

RULES OF VOLUNTARY HEALTH INSURANCE

(valid from 12 January 2023)

SPECIAL PART

TERMS AND DEFINITIONS

1. INSURANCE CONTRACT AND RELATED PARTIES.

- 1.1. Parties to the Insurance Contract (hereinafter referred to as the Parties)** shall mean the Policyholder and the Insurer.
- 1.2. Insurer** shall mean the insurance company ADB Compensa Vienna Insurance Group.
- 1.3. Policyholder** shall mean any person who has applied to the Insurer concerning the conclusion of the Insurance Contract, or to whom the Insurer has offered to conclude the Insurance Contract, or who has concluded the Insurance Contract with the Insurer.
- 1.4. Insured** shall mean a natural person specified in the Insurance Contract to whom the Insurer shall be obliged to pay the insurance benefit upon the occurrence of the Insurable Event.
- 1.5. Health Care Institution** shall mean a state-licensed legal entity that has the right to provide Health Care services in accordance with the procedure established by the applicable law.
- 1.6. Partner** shall mean a company, institution, organisation that provides services and/or sells goods to the Insured in accordance with the co-operation agreement concluded with the Insurer.
- 1.7. Beneficiary of the Insurance Benefit** shall mean the Partner or the Insured, or their successors in rights and obligations, heirs who acquire the right to the Insurance Benefit or a thereof in accordance with the concluded Insurance Contract and/or in accordance with the procedure and conditions established by the applicable law.
- 1.8. Insurance Contract** shall mean a contract between the Insurer and the Policyholder, according to which, upon the occurrence of the Insurable Event, the Insurer undertakes to pay the Insurance Benefit to the Beneficiary of the Insurance Benefit in accordance with the procedure established in the contract and for the remuneration provided for in the contract, and the Policyholder undertakes to pay the insurance premiums properly and in due time and fulfil other obligations assumed by the contract.
- 1.9. Insurance Policy** shall mean a document issued by the Insurer confirming the conclusion of an insurance contract and stipulating the terms of the Insurance Contract.

- 1.10. Rules** shall mean the rules of the Voluntary Health Insurance applicable to the Insurance Contract.

2. INSURED OBJECT

- 2.1. Insurance Object** shall mean the property interests related to the Insured's health and its care.
- 2.2. Insurance Period** shall mean the time period from the beginning of the Insurance Coverage for the Insured to its end, which does not necessarily coincide with the term of the Insurance Contract. The Insurance Period shall mean the period from the beginning of the Insurance Contract, when the Insured is on the list of insured persons, or from the start date of the insurance coverage specified in the Insurance Policy or its Annex, when the Insured is included in the Insurance Contract during its validity period, until the end of the Insurance Contract term or, by individual agreement of the Parties – the date of termination of insurance coverage for the Insured or termination of the employment contract with the Policyholder.
- 2.3. Insurance Coverage** shall mean the Insurer's obligation to pay the Insurance Benefit after the occurrence of the Insurable Event.
- 2.4. Insurable Event** shall mean the expenses incurred during the Insurance Period for services provided to the Insured during the Insurance Period and/or goods sold, which are specified in the Insurance Programmes selected under the Insurance Contract as insured expenses.
- 2.5. Uninsurable Event** shall mean the events or circumstances that have occurred or where Uninsured Expenses have been incurred, as a result of which the Insurer does not pay the Insurance Benefit.
- 2.6. Insurance Programme (or Risk)** shall mean a certain group of insurable and uninsurable costs. When, in the case of an Insurable Event, part of the expenses for a service or product are reimbursed from one Insurance Programme, the remaining part of the expenses for the same service or product cannot be reimbursed from another Insurance Programme.
- 2.7. Territory of Validity of Insurance Coverage** shall mean the territory where the expenses incurred in the event of an Insurable Event are covered by the Insurance Coverage. Insurance Coverage shall be valid in the Republic of Lithuania.

3. SUM INSURED AND COMPENSABLE PART

3.1. Sum Insured (or Limit) shall mean a sum of money that is equal to the maximum Insurance Benefit according to one or all Insurable Events of that Insurance Programme during the Insurance Period. After the Insurer has paid out the Insurance Benefit, its liability under the Insurance Contract (Sum Insured) for the specific Insured's specific Insurance Programme shall be reduced by the amount of the benefit, i.e. the Sum Insured shall not be refundable.

3.2. Reimbursable Part (or Paid Part) shall mean the amount specified in the Insurance Programme in the Insurance Contract (in percentages), equal to the part of the insured costs paid by the Insurer in the event of an Insurable Event.

3.3. Non-Reimbursable Part (or Deductible) shall mean the part of the Insured Expenses not paid by the Insurer in the event of an Insurable Event, which is reimbursed by the Insured itself and which cannot be reimbursed from any Insurance Programme.

4. SPECIAL TERMS OF VOLUNTARY HEALTH INSURANCE

4.1. Health Disorder shall mean an acute or chronic illness of the Insured that appeared/exacerbated during the Insurance Period, or an Injury or condition that occurred to the Insured during the Insurance Period, for which the Insured applied to the Health Care Institution, expressing complaints, and for which, in the presence of medical indications, diagnostic tests are performed and treatment is applied.

4.2. Follow-up shall mean the doctor's examinations and tests that are necessary at the specified time interval (specified in the doctor's medical documents) to regularly monitor the Insured's health condition/post-operative condition.

4.3. Medical Indications shall mean the Insured's complaints described in the medical statement, which are considered by a competent doctor to be an objective reason to perform diagnostic tests, and the results of an examination of the Insured's health condition, which are considered by a competent doctor to be an objective reason to perform procedures and apply the necessary treatment.

4.4. Non-Traditional Medical Services shall mean acupuncture, **reflexotherapy**, endobiogenic medicine, electroacupuncture, bioresonance computer diagnostics, hydrocolonotherapy, phytotherapy, leech treatment, lithotherapy, aerophytotherapy, music therapy, chromotherapy, ozonotherapy, prolotherapy and other services classified as non-traditional medicine.

4.5. Injury shall mean a violation of the integrity of tissues, which occurred due to an unexpected impact of external forces independent of the Insured's will and caused a disorder of the Insured's organism.

4.6. Medical Measures shall mean medical aids, medical devices, orthopaedic goods.

4.7. Medical Aids shall mean bandages (gauze, silicone, hydrocolloid), cellulose dressing, hydrogel, gauze,

plasters, cotton wool, nasal swabs, disposable syringes (without medication), pipettes, syringe, needles, drip systems, catheters, PORT catheter needles, diagnostic strips for determining glucose levels, stents, stomas, urine and faeces collectors, thimbles, probes, tourniquets, haemostatic sponges.

4.8. Medical Devices shall mean the blood pressure measuring devices, glucometers, inhalers, hearing aids, infusion pumps.

4.9. Orthopaedic Goods shall mean the therapeutic body coverings after burns, splint systems for the spine, upper or lower limbs, prosthetic systems for arms and legs, special orthopaedic footwear for the treatment of leg deformities, orthopaedic insoles, elastic or compression socks, postoperative corsets, belts and shoes, crutches, canes.

4.10. Orthopaedic Equipment shall mean walkers, walking frames, mechanical wheelchairs, rollers, heel protectors, orthopaedic/ergonomic, repositioning and other pillows.

4.11. Nursing Equipment shall mean the toilet-shower chairs (or benches, elevations), bathroom lift (or board), handrails, transfer board, wheelchair ramp, furniture for patients (tables, steps, beds, couches, screens, cabinets, functional beds, mattresses, back supports, etc.), oxygen devices, electric wheelchairs.

4.12. Health / Rehabilitation Equipment shall mean the massage tables or chairs, fitness equipment, massagers, exercise mats, balls, weights, rubbers, jump ropes and other equipment for performing rehabilitation, physiotherapy, exercises and procedures.

4.13. Diagnostic Goods shall mean thermometers, testers, tests, diagnostic biochemical kits, disposable containers for urine, faeces and other samples, containers, test tubes.

4.14. Protective and Disinfecting Measures shall mean sterile napkins, bacilli, disposable masks or face shields, disinfectant liquids, disposable gloves, disposable gowns.

4.15. Medicinal Preparations shall mean the medicines, vitamins, food supplements, other preparations registered in the Register of Medicinal Preparations of the Ministry of Health of the Republic of Lithuania or the European Community.

4.16. Pharmacy (E-Pharmacy) shall mean a legal entity registered in the Republic of Lithuania or a branch of a legal entity that has a pharmacy licence.

4.17. ATC Code shall mean the anatomical-therapeutic-chemical code.

4.18. CHIF shall mean the Compulsory Health Insurance Fund.

4.19. Long-Term Care, Supportive Treatment shall mean the continuous, long-term care of elderly people, disabled persons or patients with chronic diseases, including services at home, nursing facility, medical centre, social support facility.

4.20. Health Insurance Card shall mean a physical or electronic card issued by the Insurer to the Insured with a unique number, which entitles the Insured to use the Insurance Protection granted thereto in accordance with the Insurance Contract.

INSURANCE PROGRAMMES

5. OUTPATIENT TREATMENT

5.1. According to this Insurance Programme, the expenses incurred for outpatient health care services provided to the Insured at a **Health Care Institution** during the Insurance Period due to a **Health Disorder and/or its Follow-up** shall be considered to be an **Insurable Event**.

5.2. Expenses for the following outpatient health care services shall be considered **Insurable Expenses**:

5.2.1. Family doctor, specialist doctor consultations, including remote consultations and home visits. The consultation of a medical examiner (e.g. echoscopist, endoscopist, radiologist) provided in this Clause shall not be considered a consultation of a medical specialist;

5.2.2. Emergency medical aid;

5.2.3. Diagnostic tests prescribed by a doctor (referral by a doctor-researcher (e.g. echoscopist, endoscopist, radiologist) shall not be valid), including costs for a doctor-researcher's consultation/description of the test and recording the test on a medium or providing it in another way:

5.2.3.1. Laboratory tests: clinical, biochemical, immunoenzymatic, hormonal, microbiological-bacteriological, cytological-histological and other laboratory tests;

5.2.3.2. Instrumental tests: computed tomography, magnetic resonance and positron emission tomography;

5.2.3.3. Other radiological, ultrasound, endoscopic and other instrumental tests;

5.2.4. Nursing and therapeutic procedures performed on the appointment of a doctor or nurses;

5.2.5. Day surgery services:

5.2.5.1. Day surgery service shall be considered to be a service that is defined in the Order of the Minister of Health of the Republic of Lithuania valid on the day of the Insurable Event and which is included in the list of day surgery services specified in this Order;

5.2.5.2. Expenses shall be paid only if:
5.2.5.2.1. the necessity of treatment was established by a competent doctor during the Insurance Period;
5.2.5.2.2. expenses are partially compensated from CHIF funds;

5.2.5.3. Day surgery services related

to the diagnosis and/or treatment of chronic diseases shall be considered to be Uninsurable Expenses;

5.2.5.4. After informing the Insured and/or the Partner in writing about the plans to receive/provide Day Surgery Services, the Insurer must inform the applicant about the scope of Insurance Coverage for these services and (non) reimbursable costs.

5.2.6. Expenses for medical aid, protection measures and disinfectants, diagnostic goods, disposable instruments, hygiene goods used by the specialists of the Health Care Institution during the provision of the services specified in this Insurance Programme shall also be considered to be Insurable Expenses. These expenses shall be reimbursed only if this Insurance Programme also reimburses the costs for the health care service during which these measures and instruments are used.

5.3. Uninsured Expenses shall be considered to be expenses for:

5.3.1. Medicinal Preparations;

5.3.2. Implants introduced into the human body, including prostheses, medical devices;

5.3.3. COVID-19 PCR, antigen, antibody and other tests, with the exception of the mandatory ones performed according to the valid instructions of the Ministry of Health of the Republic of Lithuania before providing other outpatient treatment services, which are considered to be Insured Expenses according to the Insurance Contract;

5.3.4. Food intolerance tests;

5.3.5. Food allergen tests;

5.3.6. Homeopathic consultations;

5.3.7. Endobiogenic consultations;

5.3.8. Nutritionist consultations;

5.3.9. Consultations of a physical and medical rehabilitation doctor;

5.3.10. Geneticist's consultation;

5.3.11. Dermatology treatment (including removal for diagnostic purposes) and use of functional, diagnostic equipment, tools directly related to dermatological treatment (including phototherapy, photodynamic therapy, pulsed light therapy, laser treatment, sclerotherapy):

5.3.11.1. acne;

5.3.11.2. rosacea, redness, dilated blood vessels, vascular formations, spots, pigmentation disorders, acne, scars, stretch marks;

5.3.11.3. laser treatment of nail fungus;

5.3.11.4. moles, warts, papillomas, warts, keratomas; clams;

- 5.3.11.5. other benign skin formations (including atheroma and lipoma);
- 5.3.11.6. treatment of other dermatological conditions;
- 5.3.12. Treatment (including removal for diagnostic purposes) of non-malignant tumours (benign formations) of the skin;
- 5.3.13. Treatment of oncological diseases;
- 5.3.14. Treatment of varicose veins;
- 5.3.15. Treatment of bone and joint deformities;
- 5.3.16. Diagnosis and treatment of genetic diseases, congenital diseases, anomalies, defects and diseases caused by them;
- 5.3.17. Genetic testing;
- 5.3.18. Diagnostics of sexually transmitted diseases (syphilis, gonorrhoea, trichomonosis, chlamydia, human papillomavirus, genital herpes, etc.), AIDS, HIV;
- 5.3.19. Diagnosis and treatment of such systemic and autoimmune diseases as rheumatism, rheumatoid arthritis, systemic lupus erythematosus, scleroderma, dermatomyositis, autoimmune thyroiditis, autoimmune hepatitis;
- 5.3.20. Day Surgery Services for the upper and/or lower eyelid (s).
- 5.4. Uninsured Expenses** shall also be considered to be any expenses related to:
 - 5.4.1. COVID-19 disease and health disorders that are caused by COVID-19 disease;
 - 5.4.2. Impotence disorders;
 - 5.4.3. Inability to conceive, infertility;
 - 5.4.4. Hair loss;
 - 5.4.5. Pregnancy, childbirth or health disorders, the occurrence or exacerbation of which was influenced by pregnancy, childbirth or breastfeeding;
 - 5.4.6. Farsightedness, myopia, astigmatism, strabismus;
 - 5.4.7. Prophylaxis of teeth, mouth and jaw, diseases or consequences caused by trauma;
 - 5.4.8. Usage of stem cells or autologous preparations;
 - 5.4.9. Eating disorders, obesity, overweight;
 - 5.4.10. Blood plasma, hyaluronan, botulinum injections;
 - 5.4.11. Immunotherapy;
 - 5.4.12. Contraception;
 - 5.4.13. Sleep disorders;
 - 5.4.14. Alternative medicine services;
 - 5.4.15. Sports medicine doctor services;
 - 5.4.16. Medical rehabilitation services, including consultations of specialists providing such services.
- 5.5. According to this Insurance Programme**, the expenses incurred for the following outpatient health care services provided to the Insured at the Health Care Institution during the Insurance Period shall also be considered to be an **Insurable Event**:
 - 5.5.1. Consultations and psychotherapy performed by a psychiatrist, psychiatrist-psychologist,

medical psychologist, medical psychologist-psychotherapist, medical doctor-psychotherapist, but no more than 11 (eleven) visits (including consultation) for the Insured during the Insurance Period.

6. INPATIENT TREATMENT

- 6.1. According to this Insurance Programme**, expenses incurred for inpatient health care services provided to the Insured at a **Health Care Institution** due to a Health Disorder during the Insurance Period shall be considered to be an **Insurable Event**.
- 6.2.** Expenses for the following inpatient health care services provided during inpatient treatment in a **state** health care institution shall be considered to be **Insured Expenses**:
 - 6.2.1. Single or double ward;
 - 6.2.2. Doctor's consultation, diagnostic or treatment services.
- 6.3.** Expenses for the following equipment purchased/rented after inpatient treatment in a **state** health care institution or during it due to a health disorder shall also be considered to be **Insured Expenses**:
 - 6.3.1. Medicinal Preparations and Medical Aids indicated in the inpatient statement;
 - 6.3.2. Orthopaedic Equipment (the insurance amount for such expenses shall be EUR 100);
 - 6.3.3. Nursing Equipment (insurance amount for such expenses shall be EUR 100).
- 6.4.** The expenses for the inpatient health care services specified in this Insurance Programme, provided in private health care institutions, may also be considered as **Insured Expenses** if the Parties agree individually thereon in the Insurance Contract.
- 6.5. Uninsured expenses** shall be expenses for:
 - 6.5.1. Implants, prostheses, medical devices introduced into the human body;
 - 6.5.2. Medicines for the treatment of oncological diseases.
- 6.6. Uninsured Expenses** shall also be considered to be any expenses related to:
 - 6.6.1. COVID-19 disease and health disorders that are caused by COVID-19 disease;
 - 6.6.2. Impotence disorders;
 - 6.6.3. Inability to conceive, infertility;
 - 6.6.4. Pregnancy, childbirth or health disorders, the occurrence or exacerbation of which was influenced by pregnancy, childbirth, or breastfeeding;
 - 6.6.5. Farsightedness, myopia, astigmatism, strabismus;
 - 6.6.6. Prophylaxis of teeth, mouth and jaw, diseases or consequences caused by trauma;
 - 6.6.7. Blood donation, organ (tissue), bone marrow transplantation, hemodialysis;
 - 6.6.8. Endoprosthesis;
 - 6.6.9. Usage of stem cells or autologous preparations;
 - 6.6.10. Eating disorders, obesity, overweight;

- 6.6.11. Contraception;
- 6.6.12. Medical rehabilitation services, including consultations of specialists providing such services;
- 6.6.13. Mental illnesses.

7. MEDICINAL PREPARATIONS, MEDICAL DEVICES, ORTHOPAEDIC GOODS

7.1. According to this Insurance Programme, the expenses for the purchased (or rented) goods intended for the Insured at a **Health Care Institution, Pharmacy or specialised orthopaedic store (including the e-commerce of these institutions)**, who have a hygiene passport, shall be considered to be an **Insurable Event**.

7.2. Insured Expenses, depending on the Insurance Coverage selected in the Insurance Contract, may include expenses for the following goods:

- 7.2.1. The Insured is prescribed the following in a doctor's prescription or other medical document confirming the relevant appointment: Medicinal Preparations with an ATC Code, Medical Aids, Orthopaedic Goods (Insurance Programme "DRUGS" or "MEDICINAL PREPARATIONS, MEDICAL MEASURES, ORTHOPAEDIC GOODS WITH PRESCRIPTION");
- 7.2.2. Medicinal Preparations for which a doctor's prescription or other document confirming the prescription of a medicinal product is not issued, and Medical Aids (Insurance Programme "OVER-THE-COUNTER MEDICINES, FOOD SUPPLEMENTS AND VITAMINS" or "MEDICINAL PREPARATIONS, MEDICAL MEASURES, ORTHOPAEDIC GOODS WITHOUT A PRESCRIPTION");
- 7.2.3. Homeopathic medicinal preparations of plant and animal origin;
- 7.2.4. COVID-19 tests;

7.3. Expenses for the following goods of any purpose shall be considered to be Uninsured Expenses:

- 7.3.1. Diagnostic goods;
- 7.3.2. Medical devices;
- 7.3.3. Orthopaedic equipment;
- 7.3.4. Nursing equipment;
- 7.3.5. Protection measures and disinfectants;
- 7.3.6. First aid kits, sets;
- 7.3.7. Scales, heaters;
- 7.3.8. Goods for pregnant women, nursing mothers, babies, and children;
- 7.3.9. Hygiene goods, including diapers, sheets, mats, adhesives, oral hygiene, and other goods;
- 7.3.10. Cosmetic products, including creams, hair, skin, nail care products, tanning products, make-up, make-up removers and other products;
- 7.3.11. Protection against insects, sun;
- 7.3.12. Food products, including water, juice extracts, other beverages, as well as hema-togen, energy bars, glucose tablets and

other products;

- 7.3.13. Blood plasma injections, hyaluronic injections, botulinum injections;
- 7.3.14. Medicinal Preparations affecting the sexual system, including contraceptives;
- 7.3.15. Medicinal Preparations affecting potency;
- 7.3.16. Medicinal Preparations for weight regulation;
- 7.3.17. Medicinal Preparations for systemic enzyme therapy;
- 7.3.18. Vaccines;
- 7.3.19. Contrast, diagnostic or therapeutic radioactive substances or other means for conducting examinations;
- 7.3.20. Food supplements for athletes.

8. DENTAL TREATMENT

8.1. According to this Insurance Programme, expenses incurred for dental services provided to the Insured at the Health Care Institution during the Insurance Period shall be considered to be an **Insurable Event**;

8.2. Expenses for the following dental services shall be considered to be Insured Expenses:

- 8.2.1. Oral hygiene: assessment of oral hygiene, removal of hard and soft dental plaque, fluoride applications, oral hygienist consultation (hygiene training);
- 8.2.2. Dental and/or jaw radiological examination;
- 8.2.3. Dental treatment: dental consultations, dental (including analgesia, rooting), endodontic, periodontal treatment, restoration of tooth hard tissue defects with fillings, inlays, overlays and laminates;
- 8.2.4. Dental prosthetics: consultations with a dentist concerning dental prosthetics, implantation and orthodontic treatment, production, restoration and repair of removable and non-removable dental prostheses, dental implantation (including the production of dental implants and restoration of the jaw before the expected implantation);
- 8.2.5. Orthodontist consultations concerning treatment, treatment with brace systems, splints, orthodontic plates, trainers, including expenses for braces, splints, orthodontic plates;
- 8.2.6. Consultations of an oral-facial and maxillofacial surgeon, surgical treatment of dental and/or jaw diseases, consequences of trauma, diseases of the oral cavity;
- 8.2.7. Protection measures and disinfectants used by dental specialists.

8.3. Uninsured expenses shall be expenses for:

- 8.3.1. Teeth whitening, lamination (veneering), aesthetic filling (except for cases when aesthetic filling is performed to restore dental functions or eliminate negative health effects);
- 8.3.2. Coating of teeth with sealants;

- 8.3.3. Protective, sports, bleaching splints;
- 8.3.4. Myorelaxation splints;
- 8.3.5. Splints for the treatment of bruxism;
- 8.3.6. Splints for the treatment of snoring;
- 8.3.7. Dental jewellery, hygiene, and other dental products.

9. OPTICS

9.1. According to this Insurance Programme, expenses related to sight-related services provided to the Insured during the Insurance Period in a **Health Care Institution or specialised store (optical, contact lens store) with a hygiene passport (including e-commerce of these institutions)** or purchased by the Insured for optical goods shall be considered to be an Insurable Event.

9.2. Expenses for the following vision-related services or optical goods shall be considered to be **Insured Expenses**:

- 9.2.1. Preventive eye examination, including a doctor's consultation;
- 9.2.2. Consultations of an ophthalmologist or optometrist concerning farsightedness, near-sightedness, astigmatism, strabismus and/or selection of optical devices;
- 9.2.3. Prescription glasses (eyeglass lenses, eyeglass frames purchased together with eyeglass lenses) or contact lenses, including the production service of such goods (and in cases where only the production service is provided);
- 9.2.4. Moisturizing eye drops (artificial tears) and contact lens cleaning solution;
- 9.2.5. Vision correction surgery for farsightedness, near-sightedness, astigmatism;
- 9.2.6. Vision correction surgery due to strabismus. Expenses shall be paid only if the necessity of treatment was established by a competent doctor during the Insurance Period and are partially compensated from CHIF funds.

9.3. Uninsured expenses shall be expenses for:

- 9.3.1. Glasses without dioptries;
- 9.3.2. Glasses care products and accessories (e.g. glasses cases, cleaners, wipes);
- 9.3.3. Supplements, medicinal preparations.

10. MEDICAL REHABILITATION

10.1. According to this Insurance Programme, the Insurable Event, depending on the Insurance Coverage chosen in the Insurance Contract, may be considered to be the expenses incurred by the Insured due to a Health Disorder (**Insurance Programme "Medical Rehabilitation"**) or expenses of medical rehabilitation services provided at a Health Care Institution during the Insurance Period, which, due to a health disorder for which inpatient treatment in a **Health Care Institution**, was applied continuously for at least 72 hours (**Insurance Programme "Medical Rehabilitation after 72 hours of Inpatient Treatment"**).

10.2. Expenses for the consultation of a physical med-

icine and rehabilitation doctor and the services indicated in the rehabilitation program (including the consultation costs of specialists providing such services) shall be considered to be **Insured Expenses**:

- 10.2.1. Physiotherapy (halotherapy, electrotherapy, magnetotherapy, ultrasound therapy, aerosol therapy, inhalations, phototherapy, hydrotherapy (water), pelotherapy (mud, paraffin) and other physiotherapy procedures);
- 10.2.2. Physiotherapy;
- 10.2.3. Occupational therapy;
- 10.2.4. Therapeutic massages;
- 10.2.5. Manual therapy;
- 10.2.6. Logotherapy;
- 10.2.7. Psychological help (according to the rehabilitation program).

10.3. Expenses shall be reimbursed only if the necessity of medical rehabilitation is indicated by a Health Disorder for which medical rehabilitation is prescribed by the appointment of the attending physician (the appointment of a physical and medical rehabilitation doctor, sports medicine doctor shall not be valid). After choosing the Insurance Programme "Medical rehabilitation after 72 hours of inpatient treatment", the appointment of the doctor treating the health disorder for medical rehabilitation must be issued no later than within 30 calendar days (but not later than the end of the Insurance Contract) from the last inpatient treatment of this health disorder at the Health Care Institution.

10.4. Uninsured Expenses shall be considered to be expenses when medical rehabilitation is prescribed due to:

- 10.4.1. COVID-19 disease or health disorder caused by it;
- 10.4.2. Genetic diseases, congenital diseases, anomalies, defects and diseases caused by them;
- 10.4.3. Degenerative, deforming changes or diseases;
- 10.4.4. Pregnancy, childbirth or health disorders that are caused by pregnancy, childbirth or breastfeeding;
- 10.4.5. Eating disorder, obesity, overweight;
- 10.4.6. Sleep disorders;
- 10.4.7. Exhaustion, overwork;
- 10.4.8. Mental illness;

10.5. Uninsured Expenses shall also be considered to be expenses for:

- 10.5.1. Facial massages and cosmetic procedures.

11. VACCINES

11.1. According to this Insurance Program, the expenses for the vaccination service provided to the Insured in the **Health Care Institution or Pharmacy** during the Insurance Period, including consultation and vaccine, shall be considered to be an **Insurable Event**.

12. PREVENTIVE HEALTH EXAMINATIONS

12.1. According to this Insurance Programme, the expenses for preventive health care services provided to the Insured at the **Health Care Institution** during the Insurance Period shall be considered to be an **Insurable Event**.

12.2. Expenses for the following health care services shall be considered to be **Insured Expenses**:

- 12.2.1. Mandatory health examinations of employees according to the nature of the work, in order to determine fitness for work;
- 12.2.2. Health examinations for obtaining certificates;
- 12.2.3. Health examinations in accordance with the disease prevention programmes carried out in the territory of the Insurance Coverage or established and approved in Health Care Institutions;
- 12.2.4. Examinations and doctor's consultations selected at the request of the Insured or prescribed by a doctor;
- 12.2.5. Allergen-specific immunotherapy.

12.3. Uninsured expenses shall be expenses for:

- 12.3.1. COVID-19 PCR, antigen, antibody and other tests;
- 12.3.2. Food intolerance tests;
- 12.3.3. Homeopathic consultations;
- 12.3.4. Consultations of a physical and medical rehabilitation doctor.

12.4. Uninsured Expenses shall also be considered to be any expenses related to:

- 12.4.1. Impotence disorders, impossibility to conceive, infertility;
- 12.4.2. Hair loss;
- 12.4.3. Pregnancy, childbirth or health disorders that are caused by pregnancy, childbirth or breastfeeding;
- 12.4.4. Vision examination;
- 12.4.5. Prophylaxis of teeth, mouth and jaw, diseases or consequences caused by trauma;
- 12.4.6. Eating disorders;
- 12.4.7. Contraception;
- 12.4.8. Sleep disorders;
- 12.4.9. Alternative medicine services;
- 12.4.10. Medical rehabilitation services, including consultations of specialists providing such services.

13. MATERNITY CARE

13.1. According to this Insurance Programme, expenses for health care services provided to the Insured in a **Health Care Institution** during the Insurance Period due to pregnancy or childbirth shall be considered to be an **Insurable Event**.

13.2. Expenses for periodical examinations of pregnant women, emergency medical assistance, doctor's consultations, tests, nursing and treatment procedures, operations, private ward shall be considered to be **Insured Expenses**:

- 13.2.1. Monitoring of the course of pregnancy or the general condition of the pregnant

woman;

13.2.2. Concerning complications of pregnancy, termination of pregnancy in case of medical indications;

13.2.3. For childbirth, postpartum care (including actually incurred expenses for the pre-selected doctor and/or midwife of the Health Care Institution), breastfeeding;

13.2.4. Concerning health disorders that were aggravated by pregnancy, childbirth or breastfeeding.

13.3. Insured Expenses shall also be considered to be expenses for:

13.3.1. Medical aids, protection measures and disinfectants, diagnostic goods, disposable instruments, hygiene goods used during the provision of the services specified in this Insurance Program by the specialists of the Health Care Institution. These expenses shall be reimbursed only if, according to this Insurance Programme, the expenses for the health care service, during which these tools and instruments are used, are also reimbursed;

13.3.2. Exercise and water aerobics for pregnant women.

13.4. Uninsured Expenses shall be considered to be expenses for:

13.4.1. The expenses of the new-born's father's private ward;

13.4.2. Alternative medicine services;

13.4.3. Medical rehabilitation services, including consultations of specialists providing such services and physical and medical rehabilitation doctors.

13.5. Uninsured Expenses shall also be considered to be any expenses related to:

13.5.1. Prophylaxis of teeth, mouth and jaw, diseases or consequences caused by trauma;

13.5.2. Farsightedness, near-sightedness, astigmatism, strabismus, preventive eye examination.

14. CRITICAL ILLNESSES

14.1. According to this Insurance Programme, expenses for health care services provided to the Insured during the Insurance Period, goods rented or purchased by the Insured for the monitoring or treatment of the health condition required for him/her, if the diagnosis of a disease included in the "Critical Illnesses" list for the first time in his/her life is established during the Insurance Period (Insurance Programme "Treatment of a Critical Illness"), or, if the insurance option is selected, when a one-time insurance benefit is paid, the **Insurable Event** shall be considered to be a diagnosis for the first time in the life of the Insured due to a disease specified in the "Critical Illnesses" list (Insurance Programme "Critical Illness Benefit Insurance").

14.2. In the Rules, a disease diagnosed for the first

time in life during the Insurance Period shall be considered to be only such a disease for which all of the Medical Indications, including the injury for which the disease was diagnosed, occurs during the Insurance Period.

14.3. Expenses incurred in a Health Care Institution for the following health care services shall be considered to be Insured Expenses:

- 14.3.1. Consultations, diagnostics, nursing and treatment procedures, operations by a family doctor, specialist doctor;
- 14.3.2. Single or double ward;
- 14.3.3. Medical rehabilitation: physiotherapy, kinesiotherapy, occupational therapy, therapeutic massages; manual therapy, logotherapy;
- 14.3.4. Consultations of a psychiatrist, psychiatrist-psychotherapist, medical psychologist, medical psychologist-psychotherapist, medical doctor-psychotherapist and the psychotherapy performed by them.

14.4. Expenses for goods purchased, rented or used by specialists of a Health Care Institution in a Health Care Institution, Pharmacy or specialised store with a hygiene passport, including the e-commerce of all these institutions, shall also be considered to be Insured Expenses:

- 14.4.1. Medicines. In the case of an oncological disease, the expenses of medicines shall be reimbursed only under all of the following conditions:
 - 14.4.1.1. Medicines are approved by the European Medicines Agency;
 - 14.4.1.2. Medicines are prescribed according to the recommendations of the oncologist and chemotherapist;
 - 14.4.1.3. Medicines are reimbursed by the Territorial Health Insurance Funds of the Republic of Lithuania for the treatment of a different localisation of cancer or a different stage than the one prescribed for the Insured;
- 14.4.2. Medical aids;
- 14.4.3. Infusion services;
- 14.4.4. Orthopaedic goods.

14.5. An Uninsurable Event shall be considered to be the case when:

- 14.5.1. The critical illness occurred within 45 (forty-five) days from the date of conclusion of the Insurance Contract (or the date of inclusion of the Insured in the Insurance Contract, if the Insured is provided with insurance coverage during the Insurance Period). This condition shall not apply if the Insured's insurance coverage under this Insurance Programme is valid continuously, i.e. when the end of one Insurance Contract, in which the Insured was covered under the "Critical Illness" Insurance Program, coincides with the begin-

ning of another Insurance Contract;

- 14.5.2. Critical Illness, Injury or other circumstances that caused the Critical Illness to occur before the conclusion of the Insurance Contract;
- 14.5.3. The diagnosis of a Critical Illness was established at the time when the Insured is infected with HIV or has AIDS;
- 14.5.4. Before the conclusion of the Insurance Contract, the Policyholder or the Insured provided the Insurer with false or incompletely known information about the circumstances under which the diagnosis of a Critical Illness could be expected during the Insurance Period.

14.6. Uninsured Expenses shall also be considered to be expenses for:

- 14.6.1. Alternative medicine services.

15. ADVANCED HEALTH INSURANCE

15.1. According to this Insurance Programme, expenses for health care services provided to the Insured at a Health Care Institution during the validity of the Insurance Coverage, in order to prevent or treat such a health or physiological condition of the Insured that requires a doctor's consultation, examination or treatment, shall be considered to be an Insurable Event:

- 15.1.1. Outpatient or inpatient healthcare services based on medical indications;
- 15.1.2. Preventive health examinations;
- 15.1.3. Preventive health procedures: vaccinations, allergen-specific immunotherapy;
- 15.1.4. Registration of medical data, recording on a medium or in another way;
- 15.1.5. Medical rehabilitation procedures: physiotherapy, kinesiotherapy, occupational therapy, therapeutic massages; manual therapy, logotherapy;
- 15.1.6. Dentistry services;
- 15.1.7. Vision inspection services;
- 15.1.8. Maternity care services.

15.2. Uninsured Expenses shall be considered to be expenses for:

- 15.2.1. COVID-19 PCR, antigen, antibody and other tests, with the exception of the mandatory ones performed according to the valid instructions of the Ministry of Health of the Republic of Lithuania before providing other outpatient treatment services;
- 15.2.2. Homeopathic consultations;
- 15.2.3. Endobiogenic consultations;
- 15.2.4. Nutritionist consultations;
- 15.2.5. Phototherapy, photodynamic therapy, pulsed light therapy;
- 15.2.6. Laser treatment of nail fungus;
- 15.2.7. Food intolerance tests;
- 15.2.8. Other than dental implants, prostheses, medical devices introduced into the human body;
- 15.2.9. Facial massages, non-therapeutic massages, cosmetic procedures;

- 15.2.10. Teeth whitening, lamination (veneering), aesthetic filling (except for cases when aesthetic filling is performed to restore dental functions or eliminate negative health effects);
- 15.2.11. Coating of teeth with sealants;
- 15.2.12. Injections of blood plasma, hyaluronan, botulinum;
- 15.2.13. Medicines for the treatment of oncological diseases;
- 15.2.14. Alternative medicine;
- 15.2.15. Psychologist consultations, sessions;
- 15.2.16. Dermatology treatment (including removal for diagnostic purposes) and the use of functional, diagnostic equipment, tools directly related to dermatological treatment (including phototherapy, photodynamic therapy, pulsed light therapy, laser treatment, sclerotherapy), except for the removal of formations such as moles, warts, papillomas, condylomas, keratomas, clams (laser or surgery).

15.3. Uninsured Expenses shall be considered to be any expenses related to:

- 15.3.1. Impotence disorders;
- 15.3.2. Inability to conceive, infertility;
- 15.3.3. Hair loss;
- 15.3.4. Usage of stem cells or autologous preparations;
- 15.3.5. Sleep disorders;
- 15.3.6. Eating disorders, obesity, overweight;

15.4. Expenses for consultations and psychotherapy performed by a psychiatrist, psychiatrist-psychologist, medical psychologist, medical psychologist-psychologist, medical doctor-psychologist shall be reimbursed for no more than 11 (eleven) visits (including consultation) during the Insurance Coverage period;

15.5. Costs for upper and/or lower eyelid surgery shall be reimbursed only under the following conditions:

- 15.5.1. The results of a computerised perimetry examination performed by an ophthalmologist confirm that the eyelid covers more than half of the pupil area;
- 15.5.2. Expenses shall be partially compensated from CHIF funds.

15.6. According to this Insurance Programme, the expenses for the goods purchased by the Insured during the **Insurance Period in a Health Care Institution, Pharmacy or a specialised store with a hygiene passport (contact lenses, orthopaedic goods, optics), including the e-commerce of all these institutions**, shall also be considered to be an Insurable Event:

- 15.6.1. Medicinal preparations (including homeopathic, herbal, animal origin) and medical aids;
- 15.6.2. Orthopaedic Goods prescribed for the Insured in a doctor's prescription or other medical document confirming the relevant prescription;
- 15.6.3. Prescribed to the Insured in a doctor's

prescription or other medical document confirming the relevant prescription: corrective glasses (eyeglass lenses, eyeglass frames purchased together with eyeglass lenses) or contact lenses;

- 15.6.4. Braces, splints, orthodontic plates and other goods used for dental treatment and dental prosthetics services.

15.7. Uninsured Expenses shall be considered to be expenses for the following goods:

- 15.7.1. Glasses without dioptries;
- 15.7.2. Glasses care products and accessories (e.g. glasses cases, cleaners, wipes);
- 15.7.3. Dental jewellery;
- 15.7.4. Such splints as: protective, sports, bleaching, myorelaxation, intended to treat bruxism or snoring;
- 15.7.5. Oral hygiene products;
- 15.7.6. Body hygiene, cosmetic products;
- 15.7.7. Goods for pregnant women;
- 15.7.8. Medical devices;
- 15.7.9. COVID-19 and other diagnostic tests;
- 15.7.10. Food and beverages, including products such as hematogen, energy bars, juice extracts, glucose tablets and other such products;
- 15.7.11. Contraceptives;
- 15.7.12. Medicines for the treatment of impotence disorders;
- 15.7.13. Preparations for weight reduction, slimming;
- 15.7.14. Preparations for systemic enzyme therapy;
- 15.7.15. Food supplements for athletes.

16. HEALTH PROMOTION SERVICE

16.1. According to this Insurance Programme, depending on the Insurance Coverage selected in the Insurance Contract, the expenses for the health promotion services provided to the Insured during the Insurance Period, when the services were provided in a **Health Care Institution, SPA Centre, sports club, swimming pool, amusement park or by another person (natural person or legal entity), who has a licence to engage in relevant activities, may be considered as an Insurable Event**.

16.2. Expenses for the following health promotion services shall be considered to be **Insured Expenses**:

- 16.2.1. Rehabilitation services (including specialist consultation);
- 16.2.2. Analysis of body composition, examinations of ergonomic body position;
- 16.2.3. Alternative medicine services (procedures and consultations of specialists, including homeopaths);
- 16.2.4. Nutritionist, dietitian consultations, drawing up a nutrition plan;
- 16.2.5. Consultations and sessions conducted by mental specialists;
- 16.2.6. Individual or group classes of all sports of physical activity, physical education services (including the service of leading a

class, membership fee, rental fees for halls/sports grounds, including the equipment in them, and the special clothing used).

16.3. Uninsured Expenses shall be considered to be expenses for:

- 16.3.1. Competition/participant/camp fees;
- 16.3.2. Facial massages;
- 16.3.3. Cosmetological procedures;
- 16.3.4. Hair removal procedures;
- 16.3.5. Entertainment services.

16.4. When a service subscription/multiple package of services (e.g. procedures, classes) is purchased, the Insured shall be paid only the expenses actually incurred by the Insured during the Insurance Period for the part of the period of the subscription/multiple service package that coincides with the Insurance Period.

17. AESTHETIC PROCEDURES

17.1. According to this Insurance Programme, expenses for cosmetology, plastic, beauty and/or aesthetic purposes provided to the Insured at a Health Care Institution or other legal entity licenced to engage in relevant activities during the Insurance Period and/or aesthetic goods purchased for the Insured during the Insurance Period shall be considered to be an **Insurable Event**.

17.2. Insured Expenses shall be considered to be expenses for:

- 17.2.1. Doctor's specialist consultations concerning procedures and/or operations performed for cosmetic, plastic, beauty and/or aesthetic purposes;
- 17.2.2. Cosmetology and beauty procedures (facial cleansing, aesthetic, body line improvement, anti-cellulite, body scrub, wrapping, rubbing, hair removal, teeth whitening, lamination procedures, blood plasma, hyaluronic acid, botulinum injections and other similar procedures);
- 17.2.3. Baldness, hair loss consultations, diagnosis and treatment.

17.3. Insured Expenses shall be considered to be expenses for the following goods:

- 17.3.1. Scars, hair loss, stretch marks and other similar products.

18. GENERAL EXCLUSIONS:

18.1. In any Insurance Programme, any expenses related to/caused by the following shall be considered to be an **Uninsurable Event**:

- 18.1.1. Exposure to ionising radiation, radioactive contamination or any nuclear waste, chemical contamination, radioactive, toxic or other hazardous nuclear facility or component thereof, including explosion;
- 18.1.2. Pandemics, ecological or natural catastrophes, mass disasters caused by natural disasters or circumstances that have declared a state of emergency in the country;
- 18.1.3. War, invasion, action by foreign enemies,

seizure (whether or not war has been declared), civil war, rebellion, revolution, mass disturbance, insurrection, military or usurpation force, act of terrorism;

- 18.1.4. Attempted suicide, intentional self-inflicted injury or self-inflicted injury due to mental illness;
- 18.1.5. Faults of the Policyholder, Insured or Beneficiary;
- 18.1.6. Due to the fact that the Policyholder or the Insured performed actions that are considered a criminal act according to the legislation of the Republic of Lithuania;
- 18.1.7. Arrest of the Insured or due to the fact that the Insured does not comply with the lawful demands of police officers;
- 18.1.8. The Insured's dangerous driving or if the Insured was voluntarily in a vehicle that was dangerously driven. Dangerous driving shall be considered to be driving in violation of road traffic rules due to dangerous incentives, endangering traffic safety or the safety of oneself or others;
- 18.1.9. The use of alcohol, narcotic or toxic substances (used for the purpose of intoxication) or drugs not prescribed by a doctor or addiction diseases;
- 18.1.10. Due to the fact that the Policyholder, the Insured, another person related to them worked with the mechanisms without having a legal basis for this or without having the right to work with such mechanisms (i.e. without having the appropriate qualification, certificate, etc.);
- 18.1.11. Termination of pregnancy in the absence of medical indications or childbirth outside a Health Care Institution;
- 18.1.12. Treatment of sexually transmitted diseases (syphilis, gonorrhea, trichomonosis, chlamydiosis, human papillomavirus, genital herpes, etc.), AIDS, HIV, tuberculosis and health disorders caused by them;
- 18.1.13. Supportive treatment and/or long-term care;
- 18.1.14. Services/goods provided/supplied by an institution and/or specialist who do not have a licence or hygiene passport valid on the day of the Insurable Event for the relevant activity;
- 18.1.15. Services/goods provided/supplier by the Insured's spouse (partner), parents or children;
- 18.1.16. Services/goods provided/supplied not to the Insured or anonymously;
- 18.1.17. Services/goods, the necessity of which is not substantiated by medical documents, when it is required by the terms of the Insurance Contract, or when the date and circumstances of the provision of the provided services (goods) cannot be determined;
- 18.1.18. Paid but not yet delivered services and/or goods (advance payments);

- 18.1.19. Accommodation and/or catering services, regardless of whether this service is provided as part of a service that is considered Insured Expenses;
 - 18.1.20. By purchasing a gift coupon, group purchase (discount) coupons;
 - 18.1.21. Renting or purchasing health/rehabilitation equipment;
 - 18.1.22. Blood donation;
 - 18.1.23. Transplantation of organs (tissues), bone marrow, hemodialysis (except in the Insurance Programme "Critical Illnesses");
 - 18.1.24. Endoprosthesis (except for the "Dental Treatment" Insurance Programme).
- 18.2.** Any expenses related to the following shall be considered to be **an Uninsurable Event in all**

Insurance Programmes, except for the Insurance Programme "Aesthetic Procedures":

- 18.2.1. Services provided for cosmetological, plastic, beauty and/or aesthetic purposes, including specialist consultations and procedures such as facial cleansing, body contouring, anti-cellulite, body scrubbing, wrapping, rubbing, hair removal and other procedures, mesotherapy;
- 18.2.2. Plastic, aesthetic and/or reconstructive operations and procedures, including laser or surgical treatment;
- 18.2.3. Purchase of products intended for beauty, aesthetics, including means for the treatment of acne, scars, stretch marks, prevention of insect bites and others.

GENERAL PART

1. CONCLUSION AND VALIDITY OF THE INSURANCE CONTRACT

- 1.1. The Insurance Contract shall be concluded after the Parties have agreed on the terms of the Insurance Contract for the agreed term, which, including the main terms of the Insurance Contract (selected insurance programmes, insurance amounts (or limits), reimbursed part of costs, territory of insurance coverage, list of the Insured, insurance premium), shall be specified in the Insurance Policy. The term of the Insurance Contract shall be one year.
- 1.2. The Insurance Contract shall be considered concluded when the Insurer and the Policyholder sign the Insurance Policy or the Policyholder pays the insurance premium specified in the Insurance Policy. Upon conclusion of the Insurance Contract, the Policyholder's written request and any written information shall become an integral part of the Insurance Contract.
- 1.3. Insurance coverage for the Insured shall come into effect from the beginning of the Insurance Period specified in the Insurance Policy, after the Insurer receives the Insured's consent to process his/her health data for the purposes of insurance risk assessment, conclusion and performance of the Insurance Contract, and investigation and administration of insurable events or events that may be recognised as insurable. In the absence of consent, the Insurer shall not be able to provide the Insured with the insurance services provided for in the Insurance Contract.
- 1.4. Before concluding an Insurance Contract, the Insurer shall have the right, but shall not be obliged, to demand information and documents confirming the Insured's age, state of health, profession and other circumstances relevant to the insurance risk assessment.
- 1.5. The Policyholder and/or the Insured shall be liable for the correctness of the information provided to the Insurer.
- 1.6. The Insurer shall have the right to refuse to conclude an Insurance Contract in case of unacceptable insurance risk.

2. INSURANCE PREMIUM PAYMENT PROCEDURE

- 2.1. The size of the insurance premium shall be calculated by the Insurer, assessing the insurance risk according to the information provided by the Policyholder and/or the Insured and the insurance programme(s) selected by the Policyholder, the insurance amount(s) and other terms of the Insurance Contract.
- 2.2. The insurance premium shall be paid once within the term specified in the Insurance Policy.
- 2.3. If the insurance premium or a part thereof is not paid in due time, the Insurer shall have the right to demand the payment of interest on arrears in the amount of 0.02% of the unpaid amount for each day of delay.
- 2.4. If the Policyholder fails to pay the insurance pre-

mium or a part thereof in due time, the Insurer shall notify the Policyholder thereof, stating that if the Policyholder fails to pay the insurance premium within 30 calendar days from the date of sending the notification, the Insurance Contract shall expire.

3. RIGHTS AND OBLIGATIONS OF THE PARTIES

- 3.1. **The rights of the Policyholder** before the conclusion of the Insurance Contract shall be as follows:
 - 3.1.1. to get acquainted with the Rules and get a copy thereof;
 - 3.1.2. to submit to the Insurer a request for the conclusion of an Insurance Contract in the prescribed form.
- 3.2. Upon conclusion of the Insurance Contract, the **Policyholder's rights** within the term of the Insurance Contract shall be as follows:
 - 3.2.1. in cases provided for by legal acts and the Insurance Contract, to request amendments to the terms and conditions of the Insurance Contract, including amending the list of Insured, the Beneficiary of the Insurance Benefit provided for in the Insurance Contract;
 - 3.2.2. to terminate the Insurance Contract on the grounds provided for in the Rules or legal acts.
- 3.3. **The rights of the Insurer** before the conclusion of the Insurance Contract shall be as follows:
 - 3.3.1. to demand from the Policyholder all information, including information about the Insured, necessary to assess the insurance risk;
 - 3.3.2. to refuse to conclude an Insurance Contract without giving reasons.
- 3.4. After concluding the Insurance Contract, the **Insurer** shall have the **right** to demand amendments to the terms and conditions of the Insurance Contract, including the insurance premium, within the term of the Insurance Contract, if the Policyholder has not properly fulfilled the obligation specified in the Rules to disclose material circumstances relevant to the assessment of the insurance risk, or if the insurance risk changes:
 - 3.4.1. The Insurer must notify the Policyholder in writing of its intention;
 - 3.4.2. The terms and conditions of the Insurance Contract shall be considered amended after the Policyholder agrees to the amendments to the Insurance Contract or after 30 calendar days from the notification being sent to the Policyholder, if the Policyholder does not object to the amendments to the terms and conditions of the Insurance Contract within such period;
 - 3.4.3. If the Policyholder does not agree to amend the terms and conditions of the Insurance Contract, the Insurer shall have the right to unilaterally terminate such Insurance Contract after 30 calen-

dar days from the notification of changes to the terms of the Insurance Contract being sent to the Policyholder, if the change is required due to a change in the insurance risk – to apply to the court for the termination or amendment of the Insurance Contract in the event of a substantial change in circumstances.

3.5. The obligations of the Policyholder before the conclusion of the Insurance Contract shall be as follows:

- 3.5.1. Together with the Insured (s), to provide the Insurer with all known information about the circumstances that may have a significant impact on the insurance risk assessment, the probability of the Insurable Event and the occurrence or increase of possible losses. Material circumstances shall mean the circumstances specified in the Insurance Contract or Annexes thereof and Rules, as well as other circumstances that the Insurer has requested to disclose;
- 3.5.2. At the insurer's request, to fill out an application for concluding an Insurance Contract in the prescribed form;
- 3.5.3. To notify the Insurer about all insurance contracts of the insured object for the same risks and their conditions concluded with other insurance companies.

3.6. Upon conclusion of the Insurance Contract, the Policyholder's obligations during the term of the Insurance Contract shall be as follows:

- 3.6.1. to pay the insurance premiums specified in the Insurance Contract in due time;
- 3.6.2. to immediately, but no later than within 7 calendar days:
- 3.6.3. inform the Insured about the concluded Insurance Contract and the conditions of insurance coverage provided by it, their rights according to the Insurance Contract and the obligations arising from the Insurance Contract;
- 3.6.4. to correct any incorrect or incomplete information provided to the Insurer in writing together with the Insured;
- 3.6.5. to inform the Insurer about the increase in insurance risk;
- 3.6.6. to inform the Insurer about the contact details specified in the Insurance Policy.

3.7. Upon conclusion of the Insurance Contract, the Insurer's and/or the Policyholder's (Policyholders') obligations in case of an event that may be recognised as Insurable shall be as follows:

- 3.7.1. to inform the Insurer about the event by e-mail or using the Insurer's self-service methods within the term specified in the Rules;
- 3.7.2. to disclose to the Insurer all and detailed information relevant to the circumstances of the event and to determine the amount of the Insurance benefit;

- 3.7.3. to inform the Insurer about all the same insurance protection contracts concluded with other insurance companies, where the interests of the Insured are insured, and the conditions thereof;
- 3.7.4. to give the Insurer, the Partner or the Insurer's authorised representative the opportunity to freely and without hindrance to determine the circumstances of the event and the extent of the damage;
- 3.7.5. to constantly cooperate with the Insurer during the adjustment of the Insurable Event and follow all instructions given by the Insurer.

3.8. The obligations of the Insurer shall be as follows:

- 3.8.1. to acquaint the Policyholder with the Rules and the insurance coverage conditions of the concluded Insurance Contract;
- 3.8.2. not to disclose information about the Policyholder, the Insured, the Beneficiary of the Insurance Benefit, without obtaining their consent;
- 3.8.3. after receiving the Insurer's and/or the Policyholder's notification of the event, to investigate its circumstances, calculate and pay out the Insurance Benefit in due time and, in cases established by legal acts, to inform the Policyholder, the Insured, the Beneficiary of the Insurance Benefit about the progress of the event regulation.

3.9. The rights and obligations of the Insurer arising from the Insurance Contract may be transferred in accordance with the Republic of Lithuania Law on Insurance and other legal acts:

- 3.9.1. When the Insurer transfers rights and obligations, the terms of the Insurance Contract may be amended if the Insurer notifies the Policyholder thereof in advance in writing, and the Policyholder does not object to the changes to the terms and conditions of the Insurance Contract within 60 calendar days of the notification being sent;
- 3.9.2. If the Policyholder does not agree with the intention of the Insurer to transfer the rights and obligations under the Insurance Contract and submits a request to terminate the Insurance Contract, the Insurer must return the insurance premium paid to the Policyholder for the remaining term of the Insurance Contract, without deducting the fees provided for in the Rules;
- 3.9.3. If the Policyholder does not submit a written request to terminate the Insurance Contract within the terms set in the Rules, it shall be considered that the Policyholder agrees to the transfer of rights and obligations arising from the Insurance Contract.

- 3.10.** The Policyholder shall have no right to transfer its rights and obligations under the Insurance Contract without the Insurer's written consent.

4. PAYMENT PROCEDURE OF THE INSURANCE BENEFIT

- 4.1.** The Insurance Benefit shall be paid to the Beneficiary of the Insurance Benefit:

4.1.1. To the Insured, when it paid for the services provided/purchased goods at its own expense, or upon the occurrence of an Insurable Event under the "Critical Illnesses" insurance option of the insurance programme, when a one-time Insurance Benefit is paid, or

4.1.2. To the Partner, when services were provided to the Insured/goods were delivered to the Partner and the Insured did not pay for such services/goods by itself or paid only the Insurer's Non-Reimbursable Part.

- 4.2.** When the Insurance Benefit is paid to the Insured:

4.2.1. the Insured must report the event in writing no later than within 30 calendar days from the date of the event;

4.2.2. the Insured must submit the following with the request for payment of the Insurance Benefit:

4.2.2.1. **Documents confirming the payment** of services/goods: cashier's check or payment order or cash income receipt or cash acceptance receipt;

4.2.2.2. **An invoice** for the purchase of services/goods on behalf of the Insured.

These documents must contain the details of the service/goods supplier, data on the payer and recipient of the service/goods, and a detailed description of the service or good provided (name, quantity, price, date).

4.2.2.3. According to the terms of insurance programs of the Rules, the relevant **medical documents**:

4.2.2.3.1. **A medical statement** containing information about the health disorder (course of the health disorder, examination data, diagnosis and recommended treatment);

4.2.2.3.2. A document confirming the referral, prescription or **other doctor's appointment** with the purpose of the appointment, diagnosis, disease code.

These documents must include the details of the medical institution that issued the medical statement or appointment, the date, and the documents must be signed and certified with

the personal stamp of the doctor who issued them.

4.2.2.4. A document confirming the service/goods supplier's licence and/or the right to carry out activities (e.g. individual activity certificate, business certificate) valid on the day of the Insurable Event;

4.2.2.5. The Insurer shall have the right to request additional documents justifying the fact of the Insurable Event and the amount of the payment;

4.2.2.6. The Insurer shall have the right not to pay the insurance benefit if the submitted documents do not meet the specified requirements.

- 4.3.** The Insurance Benefit shall be paid only to the bank account specified by the Beneficiary of the Insurance Benefit.

- 4.4.** The Insurer shall have the right to postpone the payment of the Insurance Benefit:

4.4.1. until the Beneficiary of the Insurance Benefit documents the fact of the Insurable Event and the amount of expenses;

4.4.2. if there is an ongoing pre-trial investigation or a court proceeding, in which a ruling, decision or sentence has been adopted that may affect the recognition of the event as insurable or uninsurable – until such a ruling, decision or sentence is adopted and becomes effective;

4.4.3. in other cases provided for in legal acts.

- 4.5.** The Insurance Benefit must be paid no later than within 30 calendar days from the day when the Insurer receives all the information necessary to determine the fact of the Insurable Event and the amount of the Insurance Benefit;

- 4.6.** If, after the payment of the Insurance Benefit, it becomes clear that according to the Insurance Contract, it should not have been paid to the Beneficiary of the Insurance Benefit or should have been less, at the written request of the Insurer within 30 calendar days, the Insured must return the Insurance Benefit or the overpaid amount to the Insurer and/or compensate the Insurer for the Insurance Benefit or the overpaid amount, which the Insurer paid to the Partner.

5. CALCULATION OF THE INSURANCE BENEFIT

- 5.1.** The amount of the Insurance Benefit shall be determined by the Insurer in accordance with the terms of the Insurance Contract, assessing the information provided by the Beneficiary of the Insurance Benefit and the Non-Reimbursable Part. In order to determine the fact of the Insurable Event and the amount of the Insurance Benefit, the Insurer may appoint a doctor or other expert(s).

- 5.2.** If the Insurer acknowledges the fact of the Insurable Event, but the Beneficiary of the Insur-

ance Benefit and the Insurer do not agree on the amount of the Insurance Benefit, at the request of the Beneficiary of the Insurance Benefit, the Insurer must pay an amount equal to the undisputed Insurance Benefit, if the exact determination of the Insurance Benefit amount lasts longer than 3 months.

- 5.3.** If the costs for the services/goods provided are partially compensated from the CHIF funds, the loss, based on which the Insurance Benefit is calculated, shall be considered to be the part (premium) not reimbursed by the CHIF funds. The Insurance Benefit shall be calculated by deducting the Non-Reimbursable Part from the premium.

6. REDUCTION OF THE INSURANCE BENEFIT OR REFUSAL TO PAY THE INSURANCE BENEFIT

- 6.1.** The Insurer, taking into account the fault of the Policyholder and/or the Insured, the severity of the violation of the terms and conditions of the Insurance Contract, its causal relationship with the Insurable Event, the amount of damage caused by the violation, shall have the right to refuse to pay the Insurance Benefit or reduce it if the Policyholder, the Insured or the Beneficiary of the Insurance Benefit:

- 6.1.1. provided the Insurer with false or incompletely known information about the circumstances that may affect the Insurer's assessment of the insurance risk when concluding the Insurance Contract.
- 6.1.2. does not properly inform the Insurer about an Insurable Event or an event that may be recognised as Insurable;
- 6.1.3. does not comply with the Insurance Contract, the terms of the Rules or the Insurer's requirements;
- 6.1.4. provided the Insurer with incorrect or incomplete information about the Insurable Event. If, as a result of providing incorrect or incomplete information, the Insurer unjustifiably paid out the Insurance Benefit or incorrectly calculated the amount thereof, the Insurer shall have the right to demand the return of the already paid Insurance Benefit or a part thereof;

- 6.2.** The Insurer shall have the right to refuse to pay the Insurance Benefit or to reduce it if, in the opinion of competent doctors, diagnostic costs were not necessary in the case of specific complaints of the Insured, or were not intended to establish the established diagnosis, or the established diagnosis and other circumstances were not the basis for applying the prescribed treatment.

- 6.3.** The Insurance Benefit shall not be paid if data about the event or its consequences are falsified, the insurer is given untrue circumstances, or other means are sought to obtain or increase the Insurance Benefit illegally and/or dishonestly.

7. END OF THE INSURANCE CONTRACT

- 7.1.** The Insurance Contract shall end in the following cases:

- 7.1.1. Upon the performance of the Insurance Contract:

- 7.1.1.1. The Insurance Period specified in the Insurance Policy ends;
- 7.1.1.2. The Insurer pays the full amount of Insurance specified in the Insurance Contract.

- 7.1.2. Upon termination of the Insurance Contract:

- 7.1.2.1. At the Policyholder's initiative, after informing the Insurer in writing 15 calendar days in advance;
- 7.1.2.2. If the Policyholder does not agree with the Insurer's intention to transfer rights and obligations under the concluded Insurance Contract. In such a case, the Policyholder shall have the right to terminate the Insurance Contract within 1 month from the date of transfer of rights and obligations, by notifying the Insurer thereof in writing 15 calendar days in advance;
- 7.1.2.3. At the initiative of the Insurer, if the Policyholder does not pay the Insurance premium in due time;
- 7.1.2.4. By agreement of the Parties under the conditions stipulated therein.

- 7.1.3. Upon termination of the Policyholder, when there is no successor of its rights and obligations;

- 7.1.4. In all cases where the Force Majeure circumstances last longer than 2 months;

- 7.1.5. The Policyholder (and if it is a legal entity – also its participant or final beneficiary) are added to the list of persons subject to the sanctions of the Republic of Lithuania, the European Union, the United Nations, the United States of America, the United Kingdom or other international sanctions. If the Insured is/are included in this list, the Insurance Contract shall end only with respect to the Insured included;

- 7.1.6. In other cases provided for by legal acts.

- 7.2.** Calculation and refund of the insurance premium in the case of expiration of the Insurance Contract:

- 7.2.1. If the Insurance Contract expires before the deadline, the Insurer shall always be entitled to the insurance premium or a part thereof for the insurance coverage actually provided;

- 7.2.2. Upon termination of the Insurance Contract at the Policyholder's initiative, the part of the paid insurance premium proportional to the remaining (unused) period of validity of the insurance coverage shall be returned thereto, after deducting from it 30% (calculated from

the insurance premium of the Insurance Contract) of the costs of concluding and performing the Insurance Contract. If the Insurance Benefits and/or the amounts expected to be paid out exceed the insurance premium of the Insurance Contract, the insurance premium shall not be refunded (if the insurance premium is paid in instalments, upon separate agreement between the Parties, the Policyholder shall remain obligated to pay the unpaid parts of the insurance premium);

7.2.3. Upon termination of the Insurance Contract due to the fact that the Policyholder does not agree with the intention of the Insurer to transfer the rights and obligations under the concluded Insurance Contract, the part of the paid insurance premium proportional to the remaining (unused) period of insurance coverage shall be refunded thereto;

7.2.4. If the legal acts do not provide otherwise, in all other cases of expiration of the Insurance Contract provided for in this Section, the insurance premium (part thereof) shall not be refunded to the Policyholder.

8. OTHER PROVISIONS

8.1. The present Insurance Contract shall be governed by the law of the Republic of Lithuania.

8.2. Any dispute arising from the Insurance Contract shall be resolved by negotiation. If the Parties do not reach an agreement, the dispute may be resolved in the courts of the Republic of Lithuania or by applying to the entity of non-judicial resolution of consumer disputes, which is competent to resolve consumer disputes: Bank of Lithuania. More detailed information on the procedure for examining consumer complaints shall be published on the Insurer's website (www.compensa.lt).

8.3. The Parties to each other or the Insured to the Insurer shall provide the information that they must provide to each other prior to the conclusion of the Insurance Contract or during its performance or after its termination by registered mail and/or e-mail to the contact details specified in the Insurance Policy or through the Insurer's self-service. Insurance intermediaries shall not be authorised to receive notifications. The Party and/or the Insured shall be deemed to have received the notification:

8.3.1. when sent by e-mail or through the Insurer's self-service – on the next business day;

8.3.2. when sent by mail – within 5 calendar days from the date of dispatch.

8.4. The Parties shall be released from the performance of their obligations under the Insurance Contract if such non-performance is caused by force majeure.

8.4.1. Force majeure shall mean circumstances that the Party to the Insurance Contract

could not control and reasonably foresee at the time of concluding the Insurance Contract and could not prevent the occurrence of such circumstances or the consequences thereof.

8.4.2. Cases when there are no goods on the market necessary to perform the obligation, when any Party to the Insurance Contract does not have the necessary financial resources or when the counterparties of the debtor violate their obligations shall not be considered to be cases of Force Majeure.

8.4.3. If the Force Majeure is temporary, then the Party to the Insurance Contract shall be released from liability only for such a period as is reasonable, taking into account the influence of the Force Majeure on the performance of the Insurance Contract.

8.4.4. If a Party to the Insurance Contract cannot or will not be able to perform any of its obligations under the Insurance Contract due to Force Majeure, it must notify the other Party to the Insurance Contract in writing about the circumstances which prevent the performance of obligations, while indicating the obligations that it cannot or will not be able to perform, no later than 14 calendar days after the occurrence of Force Majeure.

8.4.5. These provisions shall not deprive the other Party of the Insurance Contract of the right to terminate the Contract or to suspend its performance, or to demand the payment of interest.

9. PROTECTION OF PERSONAL DATA

9.1. In order to conclude the Insurance Contract, the Policyholder must provide the Insurer with the requested personal data of the Policyholder, the Insured and/or the recipient of the Insurance Benefit. If such personal data are not provided, the Insurance Contract cannot be concluded.

9.2. Before concluding the Insurance Contract, when assessing the insurance risk, personal data may be collected not only from the Policyholder, but also from other persons, e.g. from public registers, state information systems, other state institutions or bodies, other insurance companies, or other natural persons or legal entities.

9.3. The Insurer shall process personal data for the purposes of conclusion and administration of non-life insurance contracts, assessment of insurance risk, submission of offers to conclude a non-life insurance contract and evidence for preservation of the insurance contract, investigation and administration of insurable events or events that may be recognised as insurable, profiling and automatic decision-making, accounting and administration of payment orders, recovery of paid amounts (recourse, subrogation). For the purposes of debt collection, fraud preven-

tion, registration and examination of complaints and claims, declaration, execution or defence of legal claims, implementation of international sanctions. The Insurer shall also process personal data by recording telephone conversations for evidence preservation and quality assurance purposes, and video surveillance to ensure the safety of employees, customers and property. When legal acts allow it, the Insurer shall also process personal data for direct marketing purposes.

9.4. The Insurer shall process personal data under one of the following conditions:

- 9.4.1. the data subject has given consent to process his/her personal data for one or more specific purposes;
- 9.4.2. processing data shall be necessary in order to perform the Insurance Contract to which the data subject is a party, or in order to take action at the request of the data subject before concluding the Insurance Contract;
- 9.4.3. it is necessary to process the data in order to perform a legal obligation arising from the Insurer;
- 9.4.4. processing data is necessary in order to protect the vital interests of the data subject or another natural person;
- 9.4.5. it is necessary to process data in order to perform a task carried out in the public interest or in the exercise of official powers assigned to the Insurer;
- 9.4.6. processing data is necessary for the pursuit of the legitimate interests of the Insurer or a third party, except in cases where such interests of the data subject or the material rights and freedoms necessary to ensure the protection of personal data prevail over them, especially when the data subject is a child.

9.5. When concluding an Insurance Contract where the insured risk is related to the Insured's health, the Insurer shall need the Insured's health data.

9.6. Therefore, when concluding the Insurance Contract, the Insurer shall have the right to request data that affect the Insurer's decision to conclude the Insurance Contract or the decision concerning certain conditions of the Insurance Contract. Therefore, when concluding an insurance contract, the Insurer shall have the right to request data that affect the Insurer's decision to conclude an insurance contract or the decision concerning certain conditions of the insurance contract.

9.7. During the conclusion of the contract, the data subject, by giving consent to the processing of his/her health data, shall agree that:

- 9.7.1. Health data would be processed for the purposes of insurance risk assessment, conclusion and performance of insurance contracts, and investigation and administration of insurable events or events that may be recognised as insurable;

- 9.7.2. The Insurer would disclose the data of the Insured, including health data, to experts and other persons with special knowledge when it is necessary to determine the fact, consequences and amount of the insurance benefit of the insurable event;

- 9.7.3. The Insurer would receive the Insured data, including health data, from all healthcare professionals and healthcare facilities.

9.8. In the absence of the consent of the data subject (the Policyholder, the Insured, the Beneficiary of the Insurance Benefit) to process his/her health data, the Insurer shall not be able to ensure the provision of the services provided for in the Insurance Contract in relation to the relevant subject.

9.9. In the case of health insurance, the Insurer shall have the right to ask the data subject questions if they are related to diseases treated by the Policyholder or the Insured, health disorders or complaints, as well as habits (e.g. alcohol consumption, smoking). Also, the Insurer may require the Policyholder or the Insured to undergo a health examination at a Health Care Institution only if this is necessary for the insurance risk assessment.

9.10. Upon the occurrence of an insurable event, the Policyholder, the Insured, the Beneficiary of the Insurance Benefit must provide the Insurer with all available documents and information about the circumstances and consequences of the Insurable Event, necessary for determining the amount of the Insurance Benefit, including personal data of special categories (data on health status, injuries, causes of death, etc.). The Insurer shall have the right to process such data in order to find out whether the Insurable Event actually occurred, whether the Insurable Event occurred during the insurance period, and what the amount of remuneration is.

9.11. The Insurer may collect and further process health data not only from the Policyholder, the Insured, the Beneficiary of the Insurance Benefit, but also from the recipients of data, such as Health Care Institutions, the State Health Insurance Funds under the Ministry of Health or other state or municipal institutions (e.g. police institution), as well as data processed in registers, information systems or other data files about the Insured's state of health, medical services provided, illnesses diagnosed, injuries suffered, level of work capacity and causes of death.

9.12. The Insurer shall not have the right to disclose information obtained in the course of insurance activities about the Policyholder, the Insured or the Beneficiary of the Insurance Benefit, their state of health and other confidential information stipulated in the Insurance Contract, with the exception of exceptions established by law.

9.13. Automated decision-making, including profiling, may be used to assess insurance risk and calculate insurance premiums. Automatic deci-

sion-making shall be carried out by assessing the information provided by the Policyholder, information from other sources, and also taking into account the Insurer's experience of the probability of Insurable Events and potential damage. After assessing such information and using statistical risk models, the insurance risk shall be assessed accordingly and the insurance premium shall be calculated.

- 9.14.** Profiling shall be used for direct marketing purposes in order to offer the data subject who has given consent for direct marketing specific services and products that best meet the needs of the data subject, to determine service prices and in other areas where it is based on the legitimate interests of the Insurer. The Insurer shall make it possible for the data subject to choose whether he/she wishes to receive direct marketing messages from the Insurer. The data subject shall have the right to object to profiling for direct marketing purposes.
- 9.15.** Personal data shall be stored as long as it is necessary for the purposes for which it was collected, but not less than the mandatory term of storage of relevant data (documents) established by legal acts.
- 9.16.** Personal data processed by the Insurer may be disclosed to insurance intermediaries (intermediaries when concluding an insurance contract), other partners of the Insurer who participate in the performance of the insurance contract (e.g. experts, claims administration companies), banks, leasing companies (if this is necessary for the performance of the Insurance Contract or if they indicated in the Insurance Contract as the recipients of the Insurance Benefit), the Insured and the Beneficiaries of the Insurance Benefit, other insurance companies, reinsurance companies, supervisory and other state institutions (e.g. the tax inspectorate, the Board of the State Social Insurance Fund, the Bank of Lithuania), attorneys, courts, bailiffs, pre-trial investigation institutions, prosecutor's office, Financial Crimes Investigation Service, bankruptcy administrators, notaries, lawyers, auditors, medical institutions, other data processors who provide certain services (perform work) to the Insurer (e.g. IT services, archiving services, postal services, debts collection services, other companies).
- 9.17.** Personal data may be sent outside the European Union (EU) and/or the European Economic Area (EEA) if the damage occurred outside the EU and EEA. In such cases, only the minimum amount of data necessary to perform the Insurance Contract shall be sent.
- 9.18.** If the Policyholder does not pay the insurance premiums in due time, the Insurer shall have the right to transfer information about the Policyholder's non-performance of property and financial obligations to the data controllers managing joint files of debtors in accordance with the procedure established by law.

9.19. Data subjects may access their personal data by contacting the Insurer. They shall also have the right to request rectification or erasure or restriction of data processing, and the right to object to the data being processed and the right to withdraw their consent to data processing, to demand human intervention in automated decision-making, to express their point of view and challenge the decision, as well as the right to data portability.

9.20. More information on the implementation of the rights of data subjects and the processing of personal data by the Insurer shall be published in the Insurer's Privacy Policy, which can be found on the Insurer's website at <https://www.compensa.lt/privatumo-politika-privatiems/>.

9.21. In the event of personal data protection violations, data subjects shall have the right to contact the Insurer's Data Protection Officer by e-mail at dpo@compensa.lt, as well as file a complaint with the State Data Protection Inspectorate or the court.

9.22. If the Policyholder enters into an Insurance Contract for the benefit of other natural persons, the Policyholder must without undue delay inform such persons about the conclusion of the Insurance Contract and its terms and conditions, as well as about the fact that the Insurer shall process their personal data, provide them with information about the Insurer and his/her contact details, as well as inform them with the Insurance Contract, Rules. In such a case, the Insurer shall have the right to assume that the data subject has information about data processing.

10. INTERNATIONAL SANCTIONS CLAUSE

10.1. In order to ensure the proper implementation of international financial sanctions and restrictive measures, as provided for in the legal acts of the Republic of Lithuania regulating the implementation of international sanctions, the Insurer shall apply the following sanctions Clause in these Rules and the Insurance Contract, which prevents any claims for compensation of damages, when sanctions prevent obtaining Insurance Benefits:

- 10.1.1.** No (re)insurer shall be deemed to provide protection and no (re)insurer shall be liable for any loss or payment hereunder to the extent that the provision of such protection, the payment of such claim or the granting of such benefit to the (re) insurer would result in any sanctions, prohibitions or restrictions under United Nations resolutions or trade or economic sanctions, the laws of the European Union, Lithuania, the United Kingdom or the United States of America or other legislation (provided that this does not contravene any regulations or specific national laws applicable to the undersigned (re)insurer).

LIST OF CRITICAL ILLNESSES

1. **Myocardial infarction** is the irreversible damage and necrosis of myocardial cells caused by acute myocardial ischemia confirmed by a competent physician. The Insurance Benefit shall be paid only in case of type I myocardial infarction and if the diagnosis of myocardial infarction is based on all the criteria listed below:
 - 1.1. Clinical signs of myocardial infarction (pain);
 - 1.2. New electrocardiographic changes characteristic of myocardial infarction – ST elevation;
 - 1.3. The concentration of a marker of myocardial damage (cardio specific high-sensitivity troponin I or T or CK-MB mass) in blood serum increases to a concentration characteristic of myocardial infarction.
2. **A stroke** is a permanent and irreversible neurological deficit that has persisted for at least 3 months after an acute ischemic or haemorrhagic cerebral blood flow disorder confirmed by a neurologist, based on imaging studies showing newly occurring changes characteristic of a stroke. The Insurance Benefit shall not be paid:
 - 2.1. when the stroke occurred as a result of trauma and/or direct and/or postoperative indirect damage to the brain or blood vessels during surgery;
 - 2.2. when incidental findings are identified without clearly associated clinical symptoms of stroke ("silent stroke").
3. **Oncological disease** is a malignant oncological disease, confirmed by an oncologist with the indicated stage of the disease, based on histological and imaging studies. The Insurance Benefit shall not be paid if the following has been established:
 - 3.1. any precancerous condition;
 - 3.2. cervical dysplasia, cervical intraepithelial neoplasia (any stage of CIN);
 - 3.3. any non-invasive tumour (carcinoma in situ or according to the TNM classification – Tis);
 - 3.4. stage I of prostate cancer;
 - 3.5. stage I of bladder cancer;
 - 3.6. stage I of thyroid cancer;
 - 3.7. stage I of lymphogranulomatosis;
 - 3.8. stage I breast cancer (except when systemic treatment is recommended by the decision of the council of doctors);
 - 3.9. chronic lymphocytic leukaemia;
 - 3.10. skin cancer, except for malignant invasive melanoma from level III according to the Clark classification or melanoma of any stage with metastases;
 - 3.11. lymphomas of the skin, unless the disease requires chemotherapy or radiation therapy;
 - 3.12. tumours of unclear or unknown course. Stages are determined based on the latest version of the TNM classification.
4. **Renal failure** is the complete chronic and irreversible dysfunction of both kidneys, confirmed by a nephrologist and the need for treatment of this disorder with permanent dialysis or kidney(s) transplantation indicated by his/her decision.
5. **Multiple sclerosis** – in case of neurological deficit, the final diagnosis of multiple sclerosis based on the results of the magnetic resonance examination due to at least 2 (two) foci and the relevant McDonald criteria and confirmed by a neurologist.
6. **Loss of vision (blindness)** is the complete and irreversible loss of vision in both eyes due to injury and/or disease that cannot be corrected by any treatment and that persists 6 months after diagnosis by an ophthalmologist.



Deividas Raipa
Chairman of the Board



Felix Nagode
Member of the Board