HEALTH INSURANCE TERMS AND CONDITIONS

NO 010

COMPENSA
VIENNA INSURANCE GROUP

HEALTH INSURANCE TERMS AND CONDITIONS
NO 010

CONTENT

Approved by Order No V-24/24 of 12 November 2024 of the CEO of Compensa Life Vienna Insurance Group SE Lithuanian Branch

HEALTH INSURANCE TERMS AND CONDITIONS NO 010

Effective from December 1st of 2024

TERMS

1. TERMS

1.1. Capitalized terms used in the contract and in the notices of the parties or other related documents shall have the meanings defined below and shall be construed accordingly, unless otherwise explicitly required by the context or unless otherwise specified. If there are inconsistencies and/or contradictions between the definitions of terms in these Terms and Conditions and those provided for by applicable legal acts, the definition of terms and their scope provided for in these Terms and Conditions shall prevail:

1.1.1. Outpatient Surgery Service – the scheduled curative Health Care service, which may involve local or regional anesthesia, performed by the doctor performing the surgery or procedure and followed by post-operative (post-procedural) care of the Insured Person. The service must comply with the list of outpatient surgery services approved by Order No V-754 of the Minister of Health of the Republic of Lithuania of 25 July 2013, as amended and supplemented, and in force at the time of provision of the service, except for the cases provided for in these Terms and Conditions, their annexes and/or special conditions, as well as in any other documents constituting a part of the contract.

1.1.2. Outpatient Aesthetic Surgery Service – the scheduled personal Health Care service provided by a doctor of plastic and reconstructive surgery or a doctor of another professional qualification according to the competence specified in the relevant Lithuanian medical standard, which is not directly intended to improve the state of health, involving the administration of local or regional anesthesia for a patient by the doctor and the performance of a surgery or interventional procedure to alter or improve the patient's appearance for aesthetic purposes, followed by post-operative (post-procedural) care and short-term follow-up of the patient. The extent of the service is defined by Order No V-11 of the Minister of Health of the Republic of Lithuania of 6 January 2020 and its subsequent amendments and supplements.

1.1.3. Insured Person – the natural person specified in the contract to whom the Insurer undertakes to pay the Insurance Indemnity upon the occurrence of an Insured Event.

1.1.4. Day Surgery Service – the scheduled curative and/or diagnostic interventional procedure provided to the Insured Person on the day of his/her visit at a Health Care Institution and when, after the procedure has been carried out, the Insured Person's vital functions are stabilized, and he/she is discharged from the Health Care Institution on the same day. The service must comply with the list 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 subsequent amendments and supplements, in force at the time of provision of the service, except for the cases provided for in these Terms and Conditions, the Annexes thereto and/or the Special Conditions and other documents that constitute an integral part of the Contract.

1.1.5. Day Aesthetic Surgery Service – the scheduled personal Health Care service provided by a doctor of plastic and reconstructive surgery or a doctor of another professional qualification in accordance with the competence specified in the relevant Lithuanian medical standard, which is not directly intended to improve the state of health, involving a surgery or interventional procedure to alter or improve the aesthetic appearance of the person under local, regional or general anesthesia, followed by post-operative (post-procedural) care on the day of the surgery or interventional procedure, or up to 24 hours if there are indications. The service must comply with the List of Daily Aesthetic Surgery Services approved by Order No V-12 of the Minister of Health of the Republic of Lithuania of 6 January 2020 and its subsequent amendments and supplements, in force at the time of its provision.

1.1.6. Day Inpatient Service – the scheduled diagnostic and/or curative Health Care service that may include ensuring the provision of care to the Insured Person. The service must comply with the List of Day Inpatient Services approved by Order No V-660 of the Minister of Health of the Republic of Lithuania of 6 June 2014 as amended and supplemented. The duration of the service may not exceed 8 hours.

1.1.7. Policyholder – a natural person, a legal person or a quasi-legal person who enters into, or has expressed the need to enter into, a contract with the Insurer for his/her own benefit or for the benefit of another person.

1.1.8. Insurer – Compensa Life Vienna Insurance Group SE operating through Compensa Life Vienna Insurance Group SE Lithuanian Branch, or an acquirer or transferee of its rights or obligations (if applicable).

1.1.9. Implant Reimbursed by the Insurer – a medical device that is introduced / inserted / implanted into the human body to replace a non-functioning or weakly functioning organ or tissue, or to perform a missing function of the human body. These include heart valves, vascular stents and prostheses, metal screws, staples, osteosynthesis plates, screws, endobuttons, ocular lenses, electrostimulators, cochlear implants.

1.1.10. Medical Equipment Reimbursed by the Insurer – medical equipment and medical aids reimbursed by the Insurer; Orthopedic Devices; Disposable instruments and devices including implants reimbursed by the Insurer, used for Day Surgery Services, Day Inpatient Services, Outpatient Surgery Services, Inpatient Treatment Services.

1.1.11. Medical Aids Reimbursed by the Insurer – bandages, plasters, syringes, needles, insulin syringes, drip systems, urine collectors, bladder catheters, ostomy bags or stool collectors and components and care products thereof, incontinence nappies or pads, portable urinals for men and women, probes, hemostatic sponges.

1.1.12. Medically Justified Health Care Services Reimbursed by the Insurer – Health Care Services prescribed within the limits of competence of a general practitioner, medical doctor or a Specialist Doctor on the basis of the Insured Person's complaints, clinical symptoms, indications and/or objective medical reasons and which are necessary to establish/confirm a diagnosis and to cure the existing medical condition by applying a treatment.

1.1.13. Medical Device Reimbursed by the Insurer – glucose monitors and test strips for them, a blood clotting system condition testing device and diagnostic strips for it, hearing aids, parenteral nutrition systems, insulin pumps and parts thereof, inhalers.

1.1.14. Wellness Services Reimbursed by the Insurer – reimbursable wellness / health promotion services and services provided to the Insured Person, as specified in the Program of Wellness Services and/or in the Contract, with the aim of improving and strengthening the Insured Person's physical and psychological condition, preventing diseases, strengthening immunity of the Insured Person's organism, and increasing resistance to diseases and/or Injuries.

1.1.15. Insurance Cover (Insurance Coverage) – the Insurer's obligation to pay the Insurance Indemnity under the terms, conditions and procedure set out in the Contract upon the occurrence of an Insured Event.

1.1.16. Insurance Indemnity – the amount of money payable by the Insurer to the beneficiary under the Contract upon the occurrence of an Insured Event.

1.1.17. Beneficiary of the Insurance Indemnity – the Insured or the Partner, or their successors, assigns and heirs, who become entitled to the Insurance Indemnity or its part according to the procedure, Terms and Conditions set out in the Contract and/or in the applicable law.

1.1.18. Insurance Premium – the amount of money payable by the Policyholder to the Insurer for the provision of the Insurance Cover and related services under the Contract, the amount and terms of payment of which shall be specified in the Insurance Certificate (Policy).

1.1.19. Insurance Period – the period of time defined by the specific timeframe and indicated in the Contract during which the Insurance Cover is valid.

1.1.20. Insurance Certificate (Policy) – a document confirming the conclusion of the Contract and its Terms and Conditions, issued according to the procedure and time limits set by the Insurer when concluding the Contract and/or amending its Terms and Conditions. Upon the issue of a new or subsequent Insurance Certificate (Policy), the previously issued Insurance Certificates (Policies) for the same Contract shall become invalid.

1.1.21. Insurance Risk – the probability of occurrence of an Insured Event and/or the amount of the Insured Person's potential loss or damage resulting from that event.

1.1.22. Sum Insured – the amount of money specified in the Contract or calculated in accordance with the procedure prescribed in the Contract, which may not be exceeded by the Insurance Indemnity, except in the cases provided for in the Contract.

1.1.23. Insurance Terms and Conditions – these Health Insurance Terms and Conditionson the basis of which all contracts for a health insurance product distributed by the Insurer are concluded.

1.1.24. Insured Event – an event provided for in the Contract upon the occurrence of which the Insurer undertakes to pay the Insurance Indemnity according to the procedure and Terms and Conditions set out in the Contract. Only an event occurring after the entry into force of the Contract and during the period of validity of the Insurance Cover, which is not a Non-Insured Event and is not classified as non-reimbursable expenses under the Insurance Terms and Conditions, the Contract and the Special Conditions may be recognized as the Insured Event. An Insured Event must be substantiated by proper evidence and documents of a form and content acceptable to the Insurer.

1.1.25. Date of Insured Event – one of the dates set out below on the basis of which it is determined whether the Insured Event occurred during the validity of the Insurance Coverage:

a) in the case of purchase of equipment or goods - the date of actual payment for the goods or equipment purchased. Where payment for the purchase of goods or equipment is made in instalments, by making an advance payment and then paying the balance of the price of the goods or equipment, such date shall be deemed to be the date of the first payment;

b) in the case of the provision of services – the date on which the Insured Person actually received the service;

c) in the case of a critical illness – the date on which the critical illness was diagnosed.

1.1.26. E-System – an electronic system (E-health) or a program (mobile app) the Terms and Conditions of use of which are determined by the Insurer. It is intended for the exchange of documents, information and/or communications (including requests or other expressions of intent) between the Insurer and the Insured Person.

1.1.27. Specialist Doctor – a doctor who has acquired the professional qualification of a specialist doctor in accordance with the procedure established by legal acts of the Republic of Lithuania and who holds a valid medical practice license issued in accordance with the procedure established by legal acts of the Republic of Lithuania for engaging in the medical practice according to the professional qualification of a specialist doctor. A specialist doctor must provide services according to a medical standard approved by order of the Minister of Health and within the limits of his/her competence.

1.1.28. Long-term Care and Supportive Treatment – palliative care, maintenance treatment of a patient, nursing / care at home, in a Health Care Institution or other social support institution for people with serious chronic diseases where active treatment is not required.

1.1.29. Deductible – the proportion of the loss (expenses) by which the Insurance Indemnity is reduced in the case of each Insured Event. The cost of the deductible shall be borne by the Insured.

1.1.30. War and State of Emergency – war or acts of any form that are close to war in their nature, irrespective of whether or not war has been formally declared, including an invasion or similar military action, the establishment of military rule, insurrection, mass disturbances, civil commotion, the use of military weapons, occupation, revolution, civil wars, rebellions, coups d'état, siege, declaration of martial law or state of emergency, or any other events or circumstances threatening the constitutional system or social peace.

1.1.31. Customer – a natural or legal person or their representative, including the Policyholder, the Insured Person, who has used the services of the Insurer or has expressed a relevant interest or intention.

1.1.32. Card – a physical or electronic health insurance card issued by the Insurer and addressed personally to the Insured Person, which provides the Insurance Cover according to the procedure set out in the Terms and Conditions and the Contract.

1.1.33. Critical Illness – one or more of the diseases and/or surgeries specified in Section 14 of Annex 1 to the Insurance Terms and Conditions, which meet the criteria for the diagnosis of such illnesses or surgeries defined therein.

1.1.34. Critical Illness Diagnosis Date – one of the dates specified below:

a) in the case of Critical Illnesses referred to in subitems 14.4.1.4.4 to 12.4.1.6 and 14.4.1.13 of Section 14 (if the respective surgery is performed) of Annex 1 to the Insurance Terms and Conditions- the date on which the Insured Person undergoes the surgery;

b) in the case of the Critical Illness referred to in item 14.4.1.7 of Section 14 of Annex 1 to the Insurance Terms and Conditions- the date on which the Insured Person is included on the official waiting list for surgery, or the date on which the Insured Person undergoes an organ transplantation, if the Insured Person has not been included on the list of persons waiting for organ transplantation;

c) in the case of the Critical Illness referred to in subitem 14.4.1.1.1 of Section 14 of Annex 1 to the Insurance Terms and Conditions- the date of sampling for the histological test on the basis of which the Specialist Doctor diagnosed the Critical Illness;

d) in other cases of Critical Illnesses provided for in Annex 1 to the Insurance Terms and Conditions– the date on which the Insured Person is diagnosed with the Critical Illness.

1.1.35. Chronic Illness Monitoring – consultations and tests prescribed by a general practitioner, a medical doctor or a Specialist Doctor during the monitoring of the identified Chronic Illness needed to be carried out periodically at the fixed time interval (prescribed by the general practitioner or the Specialist Doctor) in order to regularly monitor the state of health of the Insured Person suffering from a certain Chronic Illness or taking certain Medicines.

1.1.36. Food Supplement – a product intended to supplement the normal human diet, manufactured using vitamins and minerals having a nutritional or physiological effect. The product must be labelled as a food supplement and be included in the list of food supplements notified by the State Food and Veterinary Service.

1.1.37. Beneficiary – a natural or legal person indicated in the Contract or designated by the Policyholder in the Contract and appointed by the Insured Person, who becomes eligible for an Insurance Indemnity.

1.1.38. Non-insured Event – an event or circumstances referred to in these Terms and Conditionsand/or in the Contract and the Special Conditions, in the case of which the Insurer does not pay the Insurance Indemnity.

1.1.39. Non-reimbursable Expenses – expenses incurred by the Insured Person as specified in the Health Insurance Program which are not reimbursed by the Insurer under the Contract, even if they are incurred as a result of Health Impairments.

1.1.40. Remote Consultations – Health Care services provided by means of communication without physical presence of the Insured Person. The service provider must operate in the Republic of Lithuania according to the procedure established by the applicable law.

1.1.41. Orthopedic Devices – splints and prosthetic systems, sticks, crutches, inserts, compression devices, post-operative boots.

1.1.42. Complementary and Alternative Health Care – activities licensed by the State which include health recreation, natural and traditional medicine and are carried out using data from research-based medicine, biological, psychological and social tools and/or empirical knowledge. The scope of services is specified in the Law of the Republic of Lithuania on Complementary and Alternative Health Care (No XIII-2771 14/01/2020), as amended and supplemented.

1.1.43. Offer – the Terms and Conditions under which the Insurer agrees and offers the Policyholder to conclude the Contract.

1.1.44. Partner – an entity (legal person) with whom the Insurer has concluded a relevant agreement on servicing of the Insurer's Customers and other conditions of cooperation in providing health insurance services. The Partner shall not be an agent of the Insurer. The List of Partners is posted on the Insurer's website.

1.1.45. Permanent Neurological Deficit – functional disorders of the nervous system characterized by several of the following symptoms determined by a neurologist: sensory and motor disorders such as numbness, hyperesthesia (hypersensitivity), paralysis, local weakness, speech impairment (dysarthria), inability to speak (aphasia), swallowing disorders (dysphagia), walking impairment, coordination disorder, tremors, seizures, lethargy, dementia, visual impairment, delusions or coma.

1.1.46. Application – an application for the conclusion of the Contract and/or for the amendment to its - Terms and Conditions, duly completed and signed by the Policyholder according to the form and content specified by the Insurer and the documents accompanying it, or an application for payment duly completed and signed by the Insured Person according to the form and content specified by the Insurer and the documents accompanying it.

1.1.47. CHIF – the Compulsory Health Insurance Fund.

1.1.48. Radiation – radioactive emanation, contamination or poisoning (intoxication), or exposure to nuclear reactions or nuclear energy, including as a result of the unlawful use of nuclear weapons.

1.1.49. Rehabilitation Therapy – complex, continuous application of Rehabilitation Therapy methods aimed to restore impaired biosocial functions of a patient, or, in the case of irreversible changes in the body, to compensate for them, or to maintain the level of the Insured Person's biosocial functional capacity caused by the Insured Person's health impairment (acute condition, exacerbation of illness, or Injury) after ineffective or insufficiently effective medical, surgery, immobilization treatment.

1.1.50. Specialized Medical Supplies Store – a specialized (including the e-commerce platform of these institutions) store / showroom selling only orthopedic, nursing, medical goods and supplies.

1.1.51. Contract – a health insurance contract concluded between the Insurer and the Insured Person whereby the Insurer undertakes to pay the Insurance Indemnity upon occurrence of an Insured Event for the consideration and according to the procedure set out in the Contract, and the Insured Person undertakes to pay the Insurance Premiums in due time and to fulfil other obligations arising from the Contract. The Contract shall include the following integral parts: the Insurance Certificate (Policy), the Insurance Terms and Conditions, the Offer, the Terms and Conditions or requirements set out in any other documents relating to the Insurance Contract or separately concluded between the parties (e.g., the Special Conditions), as well as all annexes, amendments and supplements thereto, including the new version.

1.1.52. Health Insurance Program – the insurance program(s) specified in Annex 1 to these Insurance Terms and Conditions specifying the scope of the Insurance Risk assumed by the Insurer and the nature of the Insurance Cover.

1.1.53. Health Care Institution – an institution or company authorized by legal acts to provide Health Care services.

1.1.54. Health Care Service – a service, device and/or product specified in the Contract and provided to the Insured Person at a Health Care Institution (e.g., Medicines, Medical Equipment), aimed at diagnosing, monitoring, treating diseases and Health Impairments, , preventing, helping to restore and improve health, and ensuring the services and material provision of a person necessary to restore or improve health.

1.1.55. Health Impairment – a change in the Insured Person's health and/or physiological condition (in the case of Acute Illnesses, exacerbation of a Chronic Illness and/or injury) that requires medically justified treatment and/or diagnostics.

1.1.56. Health Care Professional – a health care professional holding a valid license for a specific activity in the Republic of Lithuania issued according to the procedure laid down by the applicable requirements.

1.1.57. Wellness and/or Rehabilitation Equipment – equipment for performing rehabilitation, physiotherapy, workout exercises and procedures, including massage tables and/or chairs, trainers, massagers, exercise mats and balls, weights, orthopedic/ergonomic pillows and mattresses, rubbers, electrodes, kinesiotapes, etc.

1.1.58. Medicines – medicinal products registered by the competent authorities in the Republic of Lithuania or in the European Community, having an ATC (anatomical-therapeutic-chemical) code and purchased in Pharmacies.

1.1.59. Pharmacy – a legal entity or its subdivision licensed to carry out pharmaceutical activities in the Republic of Lithuania, including remote sales of medicinal products.

1.1.60. International Sanction – an economic or financial sanction, embargo or any other similar sanction, prohibition or restrictive measure imposed by a decision of the United Nations, the European Union, the Republic of Lithuania, the United States of America (including sanctions administered or enforced by the Office of Foreign Assets Control of the United States Department of the Treasury), the United Kingdom or legal acts of any other country.

1.1.61. Injury – an accident occurring against the Insured Person's will due to sudden, unintentional, unexpected external forces, resulting in a bodily injury and/or impairment of functions of organs.

1.2. References in the Contract to any document shall include references to any amendment, supplement or recast thereof.

1.3. Headings and subheadings used in the Contract are provided for convenience only and shall not affect the interpretation of the Contract.

GENERAL PROVISIONS

2. GENERAL PROVISIONS

2.1. Terms and Conditions of the Contract

2.1.1. The Insurance Terms and Conditions set out the General Terms and Conditions of the Contract. They shall apply to all Contracts which enter into force from the date of entry into force of the Insurance Terms and Conditions, unless otherwise provided in the Contract. Detailed Terms and Conditions of the Contract as agreed between the parties, including but not limited to the Insurance Cover, additional or individually determined conditions shall be set out and confirmed in the Insurance Certificate (Policy).

2.1.2. The General Terms and Conditions of Insurance of the Insurer shall not apply to these Insurance Terms and Conditions.

3. IDENTIFICATION OF THE CUSTOMER

3.1. The Customer and/or his/her representative must provide the data and documents required by the Insurer of the form and content acceptable to the latter, confirming the registration data of the Policyholder, the right to enter into relevant transactions with the Insurer, the powers and identity of the representative of a natural or legal person; other documents or data relating to the conclusion, performance, termination of the Contract and the implementation of the requirements of legal acts on the prevention of money laundering and terrorist financing or tax regulations, or the implementation of any other requirements provided for by the applicable law; the identity of the Insured Person, a natural person (where required by the Insurer in the cases specified by the Insurer).

3.2. The Insurer shall have the right to refuse accepting a document of representation which does not clearly and unambiguously express the right of representation or the powers concerning the conclusion, execution of the relevant transactions, or performance of acts, etc.

3.3. The Customer undertakes to inform the Insurer within a reasonable period of time of any change, invalidity of any identification and/or representation documents, data or their expiry on other grounds. Otherwise, the Insurer shall be entitled to rely on the documents and data most recently submitted to it for that purpose.

3.4. The Insurer shall have the right to establish identification procedures for the delivery and receipt of notices, depending on the nature of the notices and the requirements for the signing or endorsement of certain documents. If there are any doubts, the Customer must confirm to the Insurer's satisfaction the Customer's intent, identity, the date of the document and/or the authenticity of the signature in a manner requested by the Insurer. The Insurer shall have the right to refrain from taking any action or to suspend the performance of its obligations under the Contract until such time as the doubts referred to above have been removed and the required confirmations obtained.

3.5. In the cases stipulated by the Insurer and/or by the Contract, the Customer may be identified via secure electronic channels acceptable to the Insurer: via the E-health electronic system, a mobile health insurance application or other means acceptable to the Insurer.

CONTRACT CONCLUSION AND EXPIRY

4. CONCLUSION, ENTRY INTO FORCE AND EXPIRY OF THE INSURANCE CONTRACT

4.1. Having assessed the information provided by the Customer at the request of the Policyholder, the Insurer shall carry out an assessment of the Insurance Risk and submit an Offer setting out the Terms and Conditions under which it agrees to assume the Insurance Risk and to conclude the Contract. The Insurer, having assessed all the information received, may propose to the Policyholder to conclude the Contract on Terms and Conditions other than those requested by the Policyholder. The Insurer's Offer shall be valid for 30 (thirty) days from the date of its issue, unless otherwise stated in the Offer. The validity of the Offer may be revoked earlier upon receipt of additional information on changes in circumstances relevant to the Insured Risk.

4.2. The Contract shall be concluded by the Policyholder confirming (accepting) the Insurer's Offer to conclude the Contract on the Terms and Conditions specified therein. In any case, the Insured shall choose the preferred nature and extent of the Insurance Cover and the Insurance Risk from among the possible options of the Health Insurance Program and/or other Terms and Conditions agreed between the parties.

4.3. When concluding the Contract, the Policyholder (or the Insured Person if the Policyholder agrees and provides for such option) may choose the following Health Insurance Programs:

4.3.1. Outpatient Treatment and Diagnostics;

4.3.2. Inpatient Services;

4.3.3. Prenatal Care, Childbirth and Postnatal Care;

4.3.4. Dental Services;

4.3.5. Medicines and Medical Equipment;

4.3.6. Vitamins, Over-the-counter Medicines;

4.3.7. Optics;

4.3.8. Preventive care;

4.3.9. Rehabilitation Therapy;

4.3.10. Alternative Medicine;

4.3.11. Medical Services;

4.3.12. Wellness Services;

4.3.13. All services;

4.3.14. Critical Illnesses.

4.4. Before concluding the Contract and/or during the term of validity of the Contract, the Insurer shall have the right to request information and data that are relevant for the assessment of the Insurance Risk, the Policyholder's needs and possibilities to fulfil the obligations assumed under the Contract and/or required by the applicable law. The Customer must provide complete, correct and full information requested by the Insurer.

4.5. In assessing the Insurance Risk, the Insurer shall have the right to take into account the Insured Person's age, state of health and other circumstances relevant to the Insurance Risk.

4.6. The Contract shall be deemed to have been concluded when all Terms and Conditions thereof have been agreed and approved by the parties.

4.7. After the entry into force of the Contract, the Insurer shall issue Cards to the Insured Persons.

4.8. The Policyholder must inform the Insured Person of the conclusion, amendment and/or termination of the Contract and properly acquaint the Insured Person with its Terms and Conditions and ensure that the Insured Person complies with all the Terms and Conditions of the Contract and its requirements in a proper and timely manner, including the submission of any consents, confirmations, data or other information requested by the Insurer.

4.9. The Contract shall enter into force: (1) upon its signature or (2) upon acceptance of the Insurer's Offer in any other way: the acceptance of the Offer shall be deemed to be the action of the Policyholder when sending to the Insurer of the complete and accurate List of Insured Persons) and submission of any other necessary documents stipulated by the Insurer (in the cases where the payment of the Insurance Premium is deferred for the Insured Person); or (3) when the Policyholder pays and the Insurer receives and attributes to the relevant Contract the Insurance Premium specified in the Insurance Certificate within the time limit set by the Insurer (in cases where the Policyholder is required to pay the Insurance Premium or part thereof immediately), unless the Contract provides for a different effective date or procedure. If the Policyholder pays the first Insurance Premium (its part) this action shall be considered to be the signature of the Insurance Contract by the Policyholder upon mutual agreement between the Policyholder and the Insurer.

4.10. The Contract shall expire:

4.10.1. upon expiry of the Insurance Period specified in the Contract;

4.10.2. when all allocated Sums Insured are used up;

4.10.3. when the Policyholder ceases as a legal entity and there is no successor to its rights and obligations;

4.10.4. upon termination of the Contract in the cases and according to the procedure provided for in the Contract and applicable law;

4.10.5. when the Insured Person dies;

4.10.6. when there are other grounds for termination of obligations prescribed by the applicable law.

4.11. If the Contract is concluded in respect of a group of Insured Persons, then it may end only in respect of the relevant Insured Person (e.g., a decedent in respect of whom the Contract has been terminated or in respect of whom all the Insurance Indemnities have been paid out) on the grounds set out in paragraph 4.10 of the Insurance Terms and Conditions; however, this shall not affect the validity of the Contract in respect of other Insured Persons.

4.12. Where there are inconsistencies and/or contradictions in the Contract between the individual parts thereof, the Terms and Conditions of the Contract shall be determined and interpreted in accordance with the rule that the terms and conditions set out in the preceding document shall prevail over The terms and Conditions set out in the succeeding document in the following order of precedence: the Insurance Certificate (Policy), including any documents setting out specific or individually agreed Terms and Conditions between the parties, the Offer (if made in writing), the Insurance Terms and Conditions.

5. HEALTH CHECK-UP

5.1. When concluding or amending the Contract; when investigating a possible Insured Event; when reasonable doubts arise as to the veracity, validity, truthfulness or completeness of the information provided by the Customer; when new circumstances or facts relating to the Insured Person's health transpire; or in any other case where the Insurer requires additional information, the Insurer shall have the right to request a health check-up of the Customer in a medical institution acceptable to and specified by the Insurer, and / or the conclusions of the relevant medical expert. The Insurer shall pay the costs of the Customer's health check-up if the Insurer requires such a check-up before the conclusion of the Contract. If the Insured Person refuses to do so during the investigation of a possible Insured Event, the Insurer shall have the right to reduce or refuse to pay the Insurance Indemnity due.

5.2. If necessary, the Insurer shall have the right to verify the Customer's health condition or medical history by submitting respective inquiries to the Partners, other medical institutions prior to the conclusion of the Contract and throughout the term of the Contract, e.g., for the purpose of investigating an Insured Event, etc. If the Insurer does not receive the above information, the Policyholder or the Customer shall be obliged to provide the Insurer with the relevant data and/or documents themselves.

6. INSURANCE PREMIUMS

6.1. The Insurance Premium shall be fixed by agreement between the Policyholder and the Insurer for the entire Insurance Period. The Insurance Premium shall depend on the insurance programs chosen by the Policyholder, the Sum Insured, the Insurance Risk Assessment and other Terms and Conditions of the Contract.

6.2. Insurance Premiums must be paid in strict compliance with the Terms and Conditions set out in the Insurance Certificate (Policy). The Insurance Premium may be paid on a periodic basis as agreed with the Insurer: annually, half-yearly, quarterly. In the event of delay in payment of the Insurance Premiums or any part thereof, default interest provided for in the Contract may be charged and, at the Insurer's option, the validity of the Insurance Cover may be suspended or the Contract terminated.

6.3. The Insurance Premium shall be payable to the Insurer by bank transfer or any other means acceptable to the Insurer non-cash in the currency of the Contract. If the Insurance Premium is paid in a currency other than the Contract Currency, the Insurer shall have the right not to accept it or to reduce it by the currency conversion and related costs.

6.4. When paying the Insurance Premium, it is necessary to provide the data required by the Insurer to properly identify and attribute the Insurance Premium to the Contract. The Policyholder shall be responsible for the payment of the Insurance Premiums in accordance with the Terms and Conditions of the Contract.

6.5. The date of payment of the Insurance Premium shall be deemed to be the date on which the Insurer attributes the Insurance Premium credited to its bank account to the relevant Contract. If the Insurer is unable to determine for which Contract the Insurance Premium has been paid, it shall be deemed to be unpaid until the Insurer determines for which Contract the Insurance Premium has been paid and attributes it to the relevant Contract.

WHAT WE COVER AND ON WHAT TERMS

7. INSURANCE OBJECT

7.1. The insurance object shall be the property interest related to the Insured Person's health and its care.

8. INSURANCE COVER

8.1. The Policyholder shall be free to choose all or part of the Insurance Programs offered by the Insurer, their scope, other Terms and Conditions of the Contract. The Insurance Risk assumed by the Insurer under the Contract will depend on this. By agreement between the Policyholder and the Insurer, the Insured Person shall be granted the Insurance Coverage, the scope and limits of which shall be specified in the Insurance Certificate (Policy), its Annexes, individual Terms and Conditions, the Insurance Terms and Conditions, and the amount of the Insurance Premium payable by the Policyholder to the Insurer.

8.2. Unless otherwise provided for in the Contract, the Insurance Cover under the Contract shall be valid only in the Republic of Lithuania, i.e. Insurance Indemnities may be paid only for Health Care services rendered in the territory of the Republic of Lithuania or for any other Insured Events that occur.

8.3. The Insurance Cover under the Contract shall commence on the first day of the Insurance Period at 00.00 and shall remain in force until 24.00 of the last day of the Insurance Period or the date of termination or expiry of the Contract on other grounds, unless otherwise provided for in the Contract (i.e., the Contract shall enter into force upon payment of the first premium or if the premium payment is deferred).

8.4. The Insurer shall have the right to unilaterally determine that the Insurance Cover shall become effective for the Insured only upon activation of the Card by the Insured and/or upon submission of any consents, approvals or other information, data or documents required by the Insurer.

8.5. The Insurance Cover may be suspended in accordance with the procedure and conditions set out in the Contract and these Terms and Conditions. If the Insured Event occurs during the suspension of the Insurance Cover, the Insurer shall not pay the Insurance Indemnity.

9. INSURED EVENTS

9.1. For an event to be recognized as the Insured Event, it must meet the conditions listed below:

9.1.1. the event must be provided for in the Contract and comply with the requirements and conditions set out in the Contract, including the definitions and criteria laid down for each Health Insurance Program, as defined in Annex 1 to the Insurance Terms and Conditions, and as may be agreed in the individual or special conditions;

9.1.2. the event must have occurred after the entry into force of the Contract, during the Insurance Period, during the period of validity of the Insurance Cover and within its limits, taking into account the date of the Insured Event;

9.1.3. if the event is related to Health Care Services provided in a Health Care Institution, the Health Care Professional providing the Health Care Services must act within the scope of his/her rights and competences under the applicable law and must hold a medical practice license issued by a competent public authority and valid in the Republic of Lithuania;

9.1.4. the Insured Event and the services rendered must relate exclusively and directly to the Insured Person. Expenses (if applicable) arising from the event and the services rendered must be borne by the Insured Person;

9.1.5. the event must be substantiated by proper evidence and documents of a form and content acceptable to the Insurer.

9.2. Insurance Indemnities shall be paid for the payment or reimbursement of expenses incurred as a result of the Insured Events provided for in the Contract, not exceeding the Sums Insured set out in the Contract.

9.3. If continuous or partial expenses are incurred as a result of an Insured Event (e.g., paying for purchased goods or equipment in instalments), then, depending on the date of the Insured Event, in accordance with the procedure laid down in sub-paragraph 1.1.25 of the Insurance Terms and Conditions, only the expenses actually incurred during the period of insurance may in any case be reimbursed.

10. SUM INSURED

10.1. The Sum Insured shall be determined for each Health Insurance Program, for each Insured Person separately, unless otherwise provided for in the Contract.

10.2. Upon payment of any Insurance Indemnity under the Contract, the corresponding Sum Insured for the Insured Person shall be reduced by the amount of this Insurance Indemnity Sum paid and may not be recovered.

WHAT WE DON'T COVER

11. NON-PAYMENT OR REDUCTION OF INSURANCE INDEMNITIES

11.1. Insurance Indemnities shall not be paid in the following cases:

11.1.1. with respect to Non-Insured Events, which may be common to all Health Insurance Programs or detailed separately for each of them;

11.1.2. with respect to Non-reimbursable Expenses;

11.1.3. when the Insured Event occurred during the period when the Insurance Cover was suspended or invalid on other grounds;

11.1.4. when the Insurer is exempted from the payment of the Sum Insured in the cases provided for in the Contract or in the applicable law;

11.1.5. where reimbursement is claimed for services / goods provided / intended not for the Insured Person personally;

11.1.6. where, on the basis of the submitted original medical records, the Insurer has taken a decision not to pay the Insurance Indemnity and the Insured Person has submitted the medical records of the same event (visit) with additional corrections made for a reassessment in order to reverse the Insurer's decision;

11.1.7. when the Insurer has been provided with false, erroneous, knowingly incorrect or incomplete information or documents, or information that could have affected the conclusion of the Contract, its Terms and Conditions, the Insurance Risk has been withheld, or other relevant information about the Health Care services provided, the Health Impairment, or other circumstances relevant for the investigation or assessment of the Insured Event has been concealed;

11.1.8. when the Contract has been used for illegal purposes, including for the purpose of profiting or fraudulently obtaining an Insurance Indemnity;

11.1.9. when obligations provided for in the Contract or in the applicable law relating to the reporting of an Insured Event have been breached or improperly fulfilled.

11.2. The Insurer shall have the right to refuse to pay the Insurance Indemnity or to reduce it by 50% in the following cases:

11.2.1. when the data or documents provided by the person claiming the Insurance Indemnity do not allow to determine fully and accurately the date, circumstances and/or consequences of the Insured Event, the expenses incurred, other relevant data, or the person prevents or hinders the investigation of the Insured Event and the access to the necessary information;

11.2.2. when the Insurer has been provided with incomplete information or documents about the Health Care Services provided, the Health Impairment, or other circumstances relevant to the investigation or assessment of the Insured Event;

11.2.3. when the Policyholder or the Insured Person fails to perform the Contract or performs it improperly, which increases the probability of the occurrence of the Insured Event or the loss / expenses resulting from it to any extent;

11.2.4. in other cases and according to the procedure set out in the Contract and/or in the applicable law.

11.3. The Insurer shall have the right not to pay the Insurance Indemnity or to reduce it proportionally:

11.3.1. if the Insured Person is insured against the same risk under several insurance contracts concluded with different insurers (double insurance) and an Insured Event occurs, the Insurance Indemnity paid by the Insurer shall be reduced in proportion to the Insurer's share of liability. In any event, the total amount paid under all insurance contracts shall not exceed the costs incurred by the Insured Person;

11.3.2. if the Insured Person is insured against the same risk under several insurance contracts concluded with different insurers (double insurance) and upon occurrence of the Insured Event another insurer has reimbursed all expenses of the Insured Person related to the Insured Event, the Insurer shall not disburse the Insured Indemnity.

12. NON-INSURED EVENTS

12.1. For the purposes of the Contract, under any Health Insurance Program the following Health Impairments, the Health Care Services provided in respect thereof and any other related illnesses or health conditions, any other services or products or supplies provided for in the Contract, as well as any expenses incurred as a result thereof, shall be considered to be Non-insured Events:

12.1.1. related to a War and State of Emergency;

12.1.2. related to Radiation, use of chemical or biological agents for non-peaceful purposes;

12.1.3. related to pandemics, as well as natural disasters and mass casualties caused by natural forces;

12.1.4. arising from the Insured Person's self-injury or attempted suicide;

12.1.5. arising from the willful termination or modification of the prescribed treatment at the Insured Person's own discretion;

12.1.6. arising from the Insured Person's planning to commit or while committing of a criminal offence or from any other act or omission contrary to law, good morals and/or public order;

12.1.7. resulting from a deliberate act or omission of the Policyholder or the Insured Person;

12.1.8. caused or aggravated by the use of, or intoxication or other exposure to, any quantity of alcohol, narcotic, toxic, psychotropic or other dangerous substances;

12.1.9. fees for issuing documents, certificates, contracts or other administrative costs.

OCCURRENCE OF AN INSURED EVENT

13. REPORTING AN INSURED EVENT

13.1. The obligation to report an Insured Event shall rest upon:

13.1.1. The Insured Person if the Health Care Services or other services and/or supplies or products provided for in the Contract have been provided to the Insured Person by a party other than the Insurer's Partner, or where they have been provided by the Insurer's Partner but the Insured Person has not used the Card to pay for them. In that case, the report shall be submitted to the Insurer in writing or via the Insurer's E-system.

13.1.2. The Partner if the Partner provides the Insured Person with Health Care Services or other services and/or supplies or products as provided for in the Contract and the Insured Person has used the Card to pay for such services and/or supplies or products in accordance with the procedure established by the Partner. In that case, the report shall be submitted in the manner specified in the cooperation agreement between the Insurer and the Partner.

13.2. A report on an Insured Event must be provided to the Insurer as soon as the Insured Event becomes known, but in any case, not later than within 30 (thirty) calendar days from the date of its occurrence, unless a different time limit is provided for in the Contract.

13.3. Late reporting of the Insured Event shall be considered as a breach of the Contract for which the Insurer shall have the right to refuse to pay the Insurance Indemnity, taking into account the period of the late reporting.

13.3.1. When the Insurance Cover was suspended or invalid on other grounds and a report on an Insured Event was not provided to the Insurer within 30 (thirty) calendar days from the date of its occurrence, Insurance Indemnity shall not be paid to the Insure person by the Insurer.

14. INVESTIGATION OF AN INSURED EVENT

14.1. After receiving a report of a potential Insured Event, the Insurer shall carry out an investigation to determine the fact, causes, circumstances, consequences and the amount of the Insurance Indemnity.

14.2. The Insured Person, the recipient of the Insurance Indemnity, must cooperate with the Insurer in the investigation of the circumstances of the event which may be recognized as an Insured Event and must ensure that the Insurer has lawful access to all the information relating to the event.

14.3. A person who claims an Insurance Indemnity must also submit to the Insurer the documents of the form and content approved in the manner prescribed by legal acts which may be also be submitted via the Insurer's E-system (e.g., an extract from www.esveikata.lt), confirming the possible Insured Event, its circumstances, causes and consequences, as referred to in paragraph 15.1 or as separately requested by the Insurer, as well as all other relevant documents and information affecting the assessment of the event or the determination of the amount of the Insurance Indemnity.

14.4. The costs of obtaining and submitting supporting documents shall be borne by the person claiming the Insurance Indemnity.

14.5. During the investigation, the Insurer may directly request information, explanations, documents, etc, from other natural and legal persons, competent authorities or bodies.

14.6. Upon receipt of all necessary information, data, documents or other evidence, the Insurer shall assess the circumstances of the event, their compliance with the requirements of the Contract and take a decision on the qualification of the event, the determination of the amount and the nature of the Insurance Indemnity and its payment or non-payment.

14.7. If, during the investigation of a potential Insured Event or in order to substantiate the Insurer's decision, the Insurer needs special knowledge or expert opinion on any circumstances, facts or their assessment, the Insurer shall have the right to seek the advice, conclusions or opinion of specialists, experts in the relevant field. The related costs shall be borne by the Insurer.

14.8. If there is a disagreement between the parties to the Contract regarding the Insurer's assessment or decision, the Insurer and the Policyholder or the Insured Person may agree to have the circumstances of the Insured Event reinvestigated or reassessed by the independent expert(s). The related costs shall be borne by the person who initiated the investigation/assessment, unless the parties agree otherwise. In that case, the experts may not be persons whose participation could give rise to a conflict of interest. Each party shall inform the independent expert(s) in writing of all facts, data and documents which might affect a fair and objective assessment of the Insured Person's state of health and/or the circumstances of the accident and/or the amount of the damage. The independent experts must present their findings to all parties at the same time. The party shall have the right to disagree with the independent experts' conclusion and to refer the dispute to the competent authorities and/or the court for settlement in accordance with the procedure laid down by the applicable law.

INSURANCE INDEMNITY

15. APPLICATION FOR AN INSURANCE INDEMNITY AND OTHER DOCUMENTS

15.1. For the purpose of investigation of a potential Insured Event and/or payment of the Insurance Indemnity by the Insurer in accordance with the procedure set out in the Contract, the following documents of the form and content acceptable to the Insurer must be provided:

15.1.1. an application for the Insurance Indemnity in the form prescribed by the Insurer;

15.1.2. a document (invoice) supporting the purchase of the services and/or supplies or products (invoice) and a document (cash receipt, cash voucher, cash acceptance slip, bank transfer statement, etc.) supporting the payment for them;

15.1.3. extracts or copies of medical records to substantiate:

15.1.3.1. the fact of the Insured Event, the date of the Insured Event and the circumstances of the Insured Event (the Health Impairment and the circumstances of its occurrence, the progress of its development; the Insured Person's health condition; the tests prescribed to confirm the Health Impairment; the results of the tests performed, etc.);
15.1.3.2. the disease code or codes according to the official International Classification of Diseases (ICD-10-AM) approved by the Minister of Health of the Republic of Lithuania;

15.1.3.3. any other information that may be relevant for a proper and complete investigation of the Insured Event or requested by the Insurer;

15.1.4. Prescription or other medical document or a copy of the prescription for the medicine, medical devices reimbursed by the Insurer or a copy thereof. For reimbursement under the Health Insurance Program "Medicines and Medical Equipment", a prescription or other medical document shall be mandatory in all cases regardless of whether the Medicines or the Medical Equipment reimbursed by the Insurer can be issued and purchased only with a prescription or also without it. If the Medicines are purchased with an electronic prescription, the Insured Person must provide a copy of the electronic prescription or a copy of the medical document specifying the medicines prescribed for the Insured Person by the doctor;

15.1.5. Copies of the individual activity certificate or business license of the person who provided the service (if the service was provided by a person engaged in such activity);

15.1.6. Consents or other documents or data required under the Health Insurance Program concerned;

15.1.7. Other documents substantiating the Insured Event and its circumstances, reasonably requested by the Insurer.

16. INSURANCE INDEMNITY

16.1. If the event is recognized as an Insured Event, the Insurer shall pay the Insurance Indemnity less the amount of the Deductible and after applying any other limitations on the calculation and/or payment of the Insurance Indemnity provided for in the Contract.

16.2. The Insurance Indemnity shall be paid to:

16.2.1. to the Partner in accordance with the procedure set out in the cooperation agreement with the Partner, if the Partner provides the Insured Person with Health Care Services or any other services / supplies or products provided for in the Contract, and the Insured Person uses the Card to pay for these services / supplies or products in accordance with the procedure established by the Partner;

16.2.2. to the Insured Person, if the Health Care Services or other services / supplies or products specified in the Contract have been provided to the Insured Person not by the Partner or by the Partner, but the Insured Person has not used the Card to pay for them and has paid for them himself;

16.2.3. to legal heirs of the Insured Person if, after the Insured Event, the Beneficiary, a natural person, has died without having received the Insurance Indemnity due to him/her, according to the submitted inheritance documents complying with the requirements of legal acts of the Republic of Lithuania;

16.2.4. in the case provided for in paragraph 14.2.1 of Annex 1 to the Insurance Terms and Conditions– to the Insured Person.

16.3. The Insurance Indemnity shall be paid not later than within 30 (thirty) days of the date of receiving all information and/or documents required by the Insurer of the form and content acceptable to the Insurer, which are relevant to the determination of the fact of the Insured Event, its circumstances, consequences and the amount of the Insurance Indemnity.

16.4. If the event is declared as a Non-Insured Event, the Insurer shall inform about such decision and/or refusal to pay the Insurance Indemnity within 30 (thirty) days from the date of receipt of all the information relevant for determining the fact, circumstances and consequences of the event. The Insurance Indemnity shall not be paid in respect of the Insured Events provided for in these Terms and Conditions and in the Contract.

16.5. The Beneficiary of the Insurance Indemnity shall reimburse to the Insurer, without delay, but in any case not later than within 10 (ten) working days from the date of the receipt of the relevant request from the Insurer, the amounts of the Insurance Indemnity unduly disbursed by the Insurer, including overpayments due to exceeded Sums Insured.

16.6. The Insurer shall have the right to request the person applying for the Insurance Indemnity to open a bank account in his/her own name in a bank or other credit institution operating in the Republic of Lithuania, to which the Insurance Indemnity may be transferred.

16.7. The Insurer shall have the right to deduct the costs of executing the payment order (e.g., currency conversion costs, fees for submitting or executing the payment order, etc.) from the Insurance Indemnity due.

OTHER CONDITIONS AND CLAIMS

17. OTHER RIGHTS AND RESPONSIBILITIES OF THE PARTIES

17.1. Responsibilities of the Policyholder:

17.1.1. to provide the Insurer with, or procure that the Insured provides, detailed, full and true and accurate information necessary for the conclusion and performance of the Contract;

17.1.2. before concluding the Contract, to get acquainted with its Terms and Conditions, including the Insurance Terms and Conditions, in a proper and responsible manner;

17.1.3. to inform the Insured Person in a proper and timely manner about the conclusion of the Contract, its amendments or termination, to acquaint the Insured Person properly and fully with the Terms and Conditions of the Contract, including the Insurance Terms and Conditions, including explanations about the Insured Events and Non-Insured Events, and the other Terms and Conditions of the Contract;

17.1.4. to pay Insurance Premiums according to the procedure and within the time limits set out in the Contract;

17.1.5. to act as the Insurer's main point of contact for communication and co-operation with the Insured Persons, both in concluding and performing the Contract, as well as for communicating information to the Insured Persons relating to the Contract, for obtaining the necessary data or consent from the Insured Persons, etc.;

17.1.6. to inform the Insurer of any existing insurance contracts or to inform the Insurer within a reasonable period of time of any new insurance contracts concluded with other insurers in respect of the same Insurance Risks for which the Contract is concluded with the Insurer;

17.1.7. to take all possible measures to avoid or reduce the Insurance Risk and to comply with the Insurer's instructions, if such instructions have been given to the Insured Person;

17.1.8. to immediately notify the Insurer of any increase in the Insured Risk or any other circumstances which materially affect the Terms and Conditions of the Contract;

17.1.9. to enable the Insurer or its authorized representative to check whether the Policyholder and the Insured Person are complying with the Terms and Conditions of the Contract;

17.1.10. at any time during the validity of the Contract, to inform the Insurer immediately, within a reasonable period of time after the occurrence or discovery of the relevant circumstances or facts, of any changes in the data, facts or circumstances which were provided to the Insurer at the time of concluding and/or amending the Contract, including, but not limited to, the identification data (personal identification data, taxpayer's data, data of registration or legal status of the legal entity, information about the representative and his/her powers, etc.) and the contact details (address, telephone number, email address);

17.1.11. immediately, but in any event not later than within 1 (one) working day, to notify the termination of the employment relationship with the Insured Person, to terminate the Insurance Cover for such Insured Person and to bear any losses resulting from the improper fulfilment of this obligation. In this case, the Insurer shall terminate the Insurance Cover for the Insured Person not later than the next working day following receipt of the relevant notice;

17.1.12. to inform the Insurer immediately, but not later than within 1 (one) working day, unless another time limit has been agreed in the Contract, of any changes in the List of Insured Persons;

17.1.13. upon request of the Insurer, to return the Insurance Indemnities unduly disbursed to the Insured Person, including overpayments due to exceeded Sums Insured in the cases where the Policyholder has breached the Terms and Conditions of the Contract and the Insurer has failed to recover the unduly disbursed Insurance Indemnities and/or overpayments from the Insured Person;

17.1.14. to fulfil all other duties, obligations, conditions and requirements provided for in the Contract or applicable law in a proper and timely manner.

17.2. Responsibilities of the Insured Person:

17.2.1. to get acquainted responsibly and thoroughly with the Terms and Conditions of the Contract, including the Insurance Rules, and to comply with them in a due and proper manner;

17.2.2. to provide the Insurer with the data, documents, consents, approvals or other information requested by the Insurer and necessary for the conclusion and proper performance of the Contract, for the assessment of the Insurance Risk and for the investigation of the Insured Event;

17.2.3. on own initiative and responsibility, to agree and obtain the Insurer's prior written consents or approvals for the provision of certain Health Care Services, if and when such consents or approvals are required under the terms of the relevant Health Insurance Program;

17.2.4. to protect the Card issued to him/her personally against unauthorized use, damage or loss and to assume liability for any damage resulting from any breach of this obligation;

17.2.5. to inform the Insurer immediately, but in any case not later than within 1 (one) working day after the occurrence of the respective incident, of the unauthorized use, loss, theft or other loss of the Card;

17.2.6. when and as required under the Terms and Conditions of the Contract, to notify the Insurer of the occurrence of a potential Insured Event and to provide full, correct information about the causes and circumstances of the potential Insured Event and all related data, information, documents referred to in the Contract;

17.2.7. to keep the documents confirming the Insured Event for at least 1 (one) year from the date of payment of the Insurance Indemnity, if only copies of such documents have been submitted to the Insurer, and to deliver them at the request of the Insurer;

17.2.8. on request of the Insurer, in the cases and according to the procedure set out in the Contract, to undergo a health check-up in the Health Care Institution specified by the Insurer;

17.2.9. to repay to the Insurer, in accordance with the procedure and within the time limits laid down in the Contract, any Insurance Indemnities unduly paid out by the Insurer, including overpayments due to exceeded Sums Insured;

17.2.10. at any time during the validity period of the Contract, to inform the Insurer immediately, within a reasonable period of time after the occurrence or discovery of the relevant circumstances or facts, of any changes in the data, facts or circumstances which have been provided to the Insurer, including, but not limited to, identification data (personal identity, taxpayer's details, etc.) and contact details (address, telephone number, e-mail address);

17.2.11. to fulfil all other duties, obligations, conditions and requirements provided for in the Contract or applicable law in a proper and timely manner.

17.3. Responsibilities of the Insurer:

17.3.1. to provide information about the Insurer, the insurance product and related insurance services, dispute resolution procedures and other essential information, in the cases and according to the procedure established by the applicable law and the Contract;

17.3.2. upon conclusion of the Contract, to issue to the Policyholder the Insurance Certificate (Policy) and to each Insured Person a personalized Card or other document confirming the granting of Insurance Cover under the Contract;

17.3.3. to provide information and advice on the Health Insurance Programs and other Terms and Conditions of the Contract;

17.3.4. upon the occurrence of an Insured Event, to pay the Insurance Indemnities in accordance with the Terms and Conditions set out in the Contract;

17.3.5. not to disclose any confidential information obtained in the performance of the Contract concerning the Policyholder and/or the Insured Person, with the exception of exclusions provided for in the Contract and in the applicable law;

17.3.6. to issue copies of the Contract to the Policyholder if, after the conclusion of the Contract, the Policyholder applies to the Insurer with such a request;

17.3.7. to fulfil in a proper and timely manner all other duties, obligations, conditions and requirements provided for in the Contract or applicable law.

17.4. Rights of the Insurer:

17.4.1. The Insurer shall have the right to unilaterally and without separate notice to the Policyholder to establish and change the List of Partners, the Terms, Conditions, requirements or restrictions of cooperation with the Partner in relation to the provision of all or certain Health Care Services to the Insurer's Customers. The Partners may not in any event be authorized to interpret the Terms and Conditions of the Contract or to perform the obligations of the Insurer or the Customer under the Contract;

17.4.2. to unilaterally establish, during the term of the Insurance Contract, the list of service providers whose services or medicines purchased in the course of such services, medical devices reimbursed by the Insurer, or any expenses incurred by the Insurer's Customers will not be reimbursed by the Insurer informing the Policyholders in writing not later than 30 (thirty) days prior to the date of entry into force of such list and/or its amendments;

17.4.3. other rights of the parties provided for in the Contract and applicable law.

18. AMENDMENT TO THE INSURANCE CONTRACT

18.1. General Provisions

18.1.1. The Terms and Conditions of the Contract may be amended or supplemented only by a separate written agreement between the Policyholder and the Insurer, unless otherwise specified in other paragraphs of the Contract or in the applicable law.

18.2. Amendments to the Contract initiated by the Policyholder

18.2.1. The Policyholder must inform the Insurer in writing of the desired amendment to the Terms and Conditions of the Contract not later than 30 (thirty) days prior to the effective date of the desired amendment.

18.2.2. Amendments to the List of Insured Persons (termination of the Contract in respect of a part of the Insured Persons and/or inclusion of new Insured Persons) shall be carried out with the consent of the Insurer and in accordance with the Terms and Conditions agreed by both parties.

18.2.3. Unless otherwise provided for in the Contract, amendments to the Contract shall become effective in the calendar month following receipt and acceptance of the Insurer's request to amend the Terms and Conditions of the Contract, unless by its nature such amendment becomes effective from the date of its receipt or unless the parties have agreed otherwise.

18.3. Amendments to the Contract initiated by the Insurer

18.3.1. The Insurer's right to amend the Terms and Conditions of the Contract is provided for in the Contract and in the applicable law.

18.3.2. The Insurer shall have the right to unilaterally amend and/or supplement these Terms and Conditions and/or the procedure for the administration of Health Insurance Contracts. By decision of the Insurer, such amendments and/or annexes shall also apply to the insurance contracts concluded on the basis thereof, duly disclosed in advance on the Insurer's website. Amendments to the Terms and Conditions and other related documents of the Insurer shall enter into force and shall apply from the date stated publicly therein.

19. SUSPENSION AND RENEWAL OF THE INSURANCE COVER

19.1. If the Policyholder fails to pay the Insurance Premium or part thereof at the time specified in the Contract, the Insurer shall have the right to notify the Policyholder thereof in writing or by other means of submission of notices, stating that, if the Insured fails to pay the Insurance Premium or part thereof within 30 (thirty) days of the date on which such notice is sent, the Insurance Cover under the Contract may be suspended, with suspension of the validity of the Insured Persons' Cards. The suspension shall be carried out after sending a notice to the Policyholder specifying an additional time limit for the payment of the outstanding amount to the Insurer informing the Policyholder that the failure to pay within this additional time limit will result in the termination of the Contract and the automatic termination of the Insurance Cover. If the Policyholder covers such debt within the time limit specified by the Insurer, the suspension of the Insurance Cover shall be removed and the validity of the Insured Persons' Cards shall be restored.

19.2. If the suspension of the Insurance Cover due to non-payment of the Insurance Premium continues for more than 1 (one) month, the Insurer shall have the right to unilaterally terminate the Contract by informing the Policyholder in writing of the terminated Contract. In that case, the Insured Persons' Cards shall be deactivated and shall cease to be valid from the same moment when the Contract is terminated.

19.3. If it transpires that the Insured Person's Card has been lost, the Insurer shall suspend the validity of the issued Card and issue a new Card to the Insured Person in accordance with the prescribed procedure.

19.4. If it transpires that the Card is being used by a person other than the Insured Person, the Insurer shall have the right to suspend the validity of the Insurance Cover for the Insured Person concerned.

19.5. If the Insured Event occurs during the suspension of the Insurance Cover, the Insurer shall not pay the Insurance Indemnity and/or reimburse any other expenses incurred by the Insured Persons during the suspension of the Insurance Cover.

19.6. If during the investigation of the Insured Event it appears that the Insured Person has acted in the manner provided for in subparagraphs 11.1.7 and/or 11.1.8 of the Insurance Terms and Conditions, or has failed to fulfil the obligation provided for in paragraph 16.5 of the Insurance Terms and Conditions, the Insurer shall have the right to unilaterally suspend or cancel the validity of the Insurance Cover either temporarily or for an unlimited period of time by informing the Policyholder and the Insured Person thereof. In that case, the Insurance Premiums shall not be recalculated and shall not be refunded in respect of the Insured Person.

20. TERMINATION OF THE CONTRACT

20.1. Contract termination or expiry procedure

20.1.1. The Contract may be terminated by a separate written agreement between the parties, at the written request of the Policyholder, by a court decision or by a notice from the Insurer in the cases and according to the procedure set out in the Contract and/or in the applicable law.

20.1.2. Upon termination or expiry of the Contract before the end of the Insurance Period on other grounds, the Insurer shall always retain the right to the Insurance Premiums due but unpaid prior to the respective termination or expiry of the Contract, as well as to the sums arising as a result of the difference between the Insurance Indemnities actually paid out and the Insurance Premiums actually received (where the Contract provides for their periodic payment). The Policyholder must pay them not later than the last day of validity of the Contract.

20.1.3. Unless otherwise provided in the Contract, the Insurance Terms and Conditions or the applicable law, in the event of termination of the Contract or its expiry before the end of the Insurance Period on other grounds, the Insurance Premiums paid shall not be refunded to the Policyholder.

20.2. Contract termination initiated by the Policyholder

20.2.1. At any time during the term of validity of the Contract, the Policyholder shall have the right to terminate the Contract by notifying the Insurer in writing not later than 30 (thirty) days before the anticipated Contract termination date.

20.2.2. If the Contract is terminated at the initiative of the Policyholder due to the fault of the Insurer, the Policyholder shall be refunded that part of the Insurance Premiums paid by the Policyholder which exceeds the amount of the Insurance Indemnities already paid out under the Contract and the amount of the Insurance Indemnities to be paid out.

20.2.3. If the Contract is terminated at the initiative of the Policyholder through no fault of the Insurer, the part of the Insurance Premium to be refunded or payable to the Policyholder shall be recalculated as follows:

20.2.3.1. where the Contract is terminated before the effective date of the Insurance Cover and the Policyholder has paid all or part of the Insurance Premium, the Insurance Premium actually paid shall be refunded to the Policyholder, without deducting any administrative expenses;

20.2.3.2. when the provision of Insurance Cover has commenced and the Policyholder has paid all or part of the Insurance Premium, the Insurer shall deduct from the Insurance Premium actually paid by the Policyholder for the remaining Insurance Period from the date of termination of the Contract, the costs of concluding and executing the Contract (30% of the amount to be refunded), and the Insurance Indemnities paid out under the Contract and the Insurance Indemnities expected to be paid/reserved under it. Where the costs of concluding and performing the insurance contract cannot be deducted from the Insurance Premium or its part paid by the Policyholder (this amount is insufficient), these costs must be borne by the Policyholder. The amount to be refunded to the Policyholder or payable by the Policyholder to the Insurer shall be calculated 30 (thirty) days after the date of termination of the relevant Contract and shall be refunded by the Insurer or paid by the Policyholder within the next 30 (thirty) days.

20.3. Contract termination initiated by the Insurer

20.3.1. The Insurer shall have the right to terminate the Contract unilaterally, without going to court, by an appropriate written notice given 30 (thirty) calendar days in advance of the expected date of termination of the Contract, in the event of the following material breaches of the Contract:

20.3.1.1. at the time of conclusion or during the term of validity of the Contract, the Policyholder and/or the Insured Person has breached or improperly fulfilled the duty imposed by the applicable law to disclose full, complete, true and correct information about the circumstances affecting the assessment of the Insurance Risk, the probability of the Insured Event or the likely consequences thereof, the Terms and Conditions of the Contract;

20.3.1.2. the Policyholder and/or the Insured Person fails to perform or improperly performs other obligations under the Contract and fails to remedy the situation upon the Insurer's request within a reasonable period of time set by the Insurer, which in any case shall not be less than 14 (fourteen) calendar days;

20.3.1.3. there are other grounds for termination of the Contract provided for in the Contract or applicable law.

20.3.2. The Insurer shall have the right to terminate the Contract unilaterally, without going to court, by written notice with immediate effect (unless such notice specifies other effective dates) in the event of the following material breaches of the Contract:

20.3.2.1. if the Policyholder is late in paying the Insurance Premium or any part thereof at the time specified in the Contract and after the Insurer has given notice to cover the debt within 30 (thirty) days of the sending of the notice, the Policyholder fails to pay all the overdue payments within the specified period;

20.3.2.2. on the grounds and according to the procedure provided for in paragraph 19.2 of the Insurance Terms and Conditions;

20.3.2.3. the Policyholder fails or refuses to respond to the proposal to amend the Terms and Conditions of the Contract as provided for in the applicable law or the Contract;

20.3.2.4. the identification by the Insurer of the breaches described in subparagraphs 11.1.7 and/or 11.1.8 of these Terms and Conditions;

20.3.2.5. there are other grounds for termination of the Contract provided for in the Contract or applicable law.

20.3.3. Where the Contract is terminated at the Insurer's request due to a breach by the Policyholder of the Terms and Conditions of the Contract, the Policyholder shall not be entitled to any refund of the Insurance Premiums and shall be liable to reimburse the Insurer for any damages and direct losses incurred by the Insurer as a result of such acts.

20.4. Contract termination by agreement of the Parties

20.4.1. The Insurer and the Policyholder may separately agree in writing on other conditions and procedure for termination of the Contract.

21. TRANSFER OF RIGHTS AND RESPONSIBILITIES UNDER THE CONTRACT

21.1. Transfer of the Insurer's rights and responsibilities under the Contract

21.1.1. The Insurer shall have the right to transfer the rights and responsibilities under the Contract to another insurer or insurers upon giving notice of such intention and obtaining the permission of the competent supervisory authority in the cases and in the manner provided for by applicable law.

21.1.2. In the cases specified by the applicable law, the Insurer undertakes to publish in at least 2 (two) national newspapers the intention to assign the rights and responsibilities under the Contract and to give the Policyholder a period of at least 2 (two) months during which the Policyholder would have the right to submit to the Insurer its objections regarding the respective intentions.

21.1.3. The Policyholder shall have the right to submit to the Insurer a written objection to the intended transfer of the Policyholder's rights and responsibilities under his Contract within the time limits specified in the relevant notice.

21.1.4. If the Policyholder disagrees with the assignment of rights and obligations under the Contract and the change of the insurer, the Policyholder shall have the right to terminate the Contract within 1 (one) month from the date of the assignment of rights and obligations. In that case, the Policyholder shall be reimbursed for the Insurance Premiums actually paid for the Insurance Period remaining from the date of termination of the Contract less the costs of conclusion and performance of the Contract and the Insurance Indemnities paid and due under the Contract.

21.2. Transfer of the Policyholder's rights and responsibilities under the Contract

21.2.1. The Policyholder shall not be entitled to assign his/her rights and/or obligations under the Contract to other persons without the prior written consent of the Insurer, by giving prior notice to the Insurer, but not later than 30 (thirty) calendar days in advance.

22. NOTICES

22.1. All notices, Applications or any other expression of intent between the Insurer and the Customer must be in writing or in equivalent form and shall be delivered by hand, by registered post, by E-system (E-health electronic system or mobile application) or by email using the relevant contact details specified in the Contract or most recently provided to the other party for such purpose.

22.2. Notices from the Customer to the Insurer shall be sent using the contact details of the Insurer and shall be deemed to have been delivered when they are actually received. The Insurer's agents, Partners, brokers, etc., shall not be authorized to receive notices on behalf of the Insurer. The Insurer shall have the right to establish identification procedures for the submission and receipt of notices from the Insured depending on their nature.

22.3. Any written notice from the Insurer to the Customer shall be deemed to have been received, the relevant party's obligation to notify shall be deemed to have been fulfilled and the time limits relating thereto shall begin to run according to the following procedure and time limits:

22.3.1. on the 5th (fifth) calendar day after being sent by registered post;

22.3.2. on the date of dispatch via the E-system or by email. If the notice is sent this way on a non-working day or after working hours, the day of receipt shall be deemed to be the next working day;

22.3.3. delivering personally against signature – on the day on which the recipient receives the notice delivered to him or her and signs acknowledging its receipt.

22.4. The Party may not make any claims that it has not received notices or that the other Party's actions are not in accordance with the Terms and Conditions of the Contract, if the notice was sent using the last contact details provided by the Party.

22.5. The Insurer shall have the right to provide notices or information to the Customers publicly, in the cases and according to the procedure set out in the Contract and/or in the applicable law, or in other exceptional cases: at the Insurer's customer service branches, on the Insurer's website and/or in mass media. In such cases, notices shall be deemed to have been received on the date of their publication.

22.6. If there is any doubt, the Customer must confirm, in a manner requested by and acceptable to the Insurer, the Customer's will, identity, the date of the document and/or the authenticity of the signature The Insurer shall have the right to refrain from taking any action or to suspend the performance of its obligations under the Contract until such time as the doubts referred to above have been removed and the required confirmations obtained.

23. CONFIDENTIALITY

23.1. The Terms and Conditions of the Contract and all information received by the parties during the performance of the Contract shall be treated as confidential and shall not be made publicly available to third parties without the prior written consent of the interested Party to the Contract, except for the disclosure of relevant information to the extent necessary and to ensure further confidentiality of the information:

23.1.1. to persons who have brought lawful claims according to the Contract;

23.1.2. when such information is in the public domain (except where it has become public due to the breach of the Contract);

23.1.3. to persons providing audit services and auditing the activities or financial statements of the party according to the Contract;

23.1.4. to lawyers who provide legal services related to the Contract to any of the parties;

23.1.5. to the party's shareholders / partners and/or parent undertaking and/or subsidiaries;

23.1.6. to the intended successor or acquirer of the rights and/or obligations of the party;

23.1.7. to persons providing the Insurer with services related to the conclusion, execution, accounting, administration or storage of the Contract;

23.1.8. to the reinsurer, if the Insurance Risk is reinsured under the Contract;

23.1.9. to the competent state authorities, including courts, law enforcement agencies, the State Tax Inspectorate, etc.;

23.1.10. 23.1.10. to the insurance distributor who has mediated the conclusion of the Contract;

23.1.11. in other mandatory cases provided for in the Contract and/or established by the applicable law.

24. LIABILITY

24.1. The Parties undertake to fulfil with due care all obligations under the Contract acting in an appropriate and timely manner, in good faith and cooperating with each other, taking into account the established good practices.

24.2. For the late performance of monetary obligations under the Contract, the parties undertake to pay default interest at the rate of 0.02% on the outstanding amount per each delayed day until the proper performance of monetary obligations.

24.3. The Insurer shall not be liable for losses incurred as a result of termination of the Contract on the grounds provided for in the Contract or applicable law.

24.4. The Insurer shall not be liable for the inability to use the E-system and/or the Card for its intended purpose caused by technical malfunctions. The Insurer undertakes to eliminate such malfunctions within a reasonable time period if they were caused through the fault of the Insurer.

25. APPLICABLE LAW, DISPUTE SETTLEMENT PROCEDURE

25.1. The Contract shall be concluded, applied and interpreted in accordance with the law of the Republic of Lithuania.

25.2. Any and all disputes, disagreements or claims between the Insurer and the Customer arising out of or in connection with the Contract shall be settled by negotiation and in accordance with the procedure for the handling and settlement of complaints established by the Insurer and made publicly available on its website.

25.3. At the request of the party concerned, disputes may be settled by out-of-court dispute settlement procedures provided for by the applicable law. The Bank of Lithuania shall have the competence to settle disputes between consumers and financial market participants arising from the provision of financial services in accordance with the procedure established by the Bank. For more information, please visit: www.lb.lt → Dispute_settlement. Address of the Bank of Lithuania: http://www.lb.lt/ → Contacts.

25.4. In any case, if no agreement is reached, disputes shall be settled before the competent court in accordance with the procedure established by laws of the Republic of Lithuania. By agreement of the parties, the place of jurisdiction shall be Vilnius City.

26. OTHER TERMS AND CONDITIONS

26.1. The Insurer shall not provide Insurance Cover under the Contract and shall not be obliged to pay the Insurance Indemnity or any other amount under the Contract or to fulfil any other contractual obligations if this would result in the Insurer being in breach of any International Sanction and/or Money Laundering and Terrorist Financing Prevention Requirements. The Insurer will not be liable for any claims or damages arising from the foregoing.

26.2. If at any time it transpires that any of the Terms and Conditions of the Contract are or become invalid, illegal or unenforceable, the remaining Terms and Conditions of the Contract shall not in any way be affected or rendered invalid, and such invalid Terms and Conditions shall be immediately replaced by written agreement between the parties by new Terms and Conditions which are closest in terms of their meaning, purposes and content and which have the same economic effect.

26.3. If there are inconsistencies and/or contradictions between the terms and definitions stated in the Lithuanian version (original version) and English or other language versions (translated versions) of these Terms and Conditions, the terms and definitions, provided for in Lithuanian version (original version) of the Terms and Conditions shall prevail.

27. PERSONAL DATA PROCESSING

27.1. In order to conclude an insurance contract, the Policyholder must provide the Insurer with the personal data of the Insured Person requested by the Insurer. If such personal data is not provided, the Insurance contract cannot be concluded.

27.2. When concluding 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 the Terms and Conditions of the Insurance Contract, as well as about the fact that the Insurer will process their personal data, provide them with the information about the Insurer and its contact details, and acquaint them with the Terms and Conditions of the Insurance Contract, the Terms and Conditions. In that case, the Insurer shall have the right to presume that the Insured Person has the information about the processing of data.

27.3. When providing health insurance services, the Insurer shall process the Insured Person's special category (health) personal data on the basis of the consent of the Insured Person. The processing of such personal data shall be necessary in order for the Insurer to ascertain the existence of an Insured Event and to determine the amount of the Insurance Indemnity. In the event that the Insured Person does not consent to the processing of health personal data, the Insurer shall have the right not to activate the Insurance Cover and/or not to evaluate the submitted Claims for reimbursement of costs.

27.4. Upon occurrence of an Insured Event, the Beneficiary of the Insurance Indemnity must provide the Insurer with all available documents and information on the circumstances and consequences of the Insured Event, necessary for the determination of the amount of the Insurance Indemnity, including personal data of special categories (data on the state of health, injuries, causes of death, etc.). The Insurer shall have the right to process this data for the purpose of ascertaining whether the event can be recognized as an Insured Event, whether the Insured Event occurred during the Insurance Period and the amount of the indemnity, and to select the Insurance Program from which the Insured Event may be indemnified accordingly.

27.5. The Insurer shall obtain the Personal Data of the Insured Person concerning the scope of the services provided to the Insured Person, the price, the time of performance and other relevant data (including health data) for the purpose of paying the Partner directly for the services provided to the Insured Person and assessing whether the service provided constitutes an Insured Event in accordance with the Terms and Conditions of the Insurance Contract.

27.6. The Insurer may disclose the Insured Person's personal data, including the health data, to experts and other persons who have special knowledge, where this is necessary for establishing the fact of the Insured Event, the consequences and the amount of the Insurance Indemnity.

27.7. In order to assess a potential Insured Event, the Insurer may collect and further process health data not only from the Beneficiary of the Insurance Indemnity, but also from data recipients, such as health care institutions or other service providers (e.g., pharmacies, health service providers, opticians, etc.), as well as from the data held in registers, information systems, or other data files, on the Insured Person's health condition, medical treatment, diagnosed diseases, injuries suffered, and any other services provided for in the Insurance Contract.

27.8. In certain cases, in order to provide prompt service to the Insured Person, an automated decision may be taken to pay the Insurance Indemnity after assessing the evidence provided by the Insured Person. This means that the Insurance Indemnity shall be calculated automatically, taking into account the data entered into the system and taking into account the sums insured and the period of cover. The Insured Person shall have the right to contact the Insurer and request a review of the automated decision made in respect of the Insured Person.

27.9. Personal data shall be retained for as long as they are necessary for the purposes for which they were collected, but not less than the mandatory retention period for the relevant data/documents established by legal acts.

27.10. The personal data processed by the Insurer may be disclosed to insurance intermediaries (intermediaries involved in the conclusion of the insurance contract), other partners of the Insurer involved in the performance of the insurance contract (e.g., experts, claims management companies), Insured Persons and beneficiaries of the Insurance Indemnity, other insurance companies, reinsurance companies, supervisory and other public authorities (e.g., the Tax Inspectorate, the State Social Insurance Fund Board, the Bank of Lithuania), advocates, courts, bailiffs, pre-trial investigation bodies, the Prosecutor's Office, Financial Crime Investigation Service, insolvency administrators, notaries, lawyers, auditors, medical institutions, other data processors who provide certain services (works) to the Insurer (e.g., companies providing IT services, archiving services, postal services, debt collection services, etc.).

27.11. In those cases where the Insurer agrees with the Policyholder to extend the Insurance Cover outside the European Union (EU) and/or the European Economic Area (EEA), the 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 for the performance of the Insurance Contract shall be sent.

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

27.13. More information on the exercise of the rights of data subjects and the processing of personal data by the Insurer is published in the Insurer's Privacy Policy, which is posted on the Insurer's website http://www.compensa.lt/privatumo-politika

27.14. In the event of personal data breaches, data subjects shall have the right to contact the Insurer's Data Protection Officer at dpo@compensalife.lt, and to lodge a complaint with the State Data Protection Inspectorate.