicine services.

8.3.3. Consultations of a dentist or an oral cavity and orthognatic surgeon and examinations prescribed by them.

9. VACCINES

9.1. The Insurable Event shall be deemed to be the following Health Care Services related to vaccines, which are provided to the Insured in the Health Care Institution, and associated costs.

9.2. Reimbursable health care services:

9.2.1. Vaccines chosen by the insured or prescribed by a doctor;

9.2.2. Vaccination services, vaccination consultations.

10. REHABILITATION TREATMENT

10.1. The Insurable Event shall be deemed to be the following Health Care Services related to rehabilitation treatment due to the Insured's Health Disorder, which are provided to the Insured in the Health Care Institution, and associated costs.

10.2. Reimbursable health care services:

10.2.1. If the Medical Rehabilitation sub-type of this Health Insurance Program is chosen, the following services shall be reimbursed: physical medicine and rehabilitation doctor's consultations; consultations of a kinesiologist, ergotherapist prescribed within the competence of the medical specialist; physiotherapy (ultrasound, microwave, pulse therapy, magnet therapy and other rehabilitation treatment procedures), kinesiotherapy, ergotherapy, mud and water procedures, therapeutic massages, halotherapy, manual therapy;

10.2.2. if the Rehabilitation Treatment after 72 Hours of Stationary Treatment sub-type of this Health Insurance Program is chosen, the following services shall be reimbursed: the consultations of a kinesiologist and ergotherapist prescribed within the competence of the medical specialist; physiotherapy (ultrasound, microwave, pulse therapy, magnet therapy and other rehabilitative treatment procedures), kinesiotherapy, ergotherapy, mud and water treatments, therapeutic massages, halotherapy, manual therapy services for the treatment of a health disorder in the stationary Health Care Institution for at least 72 hours;

10.2.3. If the Rehabilitation sub-type of this Health Insurance Program is chosen, the following services shall be reimbursed:

physical medicine and rehabilitation doctor's consultations; consultations of a kinesiologist, ergotherapist prescribed within the competence of the medical specialist; physiotherapy (ultrasound, microwave, pulse therapy, magnet therapy and other rehabilitation treatment procedures), kinesiotherapy, ergotherapy, mud and water procedures, therapeutic massages, halotherapy, manual therapy;

10.2.4. If the Medical Wellness sub-type of this Health Insurance Program is chosen, the following services shall be reimbursed: sports medicine, physical medicine and rehabilitation doctor's consultations; consultations of a kinesiologist, ergotherapist; physiotherapy (ultrasound, microwave, pulse therapy, magnet therapy and other rehabilitation treatment procedures), kinesiotherapy, ergotherapy, mud and water procedures, therapeutic massages, halotherapy, manual therapy; alternative medicine services;

10.3. Non-reimbursable expenses for:

10.3.1. Overnight accommodation/accommodation, catering services;

10.3.2. Purchase or rental of wellness/rehabilitation aids;

10.3.3. Facial massages and cosmetic procedures;

10.3.4. Rehabilitation treatment services provided to the Insured due to his Health Disorder related to osteochondrosis and/or degenerative changes (if the Medical Rehabilitation sub-type of this Health Insurance Program is chosen).

11. MEDICAL SERVICES

11.1. The Insurable Event shall be deemed to be the following Health Care Services provided to the Insured to treat or prevent his Health Disorder in the Health Care Institution, Specialized Optician, Pharmacy or the Store of Orthopedic Aids and associated costs.

11.2. Reimbursable health care services:

11.2.1. Reimbursable and non-reimbursable Healthcare Services in accordance with the descriptions of the following Health Insurance Programs and subject to the following exceptions:

- a) Ambulatory treatment and diagnostics;
- b) Stationary treatment;
- c) Prenatal care, childbirth and postnatal care
- d) Dental services;
- e) Pharmaceuticals and medical aids;
- f) Vitamins, over-the-counter pharmaceuticals;
- g) Optics;
- h) Preventive and periodical health examinations and analyses;
- i) Vaccines;
- j) Rehabilitation treatment.

11.2.2. Alternative medicine services;

11.2.3. Psychologist services (including those provided by entities operating on the basis of a certificate for individual activity).

11.3. Non-reimbursable expenses for:

11.3.1. Reparative surgeries and procedures if they are performed in the absence of a Health Disorder; hair removal, botulinum toxin treatment procedures; facial massages and cosmetic procedures;

11.3.2. Purchase of hygiene aids, goods and appliances; skin and hair care, decorative cosmetics;

11.3.3. Overnight accommodation/accommodation, catering services;

11.3.4. Purchase or rental of wellness/rehabilitation aids;

11.3.5. Teeth whitening procedures;

11.3.6. Purchase of eyeglass care aids and accessories, sunglasses.

12. WELLNESS SERVICES

12.1. The Insurable Event shall be deemed to be the following Health Care and/or Wellness Services provided to the Insured in the Health Care Institution, SPA centres and sanatoriums, sports clubs, swimming pools, entertainment parks or by any other person entitled to engage in the respective activity and associated costs.

12.2. Reimbursable health care services and wellness services:

12.2.1. Consultations and services provided by a sports medicine doctor, a physical medicine and rehabilitation doctor, a kinezitherapists, a reflexologist; water, physiotherapy, manual therapy, massage, mud procedures; body composition analysis, ergonomic body position tests and other services provided for in the Contract;

12.2.2. Consultations of a psychiatrist, a medical psychologist, a psychologist, a psychologist-psychotherapist and their psychotherapeutic treatment;

12.2.3. Alternative medicine services;

12.2.4. Physical activity: individual and group health, wellness, physical education services for all sports;

12.2.5. Consultations of a dietitian, nutritionist and drawing up a nutrition plan.

12.3. If the services specified in clause 12.2.4 of Addendum No.1 to the Insurance Rules are purchased under the Wellness Services Subscription, only a part of the expenses for the period of the subscription coinciding with the validity period of the Insurance Coverage may be reimbursed.

12.4. Non-reimbursable expenses for:

12.4.1. Overnight accommodation/accommodation, catering services;

12.4.2. Purchase or rental of wellness/rehabilitation aids;

12.4.3. Facial massages and cosmetic procedures;

12.4.4. Competition / participant / camp fee; entertainment services (e.g., bowling, carting, billiards, saunas, hot tub, etc.); meditation classes/practices;

12.4.5. occupations without physical activity (e.g., brain/desk games).

13. ALL SERVICES

13.1. The Insurable Event shall be deemed to be the following Health Care and/or Wellness Services and other goods and services provided to the Insured in the Health Care Institution, Pharmacies, the store of orthopaedic aids, SPA centres and sanatoriums, sports clubs, swimming pools, entertainment parks or by any other person entitled to engage in the respective activity and associated costs.

13.2. Reimbursable services:

13.2.1. reimbursable and non-reimbursable Healthcare Services and Wellness Services in accordance with the descriptions of these Health Insurance Programs and subject to the following exceptions:

- a) Ambulatory treatment and diagnostics;
- b) Stationary treatment;
- c) Prenatal care, childbirth and postnatal care
- d) Dental services;
- e) Pharmaceuticals and medical aids;
- f) Vitamins, over-the-counter pharmaceuticals;
- g) Optics;
- h) Preventive and periodical health examinations and analyses;
- i) Vaccines;
- j) Rehabilitation treatment;
- k) Wellness services.

13.2.2. Alternative medicine services;

13.2.3. personal hygiene aids; dental care aids, including toothbrushes, toothpaste, mouthwash, irrigators, etc.; skin and hair care medical aids.

13.3. Non-reimbursable expenses for:

13.3.1. Overnight accommodation/accommodation, catering services;

13.3.2. Purchase or rental of wellness/rehabilitation aids;

13.3.3. Facial massages and cosmetic procedures; reparative surgeries and procedures if they are performed in the absence of a health disorder; hair removal, botulinum toxin treatment procedures;

13.3.4. Purchase of decorative cosmetics aids; hair styling aids, cosmetics appliances;

13.3.5. Competition / participant / camp fee; entertainment services (e.g., bowling, carting, billiards, saunas, hot tub, etc.); meditation classes/practices;

13.3.6. Occupations without physical activity (e.g., brain / desk games).

14. CRITICAL DISEASES

14.1. The Insurable Event shall be deemed to be the Critical disease diagnosed for the first time during the validity period of the Insurance Coverage provided for in the List of Critical Illnesses/Contract, due to which the Insured incurs expenses for Medically Reasonable Services that are not reimbursed by the CHIF.

14.2. Insurance Indemnity

14.2.1. The Insurance Indemnity for the Insurable Event under this Health Insurance Program (regardless of the number of Critical diseases diagnosed at one time) shall be paid to the Insured as indemnity for the expenses incurred for Health Care Services in one of the following ways chosen by the Policyholder when concluding the Contract:

14.2.1.1. As the Sum Insured for Critical Diseases provided for in the Contract; or

14.2.1.2. As Insurance Indemnities according to the requirements applicable to the Health Insurance Programs: Ambulatory Treatment and Diagnostics, Stationary Treatment, Rehabilitation Treatment, Pharmaceuticals and Medical Aids, within the limits of the Sum Insured of the relevant Health Insurance Program.

14.2.2. In case Insurance Indemnity is paid in the manner provided for in sub-clause 14.2.1.2 of Addendum No. 1 to the Insurance Rules, the expenses of the Insured sustained due to the Insurable Event that occurs during the Insurance Period shall be subject to indemnification. However, a claim for the Insurance Indemnity and reimbursement of such expenses may be submitted no later than within 6 (six) months from the last day of the Insurance Period.

14.3. Non-insurable events under this Insurance Program:

14.3.1. An event recognized as a Non-insurable one in accordance with the provisions of clause 12 of the Insurance Rules;

14.3.2. The Critical Disease or a disease that caused the Critical disease is diagnosed before the conclusion of the Contract or less than 60 (sixty) days after the entry into force of the Insurance Coverage. This period shall also be applicable if the Insurance Coverage is suspended or terminated during the validity of the Contract. However, this period shall not be applicable when the Insurance Coverage provided under the Contract under the Critical Diseases Health Insurance Program is renewed for a new Insurance Period, as well as when the Critical Disease is caused by the Accident during that period;

14.3.3. The Critical Disease does not meet the criteria for recognition as a Critical Disease and an Insurable Event as indicated in this Health Insurance Program and the List of Critical Diseases;

14.3.4. Recurrence of the same Critical Disease;

14.3.5. The Insured dies within 30 (thirty) days after he was diagnosed with one of the Critical Diseases.

14.4. The List of Critical Diseases:

14.4.1. The list of critical diseases, concepts, criteria and requirements for recognizing an event as the Insurable Event or the Non-Insurable Event:

14.4.1.1. Malignant tumor (cancer) means the uncontrolled growth, spread and invasion (penetration) of malignant cells into tissues.

The Insurance Indemnity shall be paid only in case of incontrovertible evidence of invasion into tissues and when the malignancy of the cells is supported by histological findings. The diagnosis must be confirmed by an oncologist.

The concept of cancer shall also include leukaemia and malignant lymphoma as well as myelo-dysplastic syndrome. In these cases, the diagnosis must be confirmed by an oncologist or haematologist.

The Insurance Indemnity shall not be paid for:

- Localised non-invasive tumours classified as pre-malignant changes (carcinoma in situ), including ductal and lobular carcinoma in situ of the breast, cervical dysplasia, cervical intraepithelial neoplasia (CIN-1, CIN-2 and CIN-3);
- Chronic lymphocytic leukaemia unless having progressed to at least Binet Stage B;
- Any prostate cancer unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0;
- Basal (stab) cell carcinoma and squamous cell carcinoma of the skin and malignant melanoma stage IA (T1aN0M0) unless there is evidence for metastases of this tumour;
- Papillary thyroid cancer less than 1 cm in diameter and histologically described as T1N0M0;
- Papillary micro-carcinoma of the bladder histologically described as Ta;
- Polycythemia rubra vera and essential thrombocythemia;
- Monoclonal gammopathy of undetermined significance;
- Gastric MALT Lymphoma (gastric extranodal lymphoma of the basal border) if the condition can be treated with Helicobacter-eradication (elimination);
- Gastrointestinal stromal tumour (GIST) stage I and II according to the AJCC (The American Joint Committee on Cancer) Cancer Staging Manual;
- Cutaneous lymphoma unless the condition requires treatment with chemotherapy or radiation;
- Microinvasive carcinoma of the breast (histologically classified as T1mic) unless the condition requires treatment with mastectomy, chemotherapy or radiation;
- Microinvasive carcinoma of the cervix uteri (histologically classified as stage IA1) unless the condition requires treatment with hysterectomy, chemotherapy or radiation;
- The Insured's malignancy (cancer) due to HIV or AIDS, if HIV or AIDS was diagnosed to the Insured before the conclusion of the Contract or during its validity.

14.4.1.2. Myocardial infarction shall mean the acute irreversible injury of heart muscle (necrosis) due to occlusion of an adequate artery, which prevents the blood flow to an area of myocardium.

Myocardial infarction must be supported by change in the

number of cardiac biomarkers (troponin or CK-MB enzymes) to levels considered diagnostic for myocardial infarction provided that at least 2 (two) following criteria are found:

- Ongoing angina pectoris (protracted cardiac angina);
- New electrocardiographic (ECG) changes indicative of myocardial infarction showing myocardial ischemia (new ST-T wave changes or new block of the left bundle branch)
- Development of pathological Q waves in the ECG.

The diagnosis must be confirmed by a cardiologist.

The Insurance Indemnity shall not be paid for:

- Elevations of troponin in absence of overt ischemic heart disease (e.g., myocarditis, stress-induced cardiomyopathy, palpitations, pulmonary embolism, drug intoxication);
- Myocardial infarction that occurs in the presence of intact coronary arteries due to coronary artery spasm, myocardial "bridges" (compression of the coronary arteries of the heart) or drug use;
- Myocardial infarction that occurs within 14 (fourteen) days after coronary angioplasty or graft-bypass surgery.

14.4.1.3. Insult (cerebral infarction) shall mean the death of brain tissue due to acute cerebrovascular event caused by intracranial vessels thrombosis, blood haemorrhage (including subarachnoid haemorrhage or embolism from extra-cranial sources) which causes acute onset of new neurological symptoms and a new neurological deficit.

The Insurance Indemnity shall be paid only if the fixed neurological deficit persists for more than 3 (three) months after cerebral infarction (paralytic stroke). The fixed neurological deficit must be confirmed by a neurologist and supported by imaging findings (MRT; CT, and others).

The Insurance Indemnity shall not be paid for:

- Reversible cerebral ischemic attack (RCIA) and reversible ischemic neurologic deficit (RIND);
- Direct and/or postoperative indirect injury to brain tissue or blood vessels that occurs due to injury and/or during surgery;
- Neurologic deficit due to general hypoxia, infection, inflammatory disease, migraine, or medical intervention;
- Incidental imaging findings (computer tomography or magnetic resonance tomography) without clearly related clinical cerebral infarction symptoms ("silent stroke").

14.4.1.4. Coronary artery bypass graft surgery shall mean open-heart coronary artery surgery to correct narrowing or blockage of two or more coronary arteries with bypass grafts using an autologous transplant (any superficial vein of a leg, internal thoracic artery or other suitable artery, etc.) as a bypass graft.

The Insurance Indemnity shall be paid provided only that surgery is confirmed to be necessary by a cardiologist or a cardiac surgeon and supported by angiographic findings.

The Insurance Indemnity shall not be paid for:

- Bypass surgery that is performed to treat one narrowed or blocked (occluded) coronary artery;
- Coronary artery angioplasty or stent-placement.

14.4.1.5. Prosthesis of heart valves shall mean a cardiac surgery to replace one or more heart valves in one of the following ways:

- Heart valve replacement or correction surgery performed in an open manner (opening the chest);
- Ross-procedure;
- Transcatheter correction of coronary arteries (catheter-based valvuloplasty);
- Transcatheter aortic valve implantation (TAVI).

The surgery must be confirmed to be medically necessary by a cardiologist or a cardiac surgeon and supported by echocardiogram or cardiac catheterization findings.

The Insurance Indemnity shall not be paid for transcatheter bicuspid (mitral) valve clipping.

14.4.1.6. Surgery of the aorta shall mean aortic surgery to correct (treat) aortic narrowing, occlusion, aneurysm or exfoliation

The concept includes open surgery and minimally invasive procedures such as endovascular correction. The surgery must be confirmed to be medically reasonable by a cardiac surgeon and supported by imaging findings.

The Insurance Indemnity shall not be paid for:

- Thoracic and abdominal aortic branch surgeries (including aortic and femoral artery or aortic and iliac artery bypass grafts);
- Surgery of the aorta related to hereditary connective tissue disorders (e.g. Marfan syndrome, Ehlers–Danlossyndrome);
- Surgery following traumatic injury to the aorta.

14.4.1.7. Visceral organ/bone marrow transplantation shall mean the situation when the Insured as a recipient actually undergoes the following organ transplantation surgery (regardless of the number of surgeries or transplants) or when the Insured's condition requiring such organ transplantation is considered incurable by other means and a medical specialist provides a proof that the Insured is on the official waiting list for an organ transplant.

Insurance Indemnities shall be payable for the following organ transplantation surgeries: heart, kidney (-s), liver (including split liver and living donor liver transplantation), lung (including living donor lobe or single-lung transplantation), bone marrow (allogenic hematopoietic stem cell transplantation proceeded by total bone marrow ablation), the transplantation of small bowel, pancreas, partial or full face, hand, arm and leg transplantation (composite tissue allograft transplantation).

The Insurance Indemnity shall not be paid for:

- Transplantation of other organs, body parts, or tissues (including cornea and skin);
- Transplantation of other cells (including pancreatic islet cells and stem cells other than hematopoietic).

14.4.1.8. Kidney failure shall mean the end-stage kidney failure due to irreversible failure of both kidneys to function leading to the necessity of regular haemodialysis or peritoneal dialysis.

The dialysis must be confirmed by a nephrologist and supported by the findings of kidney function analyses.

The Insurance Indemnity shall not be paid for an acute reversible kidney failure, which means when temporary renal dialysis is required.

14.4.1.9. Multiple sclerosis shall mean the multiple sclerosis diagnosed by a neurologist after a comprehensive stationary neurological examination based on clinical neurological symptoms meeting the following criteria

- Multiple neurological deficit is present for more than 6 (six)

months; and

- The disease is confirmed by magnetic resonance imaging findings showing at least 2 (two) lesions of demyelination in the brain or spinal cord indicative of multiple sclerosis.

The Insurance Indemnity shall not be paid for:

- Possible multiple sclerosis and neurologically or radiologically isolated syndromes suggestive but not diagnostic of multiple sclerosis;
- Isolated optic neuritis and/or neuromyelitis optica.

14.4.1.10. Parkinson's disease (under 65 years old) shall mean the definite initial Parkinson's disease diagnosed to the Insured by a neurologist before the Insured reaches the age of 65 (sixty five).

The Insurance Indemnity shall be paid provided that all the following conditions are met:

a) At least 2 (two) following clinical manifestations are diagnosed:

- Muscle stiffness (rigidity);
- Trembling (tremor);
- Bradykinesia (abnormal slowness of movement, sluggishness of the physical and mental response).

b) Total inability to perform, by oneself, at least three out of six activities of daily living for a continuous period of at least 3 (three) months:

- Washing: the ability to take a bath or shower (including getting into/out of a bath or shower) or satisfactory washing by other aids;
- Getting dressed and undressed: the ability to put on, take off, secure or fasten all garments, if necessary – braces, artificial limbs or other orthopedic aids;
- Feeding oneself : the ability to feed oneself when food has been prepared and made available;
- Maintaining personal hygiene: the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function;
- Getting between rooms: the ability to get from room to room on a level floor;
- Getting in/out of bed: the ability to get up/get out of bed into a chair or wheelchair and back.

The implantation of a neurostimulator to control symptoms by deep brain stimulation is, independent of the Activities of Daily Living, covered under this definition of Critical Illnesses. The implantation must be determined to be medically necessary by a neurologist or neurosurgeon.

The Insurance Indemnity shall not be paid for:

- Secondary parkinsonism (including drug- or toxin-induced parkinsonism);
- Essential tremor;
- Parkinsonism related to other neurodegenerative disorders.

14.4.1.11. Alzheimer's disease (under 65 years old) shall mean the Alzheimer's disease diagnosed by a neurologist to the Insured before the Insured reaches the age of 65 (sixty five) provided that the following needs for care of the Insured are identified and approved.

The Insurance Indemnity shall be paid provided that all the following conditions are met:

- The disease is supported by typical neuropsychological and nervous system imaging findings (e.g., computed tomography, magnetic resonance imaging);
- Loss of intellectual capacity involving impairment of memory and cognitive functions (sequencing, organizing, abstracting, and planning), which results in a significant deterioration of mental and social function;
- Diagnosed personality disorder;
- Gradual onset and continuing decline of cognitive functions;
- No disturbance of consciousness;
- Need for constant supervision 24 hours daily confirmed by a neurologist.

The Insurance Indemnity shall not be paid for other forms of mental handicap (dementia) due to brain, systemic or mental diseases.

14.4.1.12. Third-degree burns shall mean the burns of the Insured's body, which destroy all layers of the skin, cover at least 20% of the body surface area and are approved by a medical surgeon.

The body surface area can be determined either by the "Rule of Nines" or the "Lund and Browder Chart", or the "Rule of Palms" (1% of the body surface area is equal to the palm surface of the Insured's hand, i.e. both the palm and fingers).

14.4.1.13. Benign brain tumour shall mean non-malignant growth of tissue located in the cranial vault (brain, meninges, or cranial nerves) diagnosed by a neurologist and neurosurgeon and supported by imaging examination findings.

The Insurance Indemnity shall be paid provided that:

a) The tumour is treated in at least one of the following ways:

- Complete or incomplete surgical removal;
- Stereotactic radiosurgery;
- External beam radiation; or

b) None treatment options indicated in item a) are possible due to medical reasons, but the tumour causes a persistent neurological deficit, which has to be documented for at least 3 months following the date of diagnosis.

The Insurance Indemnity shall not be paid for:

- Diagnosis or treatment of any cyst, granuloma, hamartoma or malformation of the arteries or veins of the brain;
- Diagnosis of tumors of the pineal gland (pituitary gland).

14.4.1.14. Blindness shall mean total and irreversible loss of vision in both eyes as a result of injury or illness which cannot be treated by refractive correction, pharmaceuticals or surgery. The diagnosis must be supported by the findings of objective tests and the conclusion of the commission of medical experts on vision loss after the expiry of 6 (six) months after diagnosis. Profound vision loss is evidenced by either a visual acuity of 3/60 or less (0.05 or less in the decimal notation) in the better eye after correction or a visual field is less than 10° diameter in the better eye after correction. The Insurance Indemnity shall not be paid for:

- Loss of vision in one eye only;

- Different reversible vision disorders.

14.4.1.15. Deafness shall mean a permanent and irreversible loss of hearing of the Insured in both ears as a result of sickness or physical injury. The diagnosis must be confirmed by an otolaryngologist and supported by an auditory threshold (at least 90 db at 500, 1000 and 2000 hertz in the better ear using a pure tone audiogram).

14.4.1.16. Loss of speech shall mean a definite diagnosis of the total and irreversible loss of the ability of the Insured to speak confirmed by an otolaryngologist and resulting from physical injury or disease not subject to correction by any medical treatment means provided that this condition persists for a continuous period of at least 6 months. The Insurance Indemnity shall not be paid for the loss of speech due to psychiatric disorders or diseases.

14.4.1.17. Loss of limb function shall mean Total and irreversible loss of two or more limbs or their function due to injury or illness of spinal marrow and brain. Loss of limb function shall mean loss of limbs above the elbow or knee joints

The Insurance Indemnity shall be paid provided that the loss of the limb function persists for more than 3 (three) months and is confirmed by a neurologist and supported by clinical symptoms and diagnostic findings.

The Insurance Indemnity shall not be paid for:

- Paralysis due to self-harm or psychological disorders;
- Guillain-Barre syndrome;
- Periodic (reversible) or hereditary paralysis..

14.4.1.18. Coma shall mean a state of unconsciousness diagnosed by a neurologist provided that all the following conditions are satisfied:

- No response from the Insured to exogenous irritants (results in a score of 8 or less on the Glasgow coma scale) or no response to needs of nature for at least 96 (ninety six) hours;
- Need for the use of life support systems;
- Results in a persistent neurological deficit which must be assessed at least 30 (thirty) days after the onset of the coma. The Insurance Indemnity shall not be paid for:
- Medically induced coma;
- Any coma due to self-inflicted injury, alcohol or drug use.

14.4.1.19. Viral encephalitis shall mean a diagnosis of brain (cerebral hemispheres, cerebral trunk, cerebellum) fever induced by viral infection. The diagnosis must be confirmed by a neurologist after stationary examination indicating typical clinical symptoms, changes in cerebrospinal fluid, immunological/serological indicators.

The Insurance Indemnity shall be paid provided that all the following conditions are met:

- Neurological deficit; and
- Neurological deficit is documented for at least 3 months following the date of diagnosis. The Insurance Indemnity shall not be paid for:
- Encephalitis induced by HIV;
- Encephalitis caused by bacterial or protozoal infections;
- Paraneoplastic encephalomyelitis.