

HEALTH INSURANCE TERMS AND CONDITIONS No 010 Annex No 1

Effective from December 1st of 2024

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HEALTH INSURANCE PROGRAMS

- I. This Annex sets out the scope and nature of the Insurance Cover, the Insured Events, Non-Insured Events, other conditions and requirements according to the Health Insurance programs offered by the Insurer.
- II. The Annex constitutes an inseparable part to the Insurance Terms and Conditions.
- III. If there any contradictions or inconsistencies between other provisions of the Annex and of the Insurance Terms and Conditions, the conditions and requirements provided for in the Annex shall prevail.
- IV. The services / supplies or products not specified in this annex under the reimbursed services shall not be the insurance object.
- V. Under the insurance programs "Outpatient treatment and diagnostics", "Inpatient Services", "Prenatal Care, Childbirth and Postnatal Care", "Dental Services" "Preventive care" and "Rehabilitation Therapy" reimbursed shall only be those health care services that are VAT-exempt. The service provider shall in all cases be responsible for the correct classification of services subject and not subject to VAT under the relevant programs.



1. OUTPATIENT TREATMENT AND DIAGNOSTICS

1.1. The following shall be considered to be the Insured Event – the below specified Medically Justified Health Care Services provided to the Insured Person in a Health Care Institution due to a Health Impairment (Acute Illness, exacerbation and follow-up of a Chronic Illness, Injury), and the resulting costs incurred, reimbursed by the Insurer.

1.2. The below specified expenses for Health Care Services as a result of an Insured Event shall be reimbursed, except in the cases referred to in paragraph 1.3:

1.2.1. consultations by a general practitioner, a medical doctor or a Specialist Doctor, including remote consultations; home visits by general practitioners;

1.2.1.1. consultations by a plastic and reconstructive surgeon for the treatment of musculoskeletal system conditions;

1.2.2. mental health services: consultations and psychotherapeutic treatment by a psychiatrist, psychiatrist-psychotherapist, medical psychologist, medical psychologist-psychotherapist, not more than 12 (twelve) visits during the Insurance Period;

1.2.3. up to 200 EUR during the Insurance Period:

1.2.3.1. consultations and diagnostic tests by a maxillofacial surgeon for dental and/or maxillofacial injuries;

1.2.3.2. a consultation and biopsy / histology / examination by an oral surgeon or maxillo-facial surgeon for diseases other than dental/oral diseases (reimbursement of the service requires a referral from a Specialist Doctor (other than a dentist);

1.2.4. medically justified diagnostic tests prescribed by a doctor:

1.2.4.1. clinical laboratory tests: hematological, blood coagulation, immunological, biochemical, cytological, microbiological, infectious serological;

1.2.4.2. instrumental, functional, radiological tests: X-ray, ultrasound, endoscopic, computed tomography (CT), angiography, nuclear magnetic resonance (MRI), positron emission (PET) tests;

1.2.5. Nursing services;

1.2.6. Outpatient Surgery Services;

1.2.7. Day Inpatient Services;

1.2.8. Day Surgery Services (partial reimbursement by the CHIF is not mandatory);

1.2.8.1. Medical Equipment Reimbursed by the Insurer and Medicines used in providing a Day Surgery Service.

! Important clause: the costs or part of the costs of Day Surgery Services shall only be reimbursed if the Insurer has been informed of the need for the provision of Day Surgery Services by email sd@compensalife.it before the start of the treatment and the Insurer's prior written consent has been obtained. The Insured Person shall be responsible for obtaining the consent of the Insurer.

1.3. All expenses incurred to any extent in connection with and in respect of the following shall not be reimbursed:

1.3.1. consultations by doctors and diagnostic tests and treatments they prescribe for hair loss;

1.3.2. consultations by plastic and reconstructive surgeons (except in the case of treatment of musculoskeletal system disorders) and diagnostic tests and treatment prescribed by them;

1.3.3. consultations and diagnostic tests, treatment plans and rehabilitation services prescribed by doctors of physical medicine and rehabilitation; consultations and diagnostic tests and treatment plans prescribed by doctors of sports medicine;

1.3.4. consultations, diagnostic tests and treatment prescribed by general dental practitioners and dental specialists: endodontist, maxillofacial surgeon, oral surgeon, periodontist, orthodontist;

1.3.5. diagnostic tests prescribed by a doctor in order to assess the general condition of the organism;

1.3.6. diagnosis and treatment of AIDS, HIV, syphilis, gonorrhea, trichomoniasis, chlamydiosis, ureaplasmosis, human papillomavirus, herpes genitalis and other sexually transmitted diseases, including the removal of any formations from the external genital area, or the anal area;

1.3.7. laboratory tests: vitamins, pharmacogenetic tests, genetic tests; cancer markers in the absence of oncological disease; laboratory test packages/programs;

1.3.8. veloergometry, spiroveloergometry tests;

1.3.9. termination of pregnancy; Health Impairments caused or



aggravated by termination of pregnancy; pregnancy diagnostics, prenatal care; childbirth and postnatal care; Health Impairments caused by pregnancy or childbirth (e.g. gynecological, endocrine, breast, neurological, urological, etc., pathology);

1.3.10. diagnostics and treatment of infertility / inability to conceive, potency / libido disorders; assisted reproductive procedures;

1.3.11. services for the insertion, control or removal of contraceptive devices, services for the prevention of pregnancy;

1.3.12. Outpatient aesthetic surgery services, cosmetic procedures;

1.3.13. treatment of dermatological diseases (capillary diseases, pigmentation disorders, erythema, rosacea, acne, etc.); treatment of benign tumors/formations of the skin and subcutaneous tissue (moles, warts, papillomas, keratosis, mollusks, etc.);

1.3.14. sclerotherapy;

1.3.15. Outpatient Surgery Services: dermatological and plastic procedure profile services, dental procedure profile services referred to in the Annex to the Description of requirements for the provision of Outpatient Surgery Services approved by Order No V-754 of the Minister of Health of the Republic of Lithuania of 25 July 2013, and amendments thereto; services for the treatment of skin and vascular formations of the skin and the subcutaneous tissues, and for the treatment of other skin anomalies;

1.3.16. Plastic reconstructive surgery and dermatological day surgery profile procedures, Dental Day Surgery profile procedures specified in the Annex to the Description of requirements for the provision of day surgery services approved by Order No V-668 of the Minister of Health of the Republic of Lithuania of 21 August 2009, and its amendments;

1.3.17. complex surgery procedures if one of them is not included in the list of the scope of Day Surgery procedures or if one of the procedures is a Non-insured Event;

1.3.18. Day aesthetic surgery services; procedures for scar treatment; procedures to reduce / increase organ / body volume;

1.3.19. treatment of benign tumors of internal organs;

1.3.20. vasectomies and other surgical sterilization procedures;

1.3.21. treatment of overweight / obesity;

1.3.22. vision correction procedures and surgeries;

1.3.23. hemodialysis procedures;

1.3.24. treatment using stem cells or autologous preparations (including but not limited to PRP/blood plasma injections);

1.3.25. treatment by immunotherapy;

1.3.26. the purchase of Medicines, Medical Equipment and other products, unless the Medicines and Medical Equipment are used during the Day Surgery Service;

1.3.27. Long-term nursing / care and supportive treatment services;

1.3.28. Complementary and Alternative Health Care Services;

1.3.29. the cases set out in paragraphs 11 and 12 of the Health Insurance Terms and Conditions.



2. INPATIENT SERVICES

2.1. The following shall be considered to be the Insured Event – expenses incurred by the Insured Person as a result of his/her Health Impairment (Acute Illness, exacerbation of a Chronic Illness, Injury), for the detection and treatment of which therapeutic or surgical inpatient treatment was necessary in an inpatient Health Care Institution (hospital) and where the Insured Person was hospitalized for more than 24 hours, and where the following Health Care Services or other services were provided.

2.2. The below specified expenses for Health Care Services as a result of an Insured Event shall be reimbursed, except in the cases referred to in paragraph 2.3:

2.2.1. if the Health Insurance program sub-type Inpatient Additional Services in Public Hospitals is chosen – medical equipment, medicines, paid wards, reimbursed by the Insurer prescribed to and purchased by the Insured Person during inpatient treatment in public hospitals;

2.2.2. if the Health Insurance program sub-type Inpatient Additional Services in Private Hospitals is chosen – medical equipment, medicines, paid wards, reimbursed by the Insurer prescribed to and purchased by the Insured Person during inpatient treatment in private hospitals;

2.2.3. if the Health Insurance program sub-type Inpatient Treatment in Hospitals is chosen – therapeutic and surgery treatment services rendered to the Insured Person during inpatient treatment in private and public hospitals, and medical equipment, medicines, paid wards reimbursed by the Insurer prescribed to and purchased by the Insured Person during inpatient treatment.

2.3. All expenses incurred to any extent in connection with and in respect of the following shall not be reimbursed:

2.3.1. termination of pregnancy; Health Impairments caused or aggravated by the termination of pregnancy; pregnancy diagnostics, prenatal care; childbirth and postnatal care; Health Impairments caused by pregnancy or childbirth (e.g. gynecological, endocrine, breast, neurological, urological, etc., pathologies);

2.3.2. oral and maxillofacial surgery services (except for oncological conditions) in an inpatient Health Care facility;

2.3.3. the purchase of joint endo-prosthetic implants and joint endo-prosthesis operations; organ transplantation procedures ; bone marrow transplantation procedures;

2.3.4. plastic and cosmetic surgery; overweight/obesity surgery;

2.3.5. inpatient Rehabilitation Therapy Services;

2.3.6. mental illness / psychiatric treatment services;

2.3.7. Long-term nursing / care and supportive treatment services;

2.3.8. Medical Equipment and Medicines for home treatment;

2.3.9. the cases set out in paragraphs 11 and 12 of the Health Insurance Terms and Conditions.



3. PRENATAL CARE, CHILDBIRTH AND POSTNATAL CARE

3.1. The following shall be considered to be the Insured Event – the following Health Care services provided to the Insured Person during her pregnancy, while giving birth during her postnatal period in a Health Care Institution, and the resulting costs incurred.

3.2. The below specified expenses for Health Care Services as a result of an Insured Event shall be reimbursed:

3.2.1. pregnancy diagnostics, prenatal care services (i.e. periodic prenatal visits; monitoring of normal or high-risk pregnancy) provided in accordance with the current requirements of the applicable law on prenatal health check-ups;

3.2.2. diagnostics and treatment of Health Impairments detected during prenatal visits; Diagnostics and treatment of Health Impairments aggravated during pregnancy, complications of pregnancy (e.g., gynecological, endocrine, breast, neurological, urological, etc.,

pathology);

3.2.3. fetal diagnostics, prenatal tests; geneticist consultations and diagnostic tests prescribed by a geneticist;

3.2.4. diagnostics and treatment of Health Impairments developed or aggravated during childbirth, after childbirth and/or while breastfeeding;

3.2.5. pregnancy care, childbirth and postnatal care services provided to the Insured Person, and a paid ward for postnatal care in inpatient Health Care Institutions;

3.2.6. pregnancy termination services provided to the Insured Person and health problems resulting from the termination of pregnancy.



4. DENTAL SERVICES

4.1. The following shall be considered to be the Insured Event – the following services related to the treatment and prevention of dental, oral and maxillofacial diseases provided to the Insured Person in Health Care Institutions related to the treatment and prevention of dental, oral and maxillofacial diseases.

4.2. The below specified expenses for Health Care Services as a result of an Insured Event shall be reimbursed, except in the cases referred to in paragraph 4.3:

4.2.1. consultation by an oral care professional, oral hygiene assessment, hard and soft dental plaque removal, fluoride application services;

4.2.2. consultation, diagnostics and treatment by a general dental practitioner;

4.2.3. consultation, diagnostics and treatment (endodontic, surgery, periodontal, orthodontic, prosthetics-implantation) by dental specialists (dentists);

4.2.4. mouthguards for treatment (myorelaxative, bruxism,

orthodontic);

4.2.5. dental implants;

4.2.6. Outpatient Surgery Services: dental procedure profile services;

4.2.7. Day Surgery Services: services related to dental procedures.

4.3. All expenses incurred to any extent in connection with and in respect of the following shall not be reimbursed:

4.3.1. teeth whitening, including teeth whitening using mouthguards;

4.3.2. purchase of oral hygiene products (toothbrushes, dental floss, mouthwashes, irrigators, etc.);

4.3.3. rehabilitative treatment of the temporomandibular joints;

4.3.4. the purchase of protective dental mouthguards for sports;

4.3.5. the cases set out in paragraphs 11 and 12 of the Health Insurance Terms and Conditions.



5. MEDICINES AND MEDICAL EQUIPMENT

5.1. The following shall be considered to be the Insured Event – acquisition of medicines and medical equipment reimbursed by the Insurer, including rental, and expenses incurred by the Insured Person as a result of a Health Impairment in Pharmacies, Health Care Institutions, orthopedic supplies stores and other specialized medical supplies stores on the basis of a doctor's prescription or a medical document.

5.2. The below specified expenses for Health Care Services as a result of an Insured Event shall be reimbursed, except in the cases referred to in paragraph 5.3:

5.2.1. Medicines;

5.2.2. Medicines produced in pharmacies;

5.2.3. Medical Aids Reimbursed by the Insurer (the scope is specified in subparagraph 1.1.11 of the Health Insurance Terms and Conditions);

5.2.4. Medical Devices Reimbursed by the Insurer (the scope is specified in subparagraph 1.1.13 of the Health Insurance Terms and Conditions);

5.2.5. Orthopedic Devices (the scope is specified in subparagraph 1.1.41 of the Health Insurance Terms and Conditions);

5.2.6. Medicines and Medical Equipment Reimbursed by the Insurer used in Day Inpatient care, Outpatient Surgery.

! Important clause: if the goods listed in paragraph 5.2 are reimbursed by the funds of the CHIF, the Insurer shall reimburse only



the excess paid amount for the goods purchased.

5.3. All expenses incurred to any extent in connection with and in respect of the following shall not be reimbursed:

5.3.1. medicines for treatment of addictive disorders, potency disorders, weight loss; sex hormones and medicines affecting the reproductive system; contraceptives;

5.3.2. Medicines with ATC code A11 or A12 (vitamins and minerals);

5.3.3. Medical Equipment and Medicines used in Day Surgery and Inpatient Treatment;

5.3.4. herbal-based, animal-based, homeopathic medicines and other Medicines without an ATC code;

5.3.5. the cases set out in paragraphs 11 and 12 of the Health Insurance Terms and Conditions.



6. VITAMINS, OVER-THE-COUNTER MEDICINES

6.1. The following shall be considered to be the Insured Event – Vitamins, food supplements, prescription and over-the-counter Medicines purchased by the Insured Person in pharmacies, Health Care Institutions for the purpose of a Health Impairment or for the prevention of a Health Impairment, and the resulting costs incurred.

6.2. The below specified expenses for Health Care Services as a result of an Insured Event shall be reimbursed, except in the cases referred to in paragraph 6.3:

6.2.1. Vitamins, mineral additives, Food Supplements;

6.2.2. homeopathic medicinal products and medicinal products of plant-based or animal-based and other medicinal products without ATC code;

6.2.3. Medicines;

6.2.4. Medicines with ATC code A11 or A12 (Vitamins and mineral additives).

6.3. All expenses incurred to any extent in connection with and in respect of the following shall not be reimbursed:

6.3.1. Medicines for treatment of addictive disorders, potency disorders, weight loss; sex hormones and medicines affecting the reproductive system; contraceptives;

6.3.2. foodstuffs, dietetic and functional foods, sports foods and other non-notified food supplements;

6.3.3. the cases set out in paragraphs 11 and 12 of the Health Insurance Terms and Conditions.



7. OPTICS

7.1. The following shall be considered to be the Insured Event – the following Health Care services and expenses provided to the Insured Person due to a visual impairment at Opticians' Shops, E-opticians, Health Care Institutions.

7.2. The below specified expenses for Health Care Services as a result of an Insured Event shall be reimbursed, except in the cases referred to in paragraph 7.3:

7.2.1. consultation with an ophthalmologist or optometrist on the selection of optical instruments;

7.2.2. corrective spectacle lenses, contact lenses; corrective spectacle frames and contact lens care products prescribed by an ophthalmologist or optometrist;

7.2.3. vision correction and/or vision preservation surgeries, and medical equipment used during these surgeries, reimbursed by the Insurer;

7.2.4. manufacturing service for corrective glasses or corrective lenses;

7.2.5. dioptric sunglasses.

7.3. All expenses incurred to any extent in connection with and in respect of the following shall not be reimbursed:

7.3.1. eyeglasses' care products and accessories (e.g. eyeglass cases, cleaners, wipes, etc.);

7.3.2. sunglasses; safety glasses for computer work;

7.3.3. artificial tear products;

7.3.4. parts for eyeglasses, eyeglasses' repair / fixing services;

7.3.5. the cases set out in paragraphs 11 and 12 of the Health Insurance Terms and Conditions.



8. PREVENTIVE CARE

8.1. The following shall be considered to be the Insured Event – the following Health Care Services provided to the Insured Person for the purpose of preventive care, prevention, due to an existing Health Impairment, in a Health Care Institution, in order to assess the Insured Person's general state of health, to diagnose a disease or to prevent a Health Impairment.

8.2. The below specified expenses for Health Care Services as a result of an Insured Event shall be reimbursed, except in the

cases referred to in paragraph 8.3:

8.2.1. consultations by a doctor chosen at the request of the Insured Person, laboratory and instrumental tests;

8.2.2. consultations, laboratory and instrumental tests prescribed by a general practitioner, a medical doctor or a Specialist Doctor, where they are necessary for an existing Health Impairment or were not related to the Health Impairment for which the Insured Person



applied;

8.2.3. health check-ups/laboratory test packages and programs in accordance with the health check-up programs established by Health Care Institutions/laboratories or in accordance with the current list of prophylactic/preventive health check-ups approved by the Ministry of Health;

8.2.4. The below listed diagnostic tests:

8.2.4.1. AIDS, HIV, syphilis, gonorrhea, trichomoniasis, chlamydia, ureaplasmosis, human papillomavirus, herpes genitalis and other sexually transmitted diseases;

8.2.4.2. Vitamin, cancer marker, pharmacogenetic, genetic and other molecular tests;

8.2.4.3. rapid tests;

8.2.4.4. veloergometry, spirometry;

8.2.4.5. infertility / inability to conceive, potency / libido disorders;

8.2.5. Vaccines and vaccination related expenses.

8.3. All expenses incurred to any extent in connection with and in respect of the following shall not be reimbursed:

8.3.1. pregnancy diagnostics, prenatal care; childbirth and postnatal care and services; Health Impairments caused or exacerbated by pregnancy and/or its termination; childbirth; Diagnostics of health problems caused by pregnancy, childbirth and while breastfeeding;

8.3.2. Complementary and Alternative Health Care Services;

8.3.3. consultations, diagnostic tests and treatment prescribed by general dental practitioners and dental specialists, dentists: endodontist, maxillofacial surgeon, oral surgeon, periodontist, orthodontist;

8.3.4. consultations by a physical medicine and rehabilitation doctor, rehabilitation procedures;

8.3.5. the cases set out in paragraphs 11 and 12 of the Health Insurance Terms and Conditions.



9. REHABILITATION THERAPY

9.1. The following shall be considered to be the Insured Event – medical Rehabilitation Services provided to the Insured Person in a Health Care Institution due to a Health Impairment in order to restore impaired biopsychosocial functions or irreversible changes in the body after ineffective or insufficiently effective medical, surgery or immobilization treatment. Medical rehabilitation services that meet all the following conditions shall be reimbursed:

9.1.1. a valid referral from the attending medical specialist or general practitioner for a consultation with a Physical Medicine and Rehabilitation Doctor for the establishment of a treatment plan for rehabilitation services, or a treatment plan from the attending medical specialist or general practitioner specifying the procedures to be prescribed and the number of treatments. In this case, a consultation by a Physical Medicine and Rehabilitation Doctor is not necessary;

9.1.2. rehabilitation procedures shall be carried out continuously in accordance with the prescribed rehabilitation plan;

9.1.3. if the Rehabilitation Therapy plan is not completed within the period of 90 days, a reassessment and referral by a specialist or family doctor is required to determine the need for rehabilitation services and to draw up a plan for rehabilitation services.

9.2. The below specified expenses for Health Care Services as a result of an Insured Event shall be reimbursed, except in the cases referred to in paragraph 9.3:

9.2.1. if Health Insurance Program sub-type Medical rehabilitation is chosen, the following services provided to the Insured Person for a Health Impairment not related to osteochondrosis and/or degenerative changes shall be reimbursed:

9.2.1.1. consultations by a physical medicine doctor, rehabilitation doctor, sports medicine doctor;

9.2.1.2. consultations by a physiotherapist, occupational therapist in accordance with the Rehabilitation Therapy plan;

9.2.1.3. consultations and services provided by a clinical speech and language therapist in accordance with a Rehabilitation Therapy plan established by a doctor for voice and speech disorders and communication and cognitive disability;

9.2.1.4. prescribed rehabilitation procedures: physiotherapy (ultrasound therapy, microwave therapy, pulse therapy, light therapy, electrostimulation, magnetotherapy, shock-wave therapy, laser therapy, and other physiotherapy treatments), physiotherapy, occupational therapy, hydrotherapy, balneotherapy, peloid therapy, therapeutic massage treatments, halo therapy, manual therapy;

9.2.2. if Health Insurance program sub-type Rehabilitation is chosen the below specified services if provided to the Insured Person for a Health Impairment, including Health Impairments related to osteochondrosis and/or degenerative disorders, shall be reimbursed:

9.2.2.1. consultations by a physical medicine doctor and rehabilitation doctor, consultations by a sports medicine doctor;

9.2.2.2. consultations by a physiotherapist, occupational therapist in accordance with the rehabilitation services treatment plan;

9.2.2.3. consultations and services provided by a clinical speech and language therapist in accordance with a rehabilitation services treatment plan established by a doctor for voice and speech disorders and communication and cognitive disability;

9.2.2.4. prescribed rehabilitation procedures: physiotherapy (ultrasound therapy, microwave therapy, pulse therapy, light therapy, electrostimulation, magnetotherapy, shock wave therapy, laser therapy, and other physiotherapy treatments), physiotherapy, occupational therapy, hydrotherapy, balneotherapy, peloid therapy, therapeutic massage treatments, halo therapy, manual therapy;

9.2.3. if Health Insurance program sub-type Medical rehabilitation after inpatient treatment is chosen the below specified services if provided to the Insured Person for a Health Impairment when the Insured Person has been treated at an inpatient clinic and the Insured Person has been prescribed inpatient the medical Rehabilitation Therapy for the diagnosed medical disorder, in accordance with Annex 2 of Chapter IV of Order No V-1828 of the Ministry of Health of the Republic of Lithuania of 07/12/2002. The following services shall be reimbursed:

9.2.3.1. consultations by a physical medicine doctor and rehabilitation doctor, consultations by a physiotherapist, occupational therapist in accordance with the rehabilitation services treatment plan;



9.2.3.2. consultations and services provided by a clinical speech and language therapist in accordance with a rehabilitation services treatment plan established by a doctor for voice and speech disorders and communication and cognitive disability;

9.2.3.3. services provided by a medical psychologist when the prescribed services are an integral part of Rehabilitation Therapy;

9.2.3.4. prescribed rehabilitation procedures: physiotherapy (ultrasound therapy, microwave therapy, pulse therapy, light therapy, electrostimulation, magnetotherapy, shock wave therapy, laser therapy, and other physiotherapy treatments), physiotherapy, occupational therapy, hydrotherapy, balneotherapy, peloid therapy, therapeutic massage treatments, halo therapy, manual therapy;

9.3. All expenses incurred to any extent in connection with and in respect of the following shall not be reimbursed:

9.3.1. Rehabilitation Services prescribed by a physical medicine and rehabilitation doctor without a recommendation / referral from the attending Specialist Doctor for Rehabilitation Therapy;

9.3.2. Rehabilitation Services provided for the treatment of chronic fatigue syndrome;

9.3.3. Rehabilitation Services provided in SPA centers; services provided in sanatoriums if not provided after surgery intervention or hospital treatment;

9.3.4. services provided to the Insured Person during pregnancy. Not applicable in the case of orthopedic / injury treatment and when Rehabilitation Therapy is necessary after surgery treatment;

9.3.5. accommodation / lodging, catering services;

9.3.6. the cases set out in paragraphs 11 and 12 of the Health Insurance Terms and Conditions.



10. ALTERNATIVE MEDICINE

10.1. The following shall be considered to be the Insured Event – Health Care Services provided by a health care specialist in a Health Care Institution to the Insured Person as a result of an Acute Illness, exacerbation of a Chronic Illness and its follow-up, an Injury, and the resulting costs incurred.

10.2. The below specified expenses for Health Care Services as a result of an Insured Event shall be reimbursed, except in the cases referred to in paragraph 10.3:

10.2.1. consultations and diagnostic tests prescribed by a homeopathic doctor;

10.2.2. consultations with and diagnostic tests prescribed by an endobiogenist;

10.2.3. electroacupuncture bioresonance computer diagnostics;

10.2.4. microbiota testing;

10.2.5. SIBO tests;

10.2.6. food intolerance tests;

10.2.7. apitherapy;

10.2.8. acupuncture;

10.2.9. phytotherapy;

10.2.10. hirudotherapy;

10.2.11. hippotherapy;

10.2.12. osteopathy;

10.2.13. manual therapy;

10.2.14. applied kinesiology;

10.2.15. hydrocolonotherapy;

10.2.16. reflexology;

10.2.17. relaxation therapies: autogenic training, deep breathing therapy, progressive muscle relaxation, meditation;

10.2.18. color and light therapy;

10.2.19. music and art therapy;

10.2.20. neurotherapy;

10.2.21. ozone therapy.

10.3. All expenses incurred to any extent in connection with and in respect of the following shall not be reimbursed:

10.3.1. the cases set out in paragraphs 11 and 12 of the Health Insurance Terms and Conditions.



11. MEDICAL SERVICES

11.1. The following shall be considered to be the Insured Event – Health Care Services provided to the Insured Person due to an existing Health Impairment or for the purpose of prophylaxis or for the purpose of prevention, at a Health Care Institution, Opticians', Pharmacy or an Orthopedic Supplies Store, and the resulting costs incurred.

11.2. The below specified expenses for Health Care Services as a result of an Insured Event shall be reimbursed, except in the cases referred to in paragraph 11.3:

11.2.1. The reimbursable and non-reimbursable costs listed in the descriptions of the health insurance programs listed below:

11.2.1.1. Outpatient Treatment and Diagnostics;

11.2.1.2. Inpatient Services;

11.2.1.3. Prenatal Care, Childbirth and Postnatal Care;

11.2.1.4. Dental Services;

11.2.1.5. Medicines and Medical Equipment;

11.2.1.6. Vitamins, Over-the-counter Medicines;

11.2.1.7. Optics;



11.2.1.8. Preventive care;

11.2.1.9. Rehabilitation Therapy;

11.2.1.10. Alternative Medicine;

11.2.2. Thermometers, testers, heaters, scales, blood pressure monitors and other functional diagnostic equipment and/or devices;

11.2.3. Compensatory equipment (wheelchairs, functional beds, etc.).

11.3. All expenses incurred to any extent in connection with and in respect of the following shall not be reimbursed:

11.3.1. Day Aesthetic Surgery Services in the absence of medical indications;

11.3.2. Outpatient Aesthetic Surgery Services in the absence of medical indications;

11.3.3. other aesthetic, plastic and dermatological treatment

services without medical indications;

11.3.4. cosmetological and facial procedures, hair removal;

11.3.5. teeth whitening procedures; purchase of dental and oral care products and devices;

11.3.6. accommodation / lodging, catering services;

11.3.7. purchase or rental of wellness / health promotion/ rehabilitation equipment;

11.3.8. eyeglasses care products and accessories, non-diopteric sunglasses, eyeglasses repair services;

11.3.9. purchase of hygiene products, goods and appliances; products for skin and hair care and decorative cosmetics;

11.3.10. foodstuffs, dietetic and functional foods, sports foods and other non-notified food supplements;

11.3.11. the cases set out in paragraphs 11 and 12 of the Health Insurance Terms and Conditions.



12. WELLNESS SERVICES

12.1. The following shall be considered to be the Insured Event – the following health care and wellness services provided to the Insured Person for the purpose of health promotion, prevention, prophylaxis, or due to a pre-existing Health Impairment, in a Health Care Institution, SPA centres and sanatoriums, sports clubs, swimming pools, or by any other person authorized to carry out the relevant health care or wellness activities, and the expenses incurred as a result.

12.2. The following costs of Health Care and Wellness Services shall be reimbursed as a result of an Insured Event, except in the cases specified in paragraph 12.4:

12.2.1. consultations by a sports medicine doctor, a physical medicine and rehabilitation doctor, a physiotherapist, an occupational therapist, a massage therapist; body composition analysis tests, ergonomic body positioning tests, rehabilitation procedures;

12.2.2. consultations and psychotherapy by mental health professionals;

12.2.3. manual therapy, osteopathy, applied kinesiology, acupuncture;

12.2.4. physical activities: all kinds of physical education: aerobics, basketball, football, tennis, pilates, volleyball, gymnastics, dancing, gym classes, swimming pool services, etc.;

12.2.5. consultation by a nutritionist, dietician, preparation of a diet plan;

12.2.6. packages of Rehabilitation Therapy services / sanatorium

treatment services purchased in sanatoriums or other health care institutions (excluding accommodation/ lodging, catering services);

12.2.7. SPA massage services, body care services (body wraps, applications, body scrubs), water treatments.

12.3. If the services referred to in paragraph 12.2 of Annex 1 to the Insurance Terms and Conditions are purchased under a Health Service subscription, only a part of the costs for the subscription period coinciding with the period of validity of the Insurance Cover may be reimbursed.

12.4. All expenses incurred to any extent in connection with and in respect of the following shall not be reimbursed:

12.4.1. accommodation / lodging, catering services;

12.4.2. purchase or rental of wellness / health promotion/ rehabilitation equipment;

12.4.3. cosmetological, facial procedures;

12.4.4. competition / members / camp fees; entertainment services (e.g., bowling, karting, motorsports, billiards, sauna, hot tub, etc.);

12.4.5. engaging in activities other than physical activity (e.g., brain / board games);

12.4.6. personal development courses, developmental coaching services; participation in programs / challenge / change programs;

12.4.7. the cases set out in paragraphs 11 and 12 of the Health Insurance Terms and Conditions.



13. ALL SERVICES

13.1. The following shall be considered to be the Insured Event – the below specified Health Care or Wellness Services provided to the Insured Person as a result of the existing Health Impairment or for the purpose of prophylaxis or prevention, in a Health Care Institution, Opticians', Pharmacies or Orthopedics shops, SPA centers and sanatoriums, Sports Clubs, Swimming Pools, or by any other person authorized to carry out the relevant Health Care or Wellness activities and the expenses incurred as a result.

13.2. The following services shall be reimbursed as a result of an Insured Event, except in the cases specified in paragraph 13.3:

13.2.1. The reimbursable and non-reimbursable costs listed in the descriptions of the health insurance programs listed below:

13.2.1.1. Outpatient treatment and diagnostics;



- 13.2.1.2. Day surgery services;
- 13.2.1.3. Inpatient services;
- 13.2.1.4. Prenatal care, childbirth and postnatal care;
- 13.2.1.5. Dental services;
- 13.2.1.6. Medicines and Medical equipment;
- 13.2.1.7. Vitamins, over-the-counter medicines;
- 13.2.1.8. Optics;
- 13.2.1.9. Preventive care;
- 13.2.1.10. Rehabilitation Therapy;
- 13.2.1.11. Alternative medicine;
- 13.2.1.12. Wellness services;

13.2.2. oral hygiene products (toothbrushes, dental floss, mouthwashes, irrigators, etc.) and personal hygiene products, hygiene appliances; therapeutic skin and hair care products;

13.2.3. thermometers, testers, heaters, scales and blood pressure monitors and other functional diagnostic equipment and/or devices;

13.2.4. Compensatory equipment (wheelchairs, functional beds, etc.).

! Important clause: If wellness services are purchased under a Wellness Service subscription, only the part of the costs for the subscription period that coincides with the period of validity of the Insurance Cover may be reimbursed.

13.3. All expenses incurred to any extent in connection with and in respect of the following shall not be reimbursed:

- 13.3.1. day aesthetic surgery services without medical indications;
- 13.3.2. outpatient aesthetic surgery services without medical indications;
- 13.3.3. other aesthetic, plastic and dermatological treatment services without medical indications;
- 13.3.4. accommodation / lodging, catering services;
- 13.3.5. purchase or rental of health promotion, wellness/ rehabilitation equipment;
- 13.3.6. hair removal, cosmetological procedures;
- 13.3.7. foot care services not provided by a health professional in a personal health care institution;
- 13.3.8. decorative cosmetics; purchase of hair styling products, cosmetic devices;
- 13.3.9. foodstuffs, dietetic and functional foods, sports foods and other non-notified food supplements;
- 13.3.10. competition/participation/camp fees; entertainment services (e.g., bowling, karting, motorsports, billiards, sauna, hot tub, etc.); personal development courses, developmental coaching services; participation in programs/challenges/change programs;
- 13.3.11. engaging in activities other than physical activity (e.g., brain / board games);
- 13.3.12. the cases set out in paragraphs 11 and 12 of the Health Insurance Terms and Conditions.



14. CRITICAL ILLNESSES

14.1. The following shall be considered to be the Insured Event – when the Insured Person is diagnosed for the first time with a Critical Illness specified in the List of Critical Illnesses / Contract.

14.2. The Insurance Indemnity:

14.2.1. If the Insured Person has chosen in the Critical Illness program to receive a lump sum payment in the case of an Insured Event, the Insurance Indemnity shall be paid to the Insured Person as a lump sum during the period of validity of the Insurance Contract, irrespective of the number of Critical Illnesses diagnosed;

14.2.2. If the Insured Person has chosen the reimbursement of treatment costs under the Critical Illness program in the case of an Insured Event, the Insured Person shall be reimbursed for the treatment costs incurred which meet the definition of Insured Events under the Health Insurance Programs of "Outpatient Treatment and Diagnostics", "Day Surgery Services", "Inpatient Services", "Rehabilitation Therapy", and "Medicines and Medical Equipment". Additionally, expenses incurred for pharmacogenetic and genetic tests and long-term care shall be reimbursed;

14.2.2.1. if a Critical Illness has been diagnosed during the last three months of the period of validity of the Contract, the Insured Person shall be reimbursed for the costs of treatment incurred according to the provisions of sub-paragraph 14.2.2 of Annex No 1 of the Health Insurance Terms and Conditions No 010 for another 3 months from the end of the Insurance Contract validity period from the limit of the sum insured of Critical Illnesses in force at the time of the discovery of the Critical Illness.

14.3. All expenses incurred to any extent in connection with and in respect of the following shall not be reimbursed:

14.3.1. an event recognized as a Non-Insured Event in accordance with the Terms and Conditions of paragraph 12 of the Insurance Terms and Conditions;

14.3.2. a Critical Illness diagnosed before the entry into force of the Insurance Cover or less than 45 (forty-five) days after its entry into force. This period shall also apply if the Insurance Cover has been suspended or terminated during the validity of the Contract, but shall not apply if, at the time of the renewal of the Insurance Contract, the previously valid Insurance Contract had already covered Critical Illnesses as well as if the Critical Illness was caused by an Accident during this period;

14.3.3. a Critical Illness does not meet the criteria for recognition of a Critical Illness and an Insured Event as set out in this Health Insurance Program, the List of Critical Illnesses;

14.3.4. a relapse of the same Critical Illness;

14.3.5. the Insured Person's death of within 30 (thirty) days after being diagnosed with one of the Critical Illness.

14.4. List of critical illnesses:

14.4.1. List of critical illnesses, definitions, criteria and requirements for an event to be recognized as the Insured Event or Non-insured Event:

14.4.1.1. Malignant tumor (cancer) – uncontrolled growth of malignant cells, their spread and invasion (penetration) of tissues.

The Insurance Indemnity shall only be paid if there is irrefutable evidence of tissue invasion and if the malignancy of the cells is confirmed histologically. The diagnosis must be confirmed by the



opinion of a medical specialist qualified to diagnose and treat malignant diseases.

The concept of cancer shall also include leukemia and malignant lymphoma, and myelodysplastic syndrome. In these cases, the diagnosis must be confirmed by an oncologist or hematologist.

The Insurance Indemnity shall not be paid in respect of:

- localized non-invasive tumors with only early malignant changes: parenchymal, carcinoma in situ, cervical dysplasia, cervical intraepithelial neoplasia (CIN-1, CIN-2 and CIN-3);
- chronic lymphocytic leukemia, unless diagnosed as stage B or higher according to the BINET classification;
- less than T2bN0M0 prostate cancer according to the clinical TNM classification, unless histologically classified as greater than Gleason grade 6;
- basal cell carcinoma or squamous cell carcinoma of the skin and malignant melanoma of stage IA (T1aN0M0) unless metastases from this tumor are identified;
- less than T2N0M0 papillary or follicular thyroid cancer according to TNM clinical classification;
- true polycythemia and primary thrombocythemia;
- Gastrointestinal stromal tumor (GIST), stage I and II according to the AJCC (The American Joint Committee on Cancer) cancer staging system;
- lymphoma, unless the disease requires treatment with chemotherapy or radiotherapy;
- all tumors of T1 size according to the TNM classification, unless tumor removal or chemotherapy and/or radiotherapy has been performed;
- dermatofibrosarcoma Protuberans;
- the Insured Person has been diagnosed with any cancer, HIV infection or AIDS.

14.4.1.2. Myocardial infarction – acute, irreversible damage (necrosis) to the myocardium, which develops as a result of the loss of adequate arterial blood flow to a particular myocardial segment.

Myocardial infarction must be confirmed by a change in the levels of laboratory markers of myocardial infarction (troponin or CK-MB enzymes) to levels typical of myocardial infarction if at least 2 (two) of the following criteria are present together:

- clinical symptoms of ischemia (prolonged pectoral angina);
- new electrocardiographic (ECG) abnormalities characteristic of myocardial infarction indicative of myocardial ischemia (new ST-T wave changes or new signs of blockage of the left bundle branch);
- the appearance of a pathologic Q segment on the ECG.

The diagnosis must be confirmed by a cardiologist.

The Insurance Indemnity shall not be paid in the following cases:

- troponin elevation in the absence of overt ischemic heart disease (e.g., myocarditis, stress-induced cardiomyopathy, heart attack, pulmonary embolism, drug intoxication);
- if the myocardial infarction happened in the presence of intact coronary vessels due to coronary artery spasm, myocardial bridges (blockage of the coronary arteries of the heart) or drug use;
- if the myocardial infarction occurred within 14 (fourteen) days after coronary angioplasty or bypass surgery.

14.4.1.3. Stroke (brain infarction) – death of brain tissue diagnosed for the Insured Person due to acute cerebral circulatory disturbance caused by intracranial thrombosis, hemorrhage (including subarachnoid hemorrhage, or embolization from extracranial sources) leading to acute symptoms and new neurological deficit. The diagnosis must be confirmed by a neurologist during inpatient treatment. The Insurance Indemnity shall be paid only if there is a permanent neurological deficit lasting at least 3 (three) months after the stroke (brain infarction). The permanent neurological deficit must be confirmed by a neurologist and by imaging tests (MRI; CT, etc.).

The Insurance Indemnity shall not be paid in the following cases:

- for transient ischemic attack (TIA) and reversible ischemic neurological deficit (RIND);
- direct and/or post-operative indirect damage to the brain or blood vessels due to trauma and/or surgery;
- in case of neurological deficits due to general hypoxia, infection, inflammatory disease, migraine or medical intervention;
- incidental findings on imaging studies (computed tomography or magnetic resonance imaging) without clearly associated clinical symptoms of stroke (silent stroke).

14.4.1.4. Coronary artery bypass surgery – the Insured Person has undergone open cardiovascular surgery to correct narrowing or occlusion of two or more cardiac vessels using a shunt (superficial leg vein, internal thoracic artery or other suitable artery, etc.) as an autologous transplant.

The Insurance Indemnity shall be paid only if the necessity of the operation is confirmed by a cardiologist or cardiac surgeon and supported angiographically.

The Insurance Indemnity shall not be paid in the following cases:

- if the bypass procedure was performed to treat a single narrowed or blocked (occluded) coronary artery;
- if coronary angioplasty or stent implantation has been performed.

14.4.1.5. Heart valve surgery – the Insured Person has undergone cardiac surgery to replace one or more heart valves in one of the following ways:

- open-heart surgery (opening the chest) to replace or correct heart valves;
- Ross procedure;
- transcatheter heart valve repair (catheter valvuloplasty);
- transcatheter aortic valve implantation (TAVI).

The need for surgery must be confirmed by a cardiologist or cardiac surgeon and supported by echocardiography or cardiac catheterization.

The Insurance Indemnity shall not be paid if the narrowing of the bicuspid (mitral) valve was performed using a catheter.

14.4.1.6. Aortic surgery – an aortic surgery performed on the Insured Person to correct (treat) a narrowing, blockage, aneurysm or detachment of the aorta.

The term includes open surgery procedures as well as minimally invasive procedures such as endovascular repair. The need for surgery must be confirmed by a cardiac surgeon and evidence from imaging tests.

The Insurance Indemnity shall not be paid in the following cases:

- surgery on the thoracic and abdominal branches of the aorta (including bypass surgery of the aorta and femoral artery or the aorta and iliac artery);



– aortic surgery related to congenital connective tissue diseases (e.g., Marfan syndrome, Ehlers-Danlos syndrome);

– surgeries for traumatic aortic injury.

14.4.1.7. Internal organ / bone marrow transplantation – the below specified organ transplantation surgery actually carried out on the Insured Person as a recipient (irrespective of the number of surgeries or the number of organs to be transplanted), or if the Insured Person's condition requiring such an organ transplantation surgery is considered incurable by other means, and a confirmation from a professional in the relevant field that the Insured Person has been placed on an official waiting list for organ transplantation is provided.

Organ transplantation surgeries for which Insurance Indemnities are payable: Heart, kidney(s), liver (including partial liver transplantation and living donor liver transplantation), lung (including living donor lobe transplantation or single lung transplantation), bone marrow (allogeneic haematopoietic stem cell transplantation following complete removal of bone marrow), small intestine, pancreas, partial or total transplantation of the face, hand, arm, hand or leg (composite tissue allo-transplantation).

The Insurance Indemnity shall not be paid in the following cases:

– performance of transplantation of other organs, body parts or tissues (including cornea and skin);

– performance of transplantation of other cells (including pancreatic islet cells and non-haematopoietic stem cells).

14.4.1.8. Kidney failure – the terminal stage of kidney failure due to irreversible impairment of the function of both kidneys, requiring the Insured Person to undergo continuous hemodialysis or peritoneal dialysis.

The need for dialysis must be confirmed by a nephrologist and data from kidney function tests.

The Insurance Indemnity shall not be paid for acute reversible (up to 3 months) kidney failure, i.e. when only temporary dialysis is needed.

14.4.1.9. Multiple sclerosis – after a comprehensive inpatient neurological examination based on clinical neurological symptoms, the Insured Person has been diagnosed by a neurologist as having multiple sclerosis, which meets all of the criteria listed below:

– multiple neurological deficits lasting more than 6 (six) months;

– the disease confirmed by results of a magnetic resonance imaging (MRI) scan showing at least two (2) demyelination lesions typical of multiple sclerosis in the brain or spinal cord.

The Insurance Indemnity shall not be paid in the following cases:

– if multiple sclerosis is suspected but not diagnosed, even in the presence of neurological or radiological isolated syndromes;

– if isolated optic neuritis and/or neuromyelitis of the optic nerve.

14.4.1.10. Parkinson's disease (up to 65 years of age) – the Parkinson's disease diagnosed as unambiguous and primary disease by a neurologist before the Insured Person reaches the age of 65 (sixty-five).

The Insurance Indemnity shall be paid when all of the following conditions exist:

a) a diagnosis of at least two (2) of the following clinical indications:

– muscle stiffness (rigidity);

– tremor;

– bradykinesia (very pronounced slowness of movement, sluggishness of physical and mental response);

b) total inability to carry out at least three of the following six daily life activities for at least three (3) months continuously:

– washing: the ability to wash in a bath or shower (including getting in and out of the bath or shower) or to wash satisfactorily using other assistive equipment;

– dressing and undressing: the ability to dress, undress, fasten and unfasten all clothing and, if necessary, braces, artificial limbs or other orthopedic devices;

– eating: the ability to eat on one's own when food is prepared and served;

– personal hygiene: the ability to maintain adequate personal hygiene when using the WC or otherwise managing bowel and urinary functions;

– moving around rooms: ability to move from room to room on the same floor;

– getting in and out of bed: the ability to get in and out of bed, into and out of a chair or wheelchair.

If the clinical symptoms listed above have changed as a result of the implantation of a cerebral neurostimulator, the disease is considered a Critical Illness, regardless of the ability to perform daily activities. The need for neurostimulator implantation must be confirmed by a neurologist or neurosurgeon.

The Insurance Indemnity shall not be paid in the following cases of the diagnosed:

– secondary parkinsonism (including parkinsonism caused by drugs or toxins);

– spontaneous tremor;

– parkinsonism related to other neurodegenerative disorders.

14.4.1.11. Alzheimer's disease (before reaching the age of 65 years) – the Insured Person has been diagnosed with Alzheimer's disease by a neurologist before the Insured Person has reached the age of 65 (sixty-five) years and the Insured Person's need for care has been determined and confirmed as specified below.

The Insurance Indemnity shall be paid when all of the following conditions exist:

– the disease is confirmed by typical evidence from neuropsychological testing and neuroimaging (e.g., computed tomography, magnetic resonance imaging);

– diagnosed loss of intellectual capacity, manifested by impairment of memory and cognitive functions (sequencing, organization, summarizing and planning) resulting in marked impairment of mental and social function;

– identified personality change;

– confirmed slow progression of illness and persistent decline in cognitive functions;

– unidentified consciousness disorders;

– the Insured Person's need for continuous care 24 hours a day determined and confirmed by a neurologist.

The Insurance Indemnity shall not be paid if other forms of dementia are diagnosed due to brain, systemic or mental diseases.

14.4.1.12. 3rd degree burns – burns on the body of the Insured Person leading to the destruction of all the layers of the skin covering at least 20 % of the surface area of the body and confirmed by a surgeon.

Body surface area must be determined using the "rule of nines",



the Lund-Browder diagram or the "hand palm rule" (1% of the body surface area is equal to the palm of the Insured Person's hand, i.e. the palm with fingers).

14.4.1.13. Benign brain tumor – a benign growth of tissues in the cranial cavity (brain, meninges or cranial nerves) diagnosed by a neurologist and a neurosurgeon and confirmed by imaging data.

The Insurance Indemnity shall be paid when:

a) at least one of the following options was used to treat the tumor:

- total or partial surgery removal;
- stereotactic radiosurgery;
- external beam radiotherapy; or

b) none of the treatments referred to in point (a) is medically unavailable, but the tumor causes a permanent neurological deficit which persists for at least 3 (three) months after diagnosis.

The Insurance Indemnity shall not be paid in the following cases:

- the diagnosis or treatment of any cyst, granuloma, hamartoma, or arteriovenous, venous or cavernous malformation of the brain;
- the diagnosis of a pituitary tumor.

14.4.1.14. Blindness – the total and irreversible loss of sight in both eyes due to an Injury or Illness which cannot be treated by refractive correction, medication or surgery. The diagnosis must be confirmed by objective tests and the conclusion regarding the vision loss issued by a panel of medical specialists 6 (six) months after the diagnosis. The total loss of vision (blindness) shall be considered to be the visual acuity 3/60 or less (0.05 or less on the decimal system) of the better-seeing eye or the field of vision less than 10° in diameter of the better-seeing eye after correction.

The Insurance Benefit shall not be paid in the following cases:

- loss of vision in one eye;
- various reversible visual impairments.

14.4.1.15. Deafness – permanent and irreversible deafness in both ears of the Insured Person due to illness or physical injury. Diagnosis must be made by an otolaryngologist and confirmed by audiometry (audiometric threshold of at least 90 dB in the healthy ear in the sound frequency range of 500, 1000 and 2000 hertz).

14.4.1.16. Speech loss – the total and irreversible loss of the Insured Person's ability to speak due to a physical injury or illness, certified by an otolaryngologist, which cannot be corrected by any method of treatment and which persists for at least 6 (six) months. The Insurance Indemnity shall not be paid if the loss of speech is due to mental health conditions or mental illnesses.

14.4.1.17. Loss of limb function – the diagnosed total and

permanent loss of two or more limbs or of their function of the Insured Person as a result of a spinal or brain injury or disease. A Loss of a limb shall be its loss above the knee or elbow joint.

The Insurance Indemnity shall be paid if the loss of limb function persists for more than 3 (three) months and is confirmed by a neurologist on the basis of clinical symptoms and diagnostic tests.

The Insurance Indemnity shall not be paid in the following cases of:

- paralysis due to self-injury or mental disorder;
- diagnosed Guillain-Barre syndrome;
- diagnosed periodic (transient) or congenital paralysis.

14.4.1.18. Coma – a state of loss of consciousness. The Insurance Indemnity shall be paid when all the following conditions exist:

- the Insured Person is unresponsive to external stimuli (3-8 on the Glasgow Coma Scale) or unresponsive to natural needs for at least 96 (ninety-six) hours;
- it is necessary to use life support systems;
- irreversible / persistent neurological deficit present for at least 30 (thirty) days after onset of coma.

The diagnosis must be provided by a neurologist, anesthesiologist and anesthetist.

The Insurance Indemnity shall not be paid in the following cases of:

- coma caused by the use of Medicines for medical purposes;
- coma is caused by self-injury, consumption of alcohol or narcotic drugs.

14.4.1.19. Viral encephalitis – an inflammation of the brain (cerebral hemispheres, brainstem, cerebellum) caused by a viral infection. The diagnosis must be confirmed by a neurologist after the appropriate inpatient examination, including clinical symptomatology, fluid abnormalities, immunological / serological indicators.

The Insurance Indemnity shall be paid when all of the following conditions exist:

- the development of a neurological deficit; and
- the persistence of the neurological deficit for at least 3 (three) months.

The Insurance Indemnity shall not be paid in the following cases of:

- HIV induced encephalitis;
- encephalitis caused by bacteria or protozoan parasites;
- paraneoplastic encephalomyelitis.