APPROVED by
Management Board of Compensa Vienna Insurance Group ADB
16 December 2025

Seesam
VIENNA INSURANCE GROUP

SEESAM VOLUNTARY HEALTH INSURANCE TERMS AND CONDITIONS

(Applied since 1 January 2026)

SPECIAL PART

TERMS AND DEFINITIONS

1. THE INSURANCE CONTRACT AND THE PARTIES INVOLVED

1.1. **Insurer** is the insurance company Compensa Vienna Insurance Group ADB.

1.2. **Policyholder** refers to a person who has applied to the Insurer for conclusion of an insurance contract, or who has received an offer from the Insurer to conclude an insurance contract, or who has concluded an insurance contract with the Insurer.

1.3. **Insured** means a natural person specified in the insurance contract, and upon occurrence of an Insurable Event in his/her life the insurer shall pay the Insurance Benefit.

1.4. **Healthcare Facility** is a legal entity licensed by the State under applicable law to provide Healthcare Services (including pharmacies, opticians and other legal entities licensed by the Healthcare Facility).

1.5. **Partner** means an enterprise, institution, or organisation providing services and/or selling supplies to the Insured under a cooperation agreement concluded with the Insurer.

1.6. **Beneficiary of the Insurance Benefit** is the Partner or the Insured, or the successors to their rights and obligations, and heirs who are entitled to the Insurance Benefit or part thereof in accordance with the Insurance Contract entered into and/or in accordance with the procedure and under the terms and conditions laid down by the applicable law.

1.7. **Insurance Contract** refers to a contract between the Insurer and the Policyholder (hereinafter referred to as the Parties) under which, in case of an Insured Event, the Insurer undertakes, in accordance with the procedure and for the consideration provided for in the contract, to pay the Insurance Benefit to the Beneficiary of the Insurance Benefit, and the Policyholder undertakes to pay the Premiums in due time and fulfil other obligations assumed by the contract.

1.8. **Insurance Contract/Policy** means a document issued by the Insurer confirming the conclusion of an insurance contract and setting out the essential terms and conditions of the insurance contract.

1.9. **Terms and Conditions** means the present terms and conditions of Voluntary Health Insurance applied to the insurance contract.

2. INSURANCE OBJECT

2.1. **Insurance Object** is the Insured's property interests related to his/her health and care.

2.2 **Insurance Period** is the period of time between the start and the end of the Insured's Coverage which does not necessarily overlap with the period of the Insurance Contract. The Insurance Period is the period from the start of the Insurance Contract, when the Insured is on the list of the Insured, or from the date of start of the coverage as specified in the Insurance Contract or its Annex, when the Insured is included in the Insurance Contract during its validity period, to the expiry of the Insurance Contract or, by individual agreement between the Parties, to the date of termination of the insurance coverage of the Insured or to the end of the employment contract concluded with the Insured.

2.3. **Insurance Coverage** refers to the Insurer's obligation to pay the Insurance Benefit in case of an Insured Event.

2.4. **Insurable Event** means the expenses incurred during the Insurance Period for the services rendered and/or supplies sold to the Insured during the Insurance Period, which are specified in the Insurance Contract and in the selected Insurance Programmes as insurable expenses.

2.5. **Uninsurable Event** means the events or circumstances that have occurred or non-insurable expenses that have been incurred, for which the Insurer does not pay the Indemnity.

2.6. **Insurance Programme** (or Risk) is a group of insurable and non-insurable expenses. Where, in case of an Insured Event, part of the expenses of a service or good is indemnified by one insurance programme, the remaining part of the expenses of the same service or good cannot be indemnified by another insurance programme.

2.7. **Territory of Validity of Insurance Coverage** is the territory in which the expenses incurred in case of an Insurable Event are insurable by the Insurance Coverage. Insurance coverage shall be applied in the Republic of Lithuania.

3. SUM INSURED AND COMPENSABLE PART

3.1. **Sum Insured** (or Limit) refers to an amount of money equal to the maximum Insurance Benefit payable for one or all Insured Events in the aggregate for that Insured Programme during the Insurance Period. Once the Insurer has paid out the Sum Insured, its liability under the Insurance Contract (Sum Insured) for a specific Insured Person for a specific Insurance Programme shall be reduced by the amount of the Sum Insured, i. e. the Sum Insured shall not be reinstated.

3.2. **Reimbursable Part** (or Paid Part) is the amount (in percentage) specified in the Insurance Contract in the Insurance Programme, equal to the portion of the Insurable Expenses to be paid by the Insurer in case of an Insured Event.

3.3. **Non-Reimbursable Part** (or Deductible) means the portion of the Insurable Expenses not paid by the Insurer in case of an Insured Event, which is reimbursed by the Insured himself/herself and which cannot be reimbursed by any Insurance Programme.

4. SPECIFIC TERMS OF VOLUNTARY HEALTH INSURANCE

4.1. **Health Disorder** is an exacerbation (including spontaneous change of the formation) of a chronic illness diagnosed to the Insured, or a change in the state of health of an unidentified but chronically symptomatic condition, as well as an acute illness or Injury, for which the Insured has applied to a healthcare facility for a Clinical Symptom and for which, in accordance with the Medical Indications, diagnostic tests are performed and treatment is applied.

4.2. **Medical Indications** refers to the medical symptom/symptoms described in the medical certificate for which the Insured has sought care at a healthcare facility and which are considered by a competent doctor to be an objective reason for specific tests to diagnose those symptoms, and the results of the examination and tests of the Insured's state of health carried out in response to the Insured's complaints regarding the Clinical Symptom/Symptoms, which are considered by the competent medical practitioner an objective reason for performing the procedures and applying the necessary treatment.

4.3. **Clinical Symptom** is a sign/symptom that indicates a disorder, pathological condition or illness in the body, such as fever, nausea, vomiting, suppuration, pain, signs of a change in a formation).

4.4. **Follow-up** is medical examinations and tests required by the doctor at intervals specified in the doctor's medical records to regularly monitor the progression/occurrence of the Insured's diagnosed chronic illness and to assess the post-operative condition.

4.5. **Non-traditional medical services** means acupuncture, reflexotherapy, endobiogenic medicine, electro-acupuncture, bioresonance computer diagnostics, colonic irrigation, phytotherapy, leech treatment, lithotherapy, aero-phytotherapy, music therapy, chronotherapy, ozone therapy, prolotherapy and other services included in non-traditional medicine, as well as other services of non-traditional medicine.

4.6. **Injury** is damage to the integrity of the tissues caused by an unexpected impact of external forces beyond the Insured's control, resulting in a disruption of the Insured's body.

4.7. **Medical Measures** means medical aids, medical devices, and orthopaedic supplies.

4.8. **Medical Aids** refers to bandages (gauze, silicone, hydrocolloid), alginate, hydrogel, gauze, patches, cotton wool, nasal swabs, disposable syringes (without medicines), pipettes, syringe, needles, drip systems, catheters, PORT catheter needles, glucose diagnostic strips, stents, stomas, urine and faeces collectors, thimbles, probes, tourniquets, haemostatic sponges, and other medical supplies.

4.9. **Medical Devices** refers to blood pressure monitors, glucometers, inhalers, hearing aids, infusion pumps and other medical devices.

4.10. **Orthopaedic Supplies** means therapeutic body coverings for burns, spinal, upper or lower limb splinting systems, prosthetic systems for arms and legs, special orthopaedic footwear to treat leg deformities, orthopaedic inserts, elastic or compression stockings, post-operative corsets, belts and shoes, crutches, canes and other orthopaedic supplies.

4.11. **Orthopaedic Equipment** is walkers, walking frames, mechanical wheelchairs, rollers, heel protectors, orthopaedic/ergonomic, repositioning and other pillows, as well as other orthopaedic equipment.

4.12. **Nursing Equipment** is toilet-shower chairs/benches/steps, bath hoist/board, grab rails, transfer board, wheelchair ramp, patient furniture (tables, steps, beds, couches, shifts, cabinets, functional beds, mattresses, backrests, and more), oxygen machines, electric wheelchairs and other nursing equipment.

4.13. **Health/Rehabilitation Equipment** refers to massage tables or chairs, fitness equipment, massagers, exercise mats, balls, weights, rubbers, bouncers and other equipment for rehabilitation, physiotherapy and exercises and treatments.

4.14. **Diagnostic Supplies** refers to thermometers, testers, tests, diagnostic biochemical kits, dispo-

sable containers for urine, faeces and other samples, containers, test tubes and other diagnostic supplies.

4.15. Protective and disinfecting equipment means sterile wipes, shoe covers, disposable masks or face shields, disinfecting liquids, disposable gloves, disposable gowns and other protective and disinfecting equipment.

4.16. Medicinal products are medicines, vitamins, food supplements and other products registered in the Register of Medicinal Products of the Ministry of Health of the Republic of Lithuania or the European Community.

4.17. Pharmacy (e-pharmacy) is a legal entity registered in the Republic of Lithuania or a branch of a legal entity, which has a pharmacy licence.

4.18. ATC code is Anatomical-Therapeutic-Chemical Code.

4.19. CHIF is Compulsory Health Insurance Fund.

4.20. Long-term care, supportive care means permanent, long-lasting care for the elderly, disabled people and patients with chronic illnesses, including services at home, nursing care institution, medical centre, and social welfare institution.

4.21. Health Insurance Card means a physical or electronic card issued by the Insurer to the Insured with a unique number, entitling the Insured to benefit from the Insurance Coverage provided to him/her under the Insurance Contract.

INSURANCE PROGRAMMES

5. OUTPATIENT TREATMENT

5.1. According to this Insurance Programme, an Insurable Event shall be deemed to be the expenses incurred for outpatient healthcare services provided to the Insured due to his/her **Health Disorder** during the Insurance Period and/or for the **follow-up** prescribed by a doctor in a **Healthcare Facility** during the Insurance Period.

5.2. Insurable Expenses are the expenses of the following outpatient healthcare services:

5.2.1. Consultations with a general practitioner or a specialist, including remote consultations and home visits. A consultation with a diagnostic physician (e.g. echoscopist, endoscopist, radiologist) shall not be considered as a consultation with a specialist for the purposes of this paragraph.

5.2.2. Diagnostic tests prescribed by a doctor (excluding tests prescribed by a diagnostic physician, such as an echoscopist, endoscopist, radiologist, sports medicine doctor, or a doctor of physical and medical rehabilitation or a specialist in non-traditional medicine), including the cost of the diagnostic physician's own consultation/description of the test and the cost of the test's being recorded on a medium or otherwise made available:

5.2.2.1. Laboratory tests: Clinical, biochemical, immunoenzymatical, hormonal, microbiological-bacteriological, cytological-histological and other laboratory tests.

5.2.2.2. Instrumental tests: Computed tomography, magnetic resonance imaging and positron emission tomography.

5.2.2.3. Other radiological, ultrasound, endoscopic and other instrumental tests.

5.2.3. Nursing and therapeutic procedures (including during home visits) carried out under the prescription of a doctor or nurse practitioner.

5.3. For the purposes of this insurance programme, an Insurable Event shall also be deemed to be expenses incurred for the following outpatient health care services provided to the Insured during the Insurance Period in a **Health Care Facility**:

5.3.1. Consultations and psychotherapy with licensed professionals, up to a maximum of 15 (fifteen) visits (including consultation) to the Insured during the Insurance Period by a psychiatrist, a psychiatrist-psychotherapist, a medical psychologist-psychotherapist, a medical psychologist, and a medical doctor-psychotherapist.

5.3.2. Consultations with a homeopath or endobiogenicist on a Health Disorder during the Insurance Period.

5.3.3. Nail fungus treatment.

5.4. If additionally agreed and specified in the Insurance Contract, the following outpatient healthcare services shall also be considered **Insurable Expenses**:

5.4.1. Day surgery services:

5.4.1.1. Day surgery service is defined as a service which is defined in the Order of the Minister of Health of the Republic of Lithuania in force on the date of the Insurable Event and is included in the list of day surgery services specified in this Order.

5.4.1.2. Expenses are only payable if the Health Disorder and the need for its treatment have been diagnosed by a competent doctor during the Insurance Period. This clause shall not apply if the Insured is insured under this insurance programme by the Insurer's company continuously for the same coverage, i.e. when the starting point of one Insurance Contract, during the Insurance Period of which the provision of a day-surgery service is provided, coincides with the ending point of another Insurance Contract, during the Insurance Period of which the necessity for the treatment has been established.

5.4.1.3. Coverage is also available in cases where the expenses (all or part of the expenses) are not indemnified by the CHIF, but in such a case an Insurance Benefit limit of EUR 1,000 shall be applied.

5.4.1.4. If the Insured and/or the Partner informs in writing about planned receipt/provision of day surgery services, the Insurer shall inform about the scope of coverage for these services and the (non-)indemnified expenses before the scheduled date of the surgery (unless the request is made less than 3 days before the scheduled date of surgery).

5.4.1.5. Insurable expenses also include expenses for medical aids, protective and disinfecting equipment, diagnostic supplies, disposable instruments, medicines, and implants used by healthcare professionals in the course of providing the services covered by this insurance programme. These expenses shall only be indemnified if the insurance programme also indemnifies the cost of the healthcare service that uses these supplies or instruments.

5.4.2. Treatment/removal of nevi (including the cost of histological examination of the removed nevus or part of it) when the Insured, at the time of application for this Health Disorder during the Insurance Period, is diagnosed by a specialist physician as atypia or dysplasia of the nevus by the results of an examination (siascopic, dermatoscopic, digital dermoscopic).

5.4.3. Food allergen testing.

5.4.4. Consultations with a dietitian.

5.4.5. Treatment/removal of warts (including the cost of histological examination of the removed formation or part thereof) under Medical Indications during the Insurance Period.

5.5. Non-insurable expenses are expenses for the following:

5.5.1. Medicines (except for the expenses listed in the section 'Insurable Expenses').

5.5.2. Food intolerance tests.

5.5.3. Consultations with a physical and medical rehabilitation doctor.

5.5.4. Consultations with a sports medicine doctor.

5.5.5. Consultations with a geneticist.

5.5.6. Dermatological treatment (including removal for diagnostic or other purposes) and the use of functional, diagnostic equipment, instruments directly related to dermatological treatment (including phototherapy, photodynamic therapy, pulsed light therapy, laser treatment, and sclerotherapy): skin and/or subcutaneous lesions (including papillomas, molluscs, atheromas, lipomas, and vascular lesions), keratoses, spots, pigmentation disorders, acne, scars, stretch marks, rosacea, acne and/or other dermatological conditions (except for the expenses referred to in the section 'Insurable Expenses').

5.5.7. Treatment (including removal for diagnostic or other purposes) of non-malignant tumors/benign formations of internal organs (including all formations not classified as skin and/or subcutaneous formations).

5.5.8. Treatment of oncological diseases.

5.5.9. Treatment of varicose veins, unless the CEAP grade is C4 or higher.

5.5.10. Genetic testing.

5.5.11. Diagnosis of sexually transmitted diseases (syphilis, gonorrhoea, trichomoniasis, chlamydiosis, human papillomavirus, herpes genitalis, etc.), including diagnosis of any growths on the external genital area, the anal area, as well as of AIDS and HIV.

5.5.12. Septoplasty surgery (including conchoplasty when the surgical protocol included a septoplasty).

5.5.13. Day Surgery Services for the upper eyelid/eyelids, if the case does not meet both of the following conditions - the results of a CT scan by an ophthalmologist confirming that the eyelid covers more than half of the pupil and the expenses are partly indemnified by the CHIF - and Day Surgery Services for the lower eyelid/eyelids.

5.6. Non-insurable expenses also include any expenses related to:

5.6.1. Potency disorders.

5.6.2. Inability to conceive, fertility/infertility.

5.6.3. Hair thinning, hair loss.

5.6.4. Pregnancy, childbirth or medical conditions whose onset or exacerbation has been affected by pregnancy, childbirth or breastfeeding.

5.6.5. Hyperopia, myopia, astigmatism, and strabismus.

5.6.6. Prevention of dental, oral and/or maxillofacial diseases or other dental, oral and/or maxillofacial health problems, including the consequences of trauma.

5.6.7. Using stem cells or autologous products.

5.6.8. Eating disorders, obesity, and overweight.

5.6.9. Blood plasma, hyaluronic, botulinum treatments (injections, vaporisation, etc.).

5.6.10. Immunotherapy.

5.6.11. Contraception.

5.6.12. Sleep disturbance.

5.6.13. VO2 max tests, as well as SIBO/intestinal dysbacteriosis tests.

5.6.14. Prolotherapy and other regenerative treatments.

5.6.15. Psychologist and clinical psychologist services.

5.6.16. Occupational physician services.
5.6.17. Non-traditional medical services, including tests and procedures prescribed by specialists providing these services (except for the expenses listed in the section 'Insurable Expenses').
5.6.18. Tests, procedures and treatments performed or prescribed by a sports medicine doctor.
5.6.19. Medical rehabilitation treatments, including any wave therapy treatment, and consultations with the professionals carrying out these treatments.

6. INPATIENT TREATMENT

6.1. **According to this Insurance Programme, an Insurable Event** shall be deemed to be the expenses incurred for inpatient healthcare services provided to the Insured in a public or private **Healthcare Facility** for a **Health Disorder** during the Insurance Period.

6.2. **Insurable Expenses** are expenses for the following inpatient healthcare services provided during **inpatient treatment**:
6.2.1. Single or double ward (if the service is provided in a private healthcare facility, the limit of the Insurance Benefit is EUR 30 per day).
6.2.2. Medical consultations, diagnostic tests, nursing care, therapeutic procedures, and surgeries (if the service/services is/are provided in a private healthcare facility, the expenses are indemnified at 50% of the amount and the total limit of the Insurance Benefit is EUR 150 per Insured during the Insurance Period).

6.3. **Insurable Expenses** also include the cost of the following items purchased/rented **after or during the hospitalisation at a healthcare facility, Pharmacy, in a specialised orthopaedic shop with a hygiene passport** (including e-commerce of all of the aforementioned facilities):
6.3.1. The inpatient records specify as follow: Medicines, Medical aids and Orthopaedic supplies (if the inpatient treatment service is provided in a private Healthcare Facility, the total Insurance Benefit limit for all these items is EUR 50 per Insured per Insurance Period).
6.3.2. Orthopaedic equipment (the Insurance Benefit limit for these expenses is EUR 100 per Insured per policy period).
6.3.3. Nursing equipment (the Insurance Benefit limit for these expenses is EUR 100 per Insured per policy period).
Indemnification of the expenses of these items is only available if the in-patient treatment during or after which the purchase/rental of these items is necessary is considered an Insurable Event under this insurance programme.

6.4. **Non-insurable** expenses are expenses for the following:
6.4.1. Implants, prostheses, and medical devices inserted into the human body.
6.4.2. Treatment of oncological diseases, including medications for oncological diseases.
6.4.3. Vision correction surgery for hyperopia, myopia and astigmatism.
6.4.4. Vision correction surgery for strabismus.
6.4.5. Dermatological treatment (including removal for diagnostic or other purposes) and the use of functional, diagnostic equipment, instruments directly related to dermatological treatment (including phototherapy, photodynamic therapy, pulsed light therapy, laser treatment, and sclerotherapy): skin and/or subcutaneous lesions (including papillomas, molluscs, atheromas, lipomas, and vascular lesions), keratoses, spots, pigmentation disorders, acne, scars, stretch marks, rosacea, acne and/or other dermatological conditions (except for the expenses referred to in the section 'Insurable Expenses').

6.5. **Non-insurable expenses** also include any expenses related to:
6.5.1. Day hospital and day surgery services.
6.5.2. Potency disorders.
6.5.3. Inability to conceive and infertility.
6.5.4. Hair thinning, hair loss.
6.5.5. Pregnancy, childbirth or medical conditions whose onset or exacerbation has been affected by pregnancy, childbirth or breastfeeding.
6.5.6. Hyperopia, myopia, astigmatism, and strabismus.
6.5.7. Prevention of dental, oral and/or maxillofacial diseases or other dental, oral and/or maxillofacial health problems, including the consequences of trauma.
6.5.8. Using stem cells or autologous products.
6.5.9. Eating disorders, obesity, and overweight.
6.5.10. Contraception.
6.5.11. Sleep disturbance.
6.5.12. VO2 max tests, as well as SIBO/intestinal dysbacteriosis tests.
6.5.13. Prolotherapy and other regenerative treatments.
6.5.14. Non-traditional medical services, including tests and procedures prescribed by specialists providing these services.
6.5.15. Medical rehabilitation treatments, including any wave therapy treatment, and consultations with the professionals carrying out these treatments, and consultations by a physical and medical rehabilitation doctor.
6.5.16. Blood plasma, hyaluronic, botulinum treatments (injections, vaporisation, etc.).
6.5.17. Mental diseases.

7. MEDICINES WITH/WITHOUT PRESCRIPTION, VITAMINS, AND FOOD SUPPLEMENTS

7.1. **According to this Insurance Programme, the Insurable Event** is the cost of supplies purchased (or rented) for the Insured during the Insurance Period at a **Healthcare Facility, Pharmacy or a specialised orthopaedic shop with a hygiene**

passport (including e-commerce of all of the aforementioned facilities).

7.2. Depending on the coverage chosen in the Insurance Contract, the following supplies may be considered as Insurable expenses:

7.2.1. **Insurance programme 'Medicines on Prescription'. Prescription or other medical document confirming the prescription for the Insured by a physician**: Medicinal products with an ATC code, homeopathic, medicinal products of plant and animal origin, medical aids, and orthopaedic supplies.

7.2.2. **Insurance programme 'Over-the-Counter Medicines, Vitamins and Food Supplements'**. Medicinal products for which there is no prescription or other document confirming the prescription of the medicinal product, including homeopathic, medicinal products of plant and animal origin, and Medical Aids.

7.3. Non-insurable expenses are expenses for any of the following items for any purpose:

7.3.1. Diagnostic products.
7.3.2. Medical devices.
7.3.3. Orthopaedic equipment.
7.3.4. Nursing techniques.
7.3.5. Protective and disinfecting products.
7.3.6. First aid supplies and kits.
7.3.7. Weighing scales and heaters.
7.3.8. Products for pregnant and breastfeeding women, babies and children;
7.3.9. Hygiene supplies, including nappies, pads, mats, waterproof sheet, oral hygiene and other supplies.
7.3.10. Cosmetic products, including creams, hair, skin, nail care, fake tan products, make-up, make-up removers and other products.
7.3.11. nsect and sun protection products.
7.3.12. Food products including water, juice extracts and other drinks, as well as haematogen, energy bars, glucose tablets and other products.
7.3.13. Blood plasma, hyaluronic acid, and botulinum.
7.3.14. Medicinal products affecting the reproductive system, including contraceptives.
7.3.15. Medicines that affect potency.
7.3.16. Medicines for weight management.
7.3.17. Medicines for systemic enzyme therapy.
7.3.18. Vaccines.
7.3.19. Contrast, diagnostic or therapeutic radioactive materials or other devices for testing.
7.3.20. Food supplements for athletes.

8. DENTAL TREATMENT

8.1. According to this Insurance Programme, the Insurable Event is the expenses incurred for dental services provided to the Insured during the Insurance Period in a **Health Care Facility**.

8.2. Insurable expenses are the expenses of the following dental services:

8.2.1. Oral hygiene: Oral hygiene check-up, removal of hard and soft plaque, fluoride applications, and a consultation with an oral hygienist (hygiene education).
8.2.2. Radiological examination of the teeth and/or jaw.
8.2.3. Dental treatment: Dental consultation, dental treatment (including anaesthesia, tooth extraction), endodontic treatment, periodontal treatment, restoration of defects in the hard tissues of the tooth with fillings, inlays, overlays and veneers.
8.2.4 Dental prosthetics: Dental consultation for dentures, implants and orthodontic treatment, fabrication, restoration and repair of removable and non-removable dentures, dental implants (including fabrication of dental implants and restoration of the jaw prior to the planned implant placement).
8.2.5. Dental consultation for treatment, treatment with braces, orthodontic aligners, orthodontic plates, orthodontic trays, including the cost of braces, orthodontic aligners, and orthodontic plates.
8.2.6. Consultations with an oral and maxillofacial surgeon, surgical treatment of dental and/or jaw diseases, consequences of trauma, and diseases of the oral cavity.
8.2.7. Protective and disinfecting products used by dental professionals.

8.3. Non-insurable expenses are expenses for the following:

8.3.1. Teeth whitening, veneering, and aesthetic restorations (except when aesthetic restorations are carried out to restore dental function or address adverse health effects).
8.3.2. Protective, sports, and bleaching orthodontic aligners.
8.3.3. Myorelaxant orthodontic aligners.
8.3.4. Anti-snoring mouthguards.
8.3.5. Dental jewellery, hygiene and other dental products.

9. OPTICS

9.1. According to this Insurance Programme, the Insurable Event shall be deemed to be the cost of vision-related services provided to the Insured during the Insurance Period in a **Healthcare Facility or a specialised shop (opticians, contact lens shops) with a hygiene passport**, including e-commerce in all these establishments, or of the purchase of optical supplies by the Insured.

9.2. Insurable expenses are expenses for the following vision-related services or optical supplies:

9.2.1. A preventive eye check-up, including a medical consultation.
9.2.2. Consultation by an ophthalmologist or optometrist, including consultations on farsightedness, myopia, astigmatism, strabismus and/or the selection of optical instruments.

9.2.3. Prescriptions for the Insured, as prescribed by a doctor or other medical document confirming the prescription: corrective spectacles (spectacle lenses, spectacle frames purchased with spectacle lenses) or contact lenses, including the manufacturing service for such supplies (and in cases where only the manufacturing service is provided).

9.2.4. Moisturising eye drops/artificial tears and contact lens cleaning solution.

9.2.5. Vision correction surgery for hyperopia, myopia and astigmatism.

9.2.6. Vision correction surgery for strabismus. Expenses are only indemnified if the necessity of the treatment has been established by a competent doctor during the Insurance Period, and are partially indemnified by the CHIF.

9.3. **Non-insurable expenses** are expenses for the following:

9.3.1. Non-dioptric spectacles.

9.3.2. Spectacle care products and accessories (e.g. spectacle cases, cleaners, and wipes).

9.3.3. Supplements and medicinal products.

10. MEDICAL REHABILITATION

10.1. **According to this Insurance Programme, the Insurable Event** is the expenses of medical rehabilitation services provided to the Insured in a Healthcare Facility for a Health Disorder during the Insurance Period. When concluding the Insurance Contract, the Policyholder may choose one of two **insurance options** for the Medical Rehabilitation Programme - 'Medical Rehabilitation' or 'Medical Rehabilitation after 72 hours of Inpatient Treatment'. The latter differs from 'Medical Rehabilitation' in that the expenses described in this section can **only** be indemnified in respect of rehabilitation if the Insured has been receiving **inpatient** treatment in a healthcare facility for a continuous period of **at least 72 hours** as a result of the Health Disorder.

10.2. **Insurable expenses** are the cost of the consultation with a physical medicine and rehabilitation doctor and the services specified in the rehabilitation programme (including the cost of a consultation with specialists who provide such services):

10.2.1. Physiotherapy (halotherapy, electrotherapy, magnetotherapy, ultrasound therapy, aerosol therapy, inhalation, phototherapy, hydrotherapy (water), pelotherapy (mud, paraffin), and other physiotherapy procedures).

10.2.2. Physiotherapy.

10.2.3. Occupational therapy.

10.2.4. Therapeutic massages.

10.2.5. Manual therapy.

10.2.6. Logotherapy.

10.2.7. Psychological support, but only if it is specified as an additional necessary support in the rehabilitation programme to any of the medical rehabilitation services listed above.

10.3. Indemnification is only possible if the need for medical rehabilitation is indicated by a prescription from the doctor treating the Health Disorder for which the medical rehabilitation is prescribed (prescriptions from a doctor of physical and medical rehabilitation, a doctor of sports medicine are not valid). Having selected the insurance programme 'Medical Rehabilitation after 72 hours of Inpatient Treatment', the prescription for medical rehabilitation by the doctor treating the Health Disorder must be issued not later than 30 calendar days from the date of the last day of the last inpatient treatment for that Health Disorder in a Healthcare Facility.

10.4. **Non-insurable expenses** are expenses where medical rehabilitation is prescribed for:

10.4.1. Pregnancy, childbirth or health disorders caused by pregnancy, childbirth or breastfeeding.

10.4.2. Eating disorders, obesity, and overweight.

10.4.3. Sleep disorders.

10.4.4. Exhaustion and overwork.

10.4.5. Mental illness.

10.5. **Non-insurable expenses** also include:

10.5.1. Facial massages and cosmetic treatments.

11. VACCINATION

11.1. **According to this Insurance Programme, an Insurable Event** is the expenses of a vaccination service provided to the Insured during the Insurance Period in a **Healthcare Facility**, including a consultation and vaccine.

12. PREVENTIVE HEALTH EXAMINATONS

12.1. **According to this Insurance Programme, the Insurable Event** is the expenses of preventive healthcare services provided to the Insured during the Insurance Period in a Healthcare Facility.

12.2. **Insurable expenses** are the expenses of the following healthcare services:

12.2.1. Legally required employee medical examinations based on job type, aimed at determining their fitness to work.

12.2.2. Health check-ups for obtaining medical certificates.

12.2.3. Health check-ups in accordance with disease prevention programmes carried out in the territory of the Insurance Coverage or established and approved by the Healthcare Facilities.

12.2.4. Consultations and/or laboratory and instrumental tests by a general practitioner and specialist doctors, regardless of whether there is a Health Disorder or whether the consultations/tests are performed for preventive purposes.

12.2.5. Consultations and psychotherapy by licensed professionals: Psychiatrist, psychiatrist-psychotherapist, medical psychologist-psychotherapist, medical psychologist, and medical doctor-psychotherapist.

12.2.6. Consultations with a homeopath or endobiogenicist.

12.2.7. Allergen-specific immunotherapy.

12.3. Non-insurable expenses are expenses for the following:
- 12.3.1. Food intolerance tests.
- 12.3.2. Consultations with a physical and medical rehabilitation doctor.

12.4. Non-insurable expenses also include any expenses related to:
- 12.4.1. Potency problems, inability to conceive, and infertility.
- 12.4.2. Hair thinning, hair loss.
- 12.4.3. Pregnancy, childbirth or health disorders caused by pregnancy, childbirth or breastfeeding.
- 12.4.4. Prevention of dental, oral and/or maxillofacial diseases or other dental, oral and/or maxillofacial health problems, including the consequences of trauma.
- 12.4.5. Eating disorders.
- 12.4.6. Contraception.
- 12.4.7. Sleep disturbance.
- 12.4.8. Psychologist and clinical psychologist services.
- 12.4.9. Non-traditional medical services (except for the expenses listed in the section 'Insurable Expenses').
- 12.4.10. Medical rehabilitation services, including advice from professionals providing such services.

13. PRENATAL CARE

13.1. According to this Insurance Programme, an Insurable Event is the cost of healthcare services provided to the Insured during the Insurance Period in a **Healthcare Facility** for pregnancy or childbirth.

13.2. Insurable expenses include the cost of periodic antenatal check-ups, ambulance services, medical consultations, tests, nursing and medical procedures, surgeries, and private ward:
- 13.2.1. Monitoring the progress of pregnancy or the general condition of the pregnant woman and/or the fetus/fetuses (including genetic testing of the fetus/fetuses).
- 13.2.2. For complications of pregnancy or termination of pregnancy on medical grounds.
- 13.2.3. For childbirth, postnatal care (including the actual cost of the doctor and/or midwife of the Healthcare Facility chosen in advance) and breastfeeding.
- 13.2.4. For health disorders caused by/exacerbated by pregnancy, childbirth or breastfeeding.

13.3. Insurable Expenses also include expenses for:
- 13.3.1. Medical aids, protective and disinfecting products, diagnostic supplies, disposable instruments and hygiene products used by healthcare professionals in the provision of the services covered by this insurance programme. These expenses shall only be indemnified if the insurance programme also indemnifies the cost of the healthcare service that uses these supplies or instruments.
- 13.3.2. Medical rehabilitation treatments for pregnant women, including services, such as prenatal exercise and water aerobics.

13.4. Non-insurable expenses include expenses for:
- 13.4.1. The cost of a private ward for the parent of a newborn baby.
- 13.4.2. Non-traditional medical services.

13.5. Non-insurable expenses also include any expenses related to:
- 13.5.1. Prevention of dental, oral and/or maxillofacial diseases or other dental, oral and/or maxillofacial health problems, including the consequences of trauma.
- 13.5.2. Hyperopia, myopia, astigmatism, strabismus, and eye examination.

14. CRITICAL ILLNESSES

14.1. The Insurable Event under this insurance programme shall be deemed the cost of health care services provided to the Insured during the Insurance Period, or supplies hired or purchased by the Insured for the purpose of follow-up or treating his/her Health condition, after a diagnosis of a disease included in the list of Critical Illnesses has been made for the first time in his/her life during the Insurance Period (the insurance programme 'Treatment of Critical Illnesses'), or, in the case of the lump sum insurance option, the **Insurable Event** shall be deemed to be the first diagnosis in the Insured's lifetime during the Insurance Period of an illness listed in the 'Treatment of Critical Illnesses' (the insurance programme 'Treatment of Critical Illnesses').

14.2. For the purposes of the Terms and Conditions, an illness diagnosed for the first time in a lifetime during the Insurance Period shall be deemed to be only an illness for which the totality of the Medical Indications, including the Injury that caused the diagnosis, occurs during the Insurance Period.

14.3. Insurable expenses are expenses incurred in a **Healthcare Facility** for the following healthcare services:
- 14.3.1. Consultations with a general practitioner, specialist doctor, diagnostics, nursing and treatment procedures, and surgeries.
- 14.3.2. Single or double ward.
- 14.3.3. Medical rehabilitation: Physiotherapy, kinesitherapy, occupational therapy, therapeutic massages; manual therapy, and logotherapy.
- 14.3.4. Consultations and psychotherapy with a psychiatrist, psychiatrist-psychotherapist, medical psychologist, medical psychologist-psychotherapist, and medical doctor-psychotherapist.

14.4. Insurable expenses also include the cost of the supplies purchased, rented or used by Healthcare Professionals in a **Healthcare Facility, Pharmacy or a specialised shop with a hygiene passport**, including e-commerce in all of the abovementioned facilities:
- 14.4.1. Medicines. In the case of oncological disease, indemnification of medicines is only possible if all of the following conditions are met:

14.4.1.1. The medicines are approved by the European Medicines Agency.
14.4.1.2. The medicines have been prescribed in accordance with the recommendations of the oncologist-chemotherapist.
14.4.1.3. The medicines are included in the list of medicines approved by the Territorial Health Insurance Funds of the Republic of Lithuania (coverage applies regardless of the cancer localisation or stage for which they are intended).
14.4.2. Medical supplies.
14.4.3. Infusion pumps.
14.4.4. Orthopaedic products.

14.5. Uninsurable Event is the case when:
14.5.1. A critical illness occurred within 45 (forty-five) days from the date of conclusion of the insurance contract (or the date of the Insured's inclusion in the insurance contract if the Insured is insured during the Insurance Period). This clause does not apply if the Insured is insured under this insurance programme on a continuous basis, i. e. when the moment of expiry of one Insurance Contract by which the Insured was insured under the Insurance Programme 'Critical Illnesses' overlaps with the moment of the start of another Insurance Contract.
14.5.2. Critical Illness, Injury or other circumstances leading to the Critical Illness **or clinical symptoms/indications of the Critical Illness** occurred prior to the conclusion of the Insurance Contract.
14.5.3. Diagnosis of a critical illness at a time when the Insured is infected with HIV or has AIDS.
14.5.4. Prior to the conclusion of the Insurance Contract, the Policyholder or the Insured has provided the Insurer with false or incomplete information about the circumstances under which the diagnosis of Critical Illness could have been expected to be made during the Insurance Period.

14.6. Non-insurable expenses also include:
14.6.1. Non-traditional medical services.

15. ADVANCED HEALTH INSURANCE

15.1. According to this Insurance Programme, an Insurable Event shall be deemed to be the cost of health care services provided to the Insured during the Insurance Period Coverage in a **Healthcare Facility** for the purpose of preventing or remedying a medical or physiological condition of the Insured which requires medical consultation, examination or treatment.

15.2. Insurable expenses are expenses for the following outpatient and inpatient healthcare services:
15.2.1. Consultations, diagnostic tests, nursing and therapeutic procedures and surgeries by general practitioners and specialists, whether or not prescribed by them, based on medical indications or for preventive purposes, including:
15.2.1.1. Vaccines and allergen-specific immunotherapy.
15.2.1.2. Prenatal care, childbirth, postnatal care and breastfeeding services.
15.2.1.3. Treatment/removal of atypical, dysplastic or prophylactic nevi.
15.2.1.4. Treatment/removal of warts, papillomas, molluscs, candiliomas, and keratoses based on medical indications or for prophylactic purposes.
15.2.1.5. Nail fungus treatment.
15.2.1.6. Upper eyelid surgery when the results of a CT perimetry examination by an ophthalmologist confirm that the eyelid covers more than half of the pupil and the expenses are partially indemnified by the CHIF.
15.2.2. Consultations and psychotherapy by licensed professionals: Psychiatrist, psychiatrist-psychotherapist, medical psychologist-psychotherapist, medical psychologist, and medical doctor-psychotherapist.
15.2.3. Consultations with a homeopath or endobiogenicist and other non-traditional medical services.
15.2.4. Consultations and treatments by medical rehabilitation specialists: Physiotherapy, kinesitherapy, occupational therapy, therapeutic massages; manual therapy, and logotherapy.
15.2.5. Consultations with a dietitian.
15.2.6. Food intolerance tests.
15.2.7. Dental services.
15.2.8. Eye check-up services.

15.3. Non-insurable expenses include expenses for the following services:
15.3.1. Body composition analysis tests.
15.3.2. Facial massages, non-therapeutic massages, and cosmetic treatments.
15.3.3. Teeth whitening, veneering, and aesthetic restorations (except when aesthetic restorations are carried out to restore dental function or address adverse health effects).
15.3.4. Blood plasma, hyaluronic, botulinum treatments (injections, vaporisation, etc.), including the products used for them.
15.3.5. Dermatological treatment (including removal for diagnostic or other purposes) and the use of functional, diagnostic equipment, instruments directly related to dermatological treatment (including phototherapy, photodynamic therapy, pulsed light therapy, laser treatment, and sclerotherapy): skin and/or subcutaneous lesions (including papillomas, molluscs, atheromas, lipomas, and vascular lesions), keratoses, spots, pigmentation disorders,

acne, scars, stretch marks, rosacea, acne and/or other dermatological conditions (except for the expenses referred to in the section 'Insurable Expenses').

15.3.6. Upper and/or lower eyelid/eyelids surgery (except for the expenses listed in the section 'Insurable Expenses').

15.4. Non-insurable expenses are any expenses related to:

15.4.1. Potency disorders.
15.4.2. Inability to conceive and infertility.
15.4.3. Hair thinning, hair loss.
15.4.4. Using stem cells or autologous products.
15.4.5. Sleep disturbance.
15.4.6. Eating disorders, obesity, and overweight.
15.4.7. Psychologist and clinical psychologist services.

15.5. According to this Insurance Programme, the Insurable Event shall also be deemed the cost of supplies purchased by the Insured during the Insurance Period at a **Healthcare Facility, Pharmacy or a specialised shop with a hygiene passport (for contact lenses, orthopaedics, opticians, etc.**), including e-commerce of all of the aforementioned facilities:

15.5.1. Medicinal products (including homeopathic products, medicinal products of plant and animal origin), medical aids, orthopaedic supplies.
15.5.2. Corrective spectacles (spectacle lenses, spectacle frames purchased with spectacle lenses) or contact lenses.
15.5.3. Braces, orthodontic aligners, orthodontic plates and other supplies used in dental treatment and prosthetic services.

15.6. Non-insurable expenses are expenses for the following items:

15.6.1. Non-dioptric spectacles.
15.6.2. Spectacle care products and accessories (e.g. spectacle cases, cleaners, and wipes).
15.6.3. Dental jewellery.
15.6.4. Such mouthguards as protective, sports, whitening, muscle-relaxing, and anti-snoring mouthguards.
15.6.5. Oral hygiene products.
15.6.6. Personal care and cosmetics products.
15.6.7. Pregnancy products.
15.6.8. Medical devices.
15.6.9. First aid supplies and kits.
15.6.10. Food products and drinks, including items such as haematogens, energy bars, juice extracts, glucose tablets and other such items.
15.6.11. Contraceptives.
15.6.12. Medicines to treat potency problems.
15.6.13. Weight loss and slimming products.

16. HEALTH PROMOTION SERVICE

16.1. Under this insurance programme, depending on the insurance coverage selected in the Insurance Contract, the Insurable Event may be considered to be the costs of health promotion services provided to the Insured during the Insurance Period, when the health promotion services are provided in a **Healthcare Facility, SPA Centre, Gym, Swimming Pool, Amusement Park or by any other person (natural or legal) licensed to engage in the relevant activity**.

16.2. Insurable Expenses include expenses for the following Health Promotion Services:

16.2.1. Rehabilitation services (including consultation with a specialist).
16.2.2. Body composition analysis, ergonomic body positioning tests.
16.2.3. Non-traditional medical services (treatments and consultations with specialists, including a homeopath).
16.2.4. Consultations with a dietician and nutritionist, and nutrition plan development.
16.2.5. Consultations and sessions by mental health professionals.
16.2.6. Individual or group classes in all physical activity sports, physical education services (including the cost of running the class, membership fees, hire of the hall/gym, including the inventory in them, and special clothing used).

16.3. If additionally agreed and specified in the Insurance Contract, the cost of hygiene products is also considered **the Insured Expenses**.

16.4. Non-insurable expenses include expenses for:

16.4.1. Event/participant/camp fees.
16.4.2. Facial massages.
16.4.3. Cosmetic procedures.
16.4.4. Hair removal treatments.
16.4.5. Entertainment services.

16.5. Where a subscription/multi-service package (e.g. treatments, classes) is purchased, the Insured shall be indemnified only for the expenses actually incurred by the Insured during the Insurance Period for the part of the subscription/multi-service package period overlapping with the Insurance Period.

17. AESTHETIC PROCEDURES

17.1. According to this Insurance Programme, the Insurable Event shall be deemed to be the expenses for services rendered to the Insured during the Insurance Period in a Healthcare Facility or other legal entity licensed to carry out the relevant activity for cosmetological, plastic, beauty and/or aesthetic purposes and/or aesthetic products purchased by the Insured during the Insurance Period.

17.2. Insurable Expenses include expenses for the following services:

17.2.1. Consultations with a medical specialist on procedures and/or surgeries for cosmetic, plastic, beauty and/or aesthetic purposes.
17.2.2. Cosmetic and beauty procedures (facial cleansing, aesthetics, body line enhancement, anti-cellulite, body scrubs, wraps, rubbing, hair removal, teeth whitening, lamination procedures, injections of blood plasma, hyaluronic acid, botulinum injections and other similar procedures).

17.2.3. Consultations on balding, hair loss, diagnosis and treatment.

17.3. Insurable Expenses include expenses for the following items:

17.3.1. Anti-scar, anti-hair loss, and anti-stretch mark products and other similar products.

18. GENERAL EXCLUSIONS

18.1. In any Insurance Programme, any expenses related to or arising from the following are considered Uninsurable Events:

18.1.1. Ionising radiation, radioactive contamination or exposure to any nuclear waste, chemical contamination, radioactive, toxic or other hazardous effects of a nuclear installation or component thereof, including explosion.

18.1.2. Pandemics, ecological or natural disasters, mass disasters caused by natural perils, or circumstances leading to a national state of emergency.

18.1.3. War, invasion, act of foreign enemies, seizure (whether or not war has been declared), civil war, rebellion, revolution, mass unrest, rebellion, act of military or usurped force, and act of terrorism.

18.1.4. Suicide attempt, intentional injury or injury resulting from mental illness.

18.1.5. Intent on the part of the Policyholder, Insured or Beneficiary.

18.1.6. As a result of the Policyholder or the Insured having committed acts which are considered a criminal offence under the legislation of the Republic of Lithuania.

18.1.7. Detention of the Insured or the Insured's failure to comply with the lawful demands of police officers.

18.1.8. The Insured's driving recklessly, or if the Insured was voluntarily in a vehicle that was being driven recklessly. Reckless driving is driving in violation of road traffic rules for the purpose of hooliganism, endangering road safety or the safety of oneself or others.

18.1.9. Use of alcohol, narcotic or toxic substances (used for the purpose of intoxication) or medicines not prescribed by a doctor, or addiction diseases.

18.1.10. The Policyholder, the Insured or another person related to them has worked on machinery without a legal basis or without the right to work on machinery of this type (i.e. without the appropriate qualifications, certificate, etc.).

18.1.11. Termination of pregnancy without medical indication or delivery outside a Healthcare Facility.

18.1.12. Treatment of sexually transmitted diseases (syphilis, gonorrhoea, trichomoniasis, chlamydiosis, human papillomavirus, herpes genitalis, etc.), including any formations on the external genital area, the anal area, as well as the treatment of AIDS, HIV, tuberculosis and the health problems they have caused.

18.1.13. Supportive care and/or long-term care.

18.1.14. Services/supplies provided by a facility and/or professional who does not hold a licence or hygiene passport valid for the activity in question at the date of the insured event.

18.1.15. Services/supplies provided by the Insured's spouse/cohabitant, parents or children.

18.1.16. Services/supplies provided not to the Insured or provided anonymously.

18.1.17. Services/supplies not supported by medical documentation, where required by the terms and conditions of the Insurance Contract, or where the date and circumstances of the services/supplies cannot be determined.

18.1.18. Services and/or supplies paid for but not yet delivered (advances).

18.1.19. Accommodation and/or meals, regardless of whether this service is provided as part of a service that is considered an Insured Expense.

18.1.20. Purchase of gift vouchers, group purchase /discount vouchers.

18.1.21. Renting or buying health/rehabilitation equipment.

18.1.22. Blood donation.

18.1.23. Organ/tissue and bone marrow transplants, haemodialysis (except in the insurance programme 'Critical Illness').

18.1.24. Endoprosthetics (except for the insurance programme 'Dental Treatment').

18.2. For all insurance programmes, except insurance programme 'Aesthetic Treatments', Uninsurable Events shall be considered any expenses related to:

18.2.1. Services for cosmetic, plastic, beauty and/or aesthetic purposes, including specialist consultations and treatments such as facial cleansing, body line enhancement, anti-cellulite, body scrubs, body wraps, body rubs, hair removal and other treatments, and mesotherapy.

18.2.2. Plastic, aesthetic and/or reconstructive surgeries and procedures, including laser or surgical treatments.

18.2.3. Purchase of beauty and aesthetic products, including products to treat acne, scars, stretch marks, prevent insect bites, etc.

GENERAL PART

1. CONCLUSION AND ENTRY INTO FORCE OF THE INSURANCE CONTRACT

1.1. The Insurance Contract is concluded after the Parties have agreed on the terms and conditions of the Insurance Contract for an agreed period, which, including the main terms and conditions of the Insurance Contract (the selected insurance programmes, the sums insured/limits, the indemnified portion of the expenses, the area of coverage, the list of Insured, and the premium),

shall be set out in the Insurance Contract. The period of the insurance contract is one year.

1.2. The insurance contract shall be deemed to have been concluded when the Insurer and the Policyholder sign the Insurance Policy or the Policyholder pays the premium specified in the Insurance Policy. Upon conclusion of the insurance contract, the Policyholder's written request and any information provided in writing shall become an integral part of the Insurance Contract.

1.3. The Insurance Coverage for the Insured shall come into force from the beginning of the Insurance Period specified in the insurance policy, upon the Insured's consent to the Insurer to process his/her health data for the purposes of assessing the insurance risk, concluding and executing the insurance contract, and for the purposes of investigating and administering the insured events or events that may be deemed to be insured. In the absence of consent, the Insurer will not be able to provide the Insured with the insurance services provided for in the insurance contract.

1.4. Before concluding an insurance contract, the Insurer shall have the right, but not the obligation, to request information and documents confirming the age, health, occupation and other circumstances relevant to the assessment of the insurance risk of the Insured.

1.5. The Policyholder and/or the Insured shall be responsible for the accuracy of the information provided to the Insurer.

1.6. The insurer has the right to refuse concluding an insurance contract in the event of an unacceptable insurance risk.

2. INSURANCE PREMIUM PAYMENT PROCEDURE

2.1. The amount of the insurance premium shall be calculated by the Insurer by assessing the insurance risk in accordance with the information provided by the Policyholder and/or the Insured and the insurance programme/programmes selected by the Policyholder, the sum/sums insured and the other terms and conditions of the Insurance Contract. If insurance premiums are taxable under the law, the applicable taxes are specified in the insurance policy and must be paid together with the insurance premium. Although the amounts of premiums and applicable taxes may be separated in the insurance policy, the insurance contract is considered properly paid only after the total amount—the insurance premium and applicable taxes—has been paid.If the total amount due is not paid on time or is not paid in full, the consequences that apply under the Terms and Conditions for failure to pay the insurance premium shall apply. In the event that a debt relationship arises between the insurer and the policyholder, the amounts recovered shall cover the insurance premiums and applicable taxes proportionally. If the Terms and Conditions provide for the Insurer's right to deduct insurance premiums from insurance benefits, they shall be deducted together with the applicable taxes.

2.2. The terms and methods of payment of the premium are specified in the insurance contract.

2.3. If all or the first amount payable under the insurance contract (where it has been agreed to set it out) is not paid on time, the Insurer shall also be entitled to claim interest at the rate of 0.02% of the unpaid amount for each day of delay.

2.4. If the Policyholder fails to pay the amount payable under the insurance contract, the Insurer shall notify the Policyholder, stating that if the Policyholder fails to pay for the insurance contract within 30 calendar days of the date of sending the notification, the Insurance Contract shall be terminated.

3. RIGHTS AND OBLIGATIONS OF THE PARTIES

3.1. **The Policyholder's rights** before the insurance contract is concluded are to:

3.1.1. Read the Terms and Conditions and obtain a copy thereof.

3.1.2. Submit to the Insurer an application in the prescribed form for the conclusion of an insurance contract.

3.2. Once the Insurance Contract has been concluded, the **Policyholder's rights** during the period of the Insurance Contract are:

3.2.1. In the cases provided for in the laws and the Insurance Contract, to request a change in the terms and conditions of the Insurance Contract, including a change of the list of the Insured, and the Beneficiary of the Insurance Benefit provided for in the Insurance Contract.

3.2.2. Terminate the Insurance Contract on the grounds provided for in the Terms and Conditions or by law.

3.3. **The Insurer's rights** before the insurance contract is concluded are to:

3.3.1. Require from the Policyholder all information, including information about the Insured, necessary to assess the insurance risk.

3.3.2. To refuse to conclude the insurance contract without providing any reasons.

3.4. Upon conclusion of the Insurance Contract, the **Insurer** shall have the **right** to require, during the period of the Insurance Contract, to amend the terms and conditions of the Insurance Contract, including the insurance premium, if the Policyholder has not properly fulfilled the obligation to disclose the material circumstances relevant to the assessment of the insurance risk as set out in the terms and conditions, or if the risk of the insurance risk changes:

3.4.1. The Insurer must notify the Insured in writing of its intention.

3.4.2. The terms and conditions of the Insurance Contract shall be deemed amended upon the Policyholder's acceptance of the amendments to the Insurance Contract, or 30 calendar days after the date of sending the notification to the Policyholder, if the Policyholder does not object to the amendments to the terms and conditions of the Insurance Contract within this time limit.

3.4.3. If the Policyholder does not agree with the amendments to the terms and conditions of the Insurance Contract, the Insurer shall have the right to unilaterally terminate the Insurance Contract 30 calendar days after sending the notice of the amendments of the terms and conditions of the Insurance Contract to the Policyholder. And if the amendment is required because of a change in the risk insured, to apply to the court for termination or amendment of the Insurance Contract in the event of a material change in circumstances.

3.5. **The policyholder's obligations** before the conclusion of the insurance contract are:

3.5.1. Together with the Insured, provide the Insurer with all information known to the Insurer about circumstances which may have a material impact on the assessment of the insurance risk, the probability of an Insurable Event and the occurrence or increase of potential losses. Material Circumstances are circumstances related to the activities of the Policyholder (or related undertakings) and the employee benefit programme which may lead to a significant change in the number of insured employees or other risk criteria (including, but not limited to, restructuring which would result in a change in the number of insured employees, bankruptcy, etc.), as well as the circumstances set out in the Insurance Contract or the Terms and Conditions, as well as circumstances which the Insurer has requested to be disclosed in addition to the above.

3.5.2. At the insurer's request, to fill in an application form to take out an insurance contract.

3.5.3. To notify the Insurer of all insurance contracts for the same risks of the insured object concluded with other insurance companies and terms and conditions thereof.

3.6. Once the Insurance Contract has been concluded, the **Policyholder's obligations** under the Insurance Contract are:

3.6.1. To pay the premiums stipulated in the Insurance Contract on due time.

3.6.2. Immediately, but no later than 7 calendar days:

3.6.2.1. To inform the Insured about the concluded Insurance Contract and the terms and conditions of Insurance Coverage it provides, their rights under the Insurance Contract and their obligations arising from the Insurance Contract.

3.6.2.2. Together with the Insured, to correct in writing any incorrect or incomplete information provided to the Insurer.

3.6.2.3. To inform the Insurer of the occurrence or change in material circumstances or any other increase in the insurance risk.

3.6.2.4. To inform the Insurer of the contact details specified in the Insurance Policy.

3.7. Upon conclusion of the Insurance Contract, **the obligations of the Policyholder and/or the Insured** in case of the event that may be considered an Insurable Event are to:

3.7.1. Inform the Insurer of the event by e-mail or by using the Insurer's self-service methods within the time limit specified in the Terms and Conditions.

3.7.2. Disclose to the Insurer full and complete information relevant to the circumstances of the event and to set the amount of the Insurance Benefit.

3.7.3. Inform the Insurer of all contracts concluded with other insurance companies for the same Insurance Coverage, where the interests of the Insured are insured, and the terms and conditions thereof.

3.7.4. Enable the Insurer, the Partner or the Insurer's authorised representative to determine freely and without hindrance the circumstances of the event and the amount of the damage.

3.7.5. To cooperate with the Insurer at all times during the settlement of the Insurable Event and comply with all instructions given by the Insurer.

3.8. **The Insurer's obligations** are to:

3.8.1. Acquaint the Policyholder with the Terms and Conditions and the terms and conditions of Insurance Coverage of the concluded Insurance Contract.

3.8.2. Not to disclose information about the Policyholder, the Insured or the Beneficiary of the Insurance Benefit without their consent.

3.8.3. Upon receipt of a notification from the Policyholder and/or the Insured about the event, to investigate its circumstances, calculate and pay the Insurance Benefit in due time and, in the cases prescribed by the legislation, inform the Policyholder, the Insured and the Beneficiary of the Insurance Benefit about the progress of the event regulation.

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

3.9.1. In the event of a transfer of rights and obligations by the Insurer, the terms and conditions of the Insurance Contract may be amended if the Insurer notifies the Policyholder in writing in advance and the Policyholder does not object to the amendments to the terms and conditions of the Insurance Contract within 60

calendar days from the date of the notification.

3.9.2. If the Policyholder disagrees with the Insurer's intention to transfer the rights and obligations under the Insurance Contract and submits a request for termination of the Insurance Contract, the Insurer is obliged to reimburse to the Policyholder the premium paid for the remaining term of the Insurance Contract without deducting the fees provided for in the Terms and Conditions.

3.9.3. If the Policyholder does not submit a written request for termination of the Insurance Contract within the time limits set out in the Terms and Conditions, it shall be deemed that the Policyholder agrees to the transfer of the rights and obligations arising from the Insurance Contract.

3.10. The Policyholder shall not be entitled to transfer its rights and obligations under the Insurance Contract without the written consent of the Insurer.

4. INSURANCE BENEFIT PAYMENT PROCEDURE

4.1. The Insurance Benefit is paid to the Beneficiary:

4.1.1. To the Insured, when he/she has paid for the services rendered/supplies purchased with his/her own funds, or in case of an Insurable Event under the insurance option 'Critical Illness' of the insurance programme, where a lump-sum payment is made, or

4.1.2. To the Partner, where the Insured has been provided with services/supplies by the Partner and the Insured has not paid for these services/supplies or has paid only the Insurer's Non-Indemnified Part.

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

4.2.1. The Insured must report the event in writing not later than within 90 calendar days after the date of the event.

4.2.2. The Insured must submit with the request for payment of the Insurance Benefit as follow:

4.2.2.1. **Documents proving the payment** for services/supplies: Cashier's receipt or money order or cash receipt order or cash receipt.

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

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

4.2.2.3. Relevant **medical documents** in accordance with the terms and conditions of the insurance programmes under the Terms and Conditions:

4.2.2.3.1. **Medical extract** giving details of the health disorder (course of the health disorder, examination, diagnosis and recommended treatment).

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

These documents must include the details of the medical facility that issued the medical extract or prescription, the date, and be signed and stamped by the doctor who issued them.

4.2.2.4. A document confirming the license of the service/goods supplier and/or the right to carry out activities valid on the date of the Insurable Event (e.g. self-employment certificate, business licence).

4.2.2.5. The Insurer has the right to request additional documents to substantiate the fact of the Insurable Event and the amount of the Insurance Benefit.

4.2.2.6. The Insurer has the right not to pay the Insurance Benefit if the documents submitted do not meet the requirements.

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

4.4. The Insurer shall have the right to delay payment of the Insurance Benefit in the following cases:

4.4.1. Until the Beneficiary has documented the fact of the Insurable Event and the amount of the expenses.

4.4.2. If there is a pre-trial investigation or court proceeding in progress in which a ruling, decision or verdict may affect whether or not the event is insured, until the ruling, decision or verdict is made and enters into force.

4.4.3. In other cases provided for by law.

4.5. The Insurance Benefit shall be paid not later than within 30 calendar days of the date of receipt of all the information relevant for adjusting the fact of the Insured Event, circumstances, consequences and the Insurance Benefit amount by the Insurer.

4.6. If, after the payment of the Insurance Benefit, it turns out that it should not have been paid to the Beneficiary of the Insurance Benefit under the Insurance Contract or should have been paid to a lower amount, the Insured shall, at the Insurer's written request, reimburse to the Insurer the Insurance Benefit or the overpaid amount and/or reimburse to the Insurer the amount of the Insurance

Benefit or the overpaid amount that the Insurer has paid to the Partner within 30 calendar days.

5. CALCULATION OF THE INSURANCE BENEFIT

5.1. The amount of the Insurance Benefit shall be determined by the Insurer in accordance with the terms and conditions of the Insurance Contract, taking into account the information provided by the Beneficiary of the Insurance Benefit and the Non-Indemnified Part. In order to establish the fact of the Insurable Event and the amount of the Sum Insured, the Insurer may appoint a doctor or other expert/experts.

5.2. If the Insurer accepts the fact of the Insured Event, but the Beneficiary and the Insurer do not agree on the amount of the Insurance Benefit, the Insurer shall, at the request of the Beneficiary, pay an amount equal to the undisputed Insurance Benefit, if the exact determination of the amount of the Insurance Benefit is delayed for more than 3 months.

5.3. If the cost of the services/supplies provided is partially indemnified by the CHIF, the part not indemnified by the CHIF (the premium) is considered the loss on which the Insurance Benefit is based. The Insurance Benefit is calculated by taking the Non-Compensated Part from the premium.

6. REDUCING OR REFUSING TO PAY THE INSURANCE BENEFIT

6.1. The Insurer, taking into account the culpability of the Policyholder and/or the Insured, the seriousness of the breach of the terms and conditions of the insurance contract, its causal connection with the insured event, the amount of the damage caused by the breach, shall have the right to refuse to pay the Insurance Benefit or to reduce it if the Policyholder, the Insured or the Beneficiary of the Insurance Benefit:

- 6.1.1. When concluding the Insurance Contract, provided the Insurer with false or incomplete information about circumstances that may affect the Insurer's assessment of the insurance risk.
- 6.1.2. Fails to properly inform the Insurer of an Insurable Event or of an event which may be deemed to be an Insured Event.
- 6.1.3. Fails to comply with the Insurance Contract, the Terms and Conditions of the Policy or the Insurer's requirements.
- 6.1.4. Provided the Insurer with false or incomplete information about the Insured Event. If the Insurer has unjustifiably paid out the Insurance Benefit or has incorrectly calculated the amount of the Insurance Benefit due to incorrect or incomplete information, the Insurer shall be entitled to claim the refund of the Insurance Benefit already paid out or a part of it.

6.2. The Insurer has the right to refuse to pay the Insurance Benefit or reduce it if, in the opinion of the competent doctors, the diagnostic expenses were not necessary for the specific complaints described by the Insured, or were not intended to establish a diagnosis, or the diagnosis and other circumstances did not justify the prescribed treatment.

6.3. No Insurance Benefit is payable if the details of the event or its consequences are falsified, if false information is given to the insurer, or if there is any other attempt to illegally and/or fraudulently obtain or increase the Insurance Benefit.

6.4. The Insurer will not provide insurance cover, pay indemnities, or provide other services under this Contract if it contravenes any international sanctions, prohibitions or restrictions pursuant to United Nations resolutions, trade or economic sanctions, or the laws and regulations of the European Union, the Republic of Lithuania, the United Kingdom or the United States of America (provided that this does not contravene any regulation or national law applicable to the Insurer).

7. TERMINATION OF THE INSURANCE CONTRACT

7.1. The Insurance Contract is terminated in the following cases:

- 7.1.1. Fulfilling the insurance contract:
  - 7.1.1.1. The Insurance Period specified in the Insurance Contract expires.
  - 7.1.1.2. The Insurer has paid the full amount of the Sum Insured specified in the Insurance Contract.
- 7.1.2. Upon termination of the Insurance Contract:
  - 7.1.2.1. At the initiative of the Policyholder, upon 15 calendar days' prior written notice to the Insurer.
  - 7.1.2.2. If the Policyholder does not agree with the Insurer's intention to transfer the rights and obligations under the insurance contract. In this case, the Policyholder has the right to terminate the insurance contract within 1 month from the date of the transfer of rights and obligations by giving 15 calendar days' written notice to the Insurer.
  - 7.1.2.3. On the Insurer's initiative, if the Policyholder fails to pay the Insurance premium on time.
  - 7.1.2.4. At the initiative of the Insurer, if the Policyholder (and in the case of a legal entity - also its participant or ultimate beneficiary) is included in the list of persons/entities subject to international sanctions, prohibitions or restrictions imposed by the United Nations, the European Union, the Republic of Lithuania, the United Kingdom of Great Britain and Northern Ireland or the United States of America. If the Insured is/are included in this list, the Insurance Contract shall terminate and expire only in respect of

the Insured included.

7.1.2.5. By agreement between the Parties on the terms and conditions set out therein.

7.1.3. Upon the termination of the Policyholder, when there is no successor to the Policyholder's rights and obligations.

7.1.4. In all cases where the Force Majeure lasts more than 2 months.

7.1.5. In other cases provided for by law.

7.2. Calculation of the part of the premium to be paid or refunded by the Policyholder in the event of termination of the insurance contract:

7.2.1. In the event of early termination of the insurance contract, the Insurer is always entitled to the premium or part thereof for the Insurance Coverage actually provided.

7.2.2. **Insurance contract premium** means the premium for the entire term of the insurance contract, from the start of the Insurance Coverage provided for in the insurance contract until the end of the Insurance Coverage, irrespective of the date of termination of the insurance contract. Unless the insurance contract specifies a different term, the premium is annual.

7.2.3. **Insurance contract premium used** is the part of the insurance contract premium proportionate to the Insurance Period Coverage from the start of the insurance contract until its termination.

7.2.4 In the event of termination of the insurance contract at the initiative of the Policyholder (when the Insurance Contract Premium has been paid), the part of the Insurance Contract Premium paid shall be refunded to the Policyholder in the following ways:

a) If the sum of the Insurance Contract indemnities (including reserved amounts) is less than the Insurance contract premium used, the part of the Insurance Contract Premium paid shall be refunded to the Policyholder in proportion to the remaining (unused) period of the Insurance Coverage, minus 30% (calculated on the Insurance Contract Premium) of the expenses of the conclusion and performance of the insurance contract.

b) If the amount of the Insurance Contract indemnities (including reserved amounts) is equal to or greater than the Insurance contract premium used, the part of the Insurance Contract Premium paid shall be refunded to the Policyholder in proportion to the remaining (unused) period of the Insurance Coverage, minus 30% of the expenses of concluding and executing the Insurance Contract (calculated on the basis of the Insurance Contract Premium) and the amount of the indemnities in excess of the part of the insurance premium used. Where the expenses of concluding and performing the insurance contract cannot be deducted from the premium paid by the Policyholder, or part thereof (the amount is insufficient), these expenses must be borne by the Policyholder.

7.2.5. If the insurance contract expires due to non-payment of the premium (or part thereof) by the Policyholder, if:

a) The amount of the insurance contract indemnities (including reserved amounts) is less than the Insurance contract premium used, the Policyholder shall remain liable to pay the unpaid part of the Insurance contract premium used and late payment penalties.

b) The amount of the insurance contract indemnities (including reserved amounts) is equal to or greater than the Insurance contract premium used, the Policyholder shall remain liable to pay the unpaid part of the Insurance contract premium used, the amount of the indemnities in excess of the Insurance contract premium used, and late payment penalties.

7.2.6. Where the premium of the Insurance Contract is paid in parts by separate agreement of the Parties, it shall be deemed that the part of the premium of the Insurance Contract is established solely in the interest of the convenience of the Policyholder and the total premium of the Insurance Contract shall not be broken down into shorter periods of Insurance Coverage, i.e. The amount of the premium payable by the Policyholder or refundable to the Policyholder is not subject to the agreement of the Parties for the payment of the Insurance Contract premium in parts.

7.2.7. In the event of termination of the Insurance Contract due to the Policyholder's disagreement with the Insurer's intention to transfer the rights and obligations under the concluded Insurance Contract, the part of the premium paid shall be refunded to the Policyholder in proportion to the remaining (unused) period of validity of the

Insurance Coverage.

7.2.8. Unless otherwise provided by law, in all other cases of termination of the Insurance Contract provided for in this Section, the premium (part thereof) shall not be refunded to the Insured.

8. OTHER PROVISIONS

8.1. The insurance contract is subject to the law of the Republic of Lithuania.

8.2. Any dispute arising out of the Insurance Contract shall be resolved by negotiation. If the Parties fail to reach an agreement, the dispute may be resolved by the courts of the Republic of Lithuania. For out-of-court resolution of disputes, in the cases and according to the procedure established by law, you can apply to the supervisory authority for financial market participants - the Bank of Lithuania, which handles disputes between consumers and insurance companies (address: Totorių g. 4, LT-01121 Vilnius, daugiau informacijos www.lb.lt).

8.3. The information to be provided by the Parties to each other or by the Insured to the Insurer prior to or during the conclusion of the insurance contract, or after its completion, shall be provided by registered post and/or by email to the contacts specified in the Insurance Policy or through the Insurer's self-service portal. Insurance brokers are not authorised to accept such notices. The Party and/or the Insured shall be deemed to have received the notice:

8.3.1. If sent by email or via the Insurer's self-service portal - the next working day.

8.3.2. If sent by post, within 5 calendar days of the date of posting.

8.4. The Parties shall be exempted from the performance of their obligations under the Insurance Contract if such non-performance is due to Force Majeure.

8.4.1. Force Majeure are circumstances beyond the control and reasonable foreseeability of the party to the Insurance Contract at the time of conclusion of the Insurance Contract and the party to the Insurance Contract could not have prevented the occurrence of such circumstances or their consequences).

8.4.2. Force Majeure does not include cases where the supplies needed to fulfil the obligation are not available on the market, where a Party to the Insurance Contract does not have the necessary financial resources, or where the debtor's counterparties are in breach of their obligations.

8.4.3. If the Force Majeure is temporary, the Party to the Insurance Contract shall be exempted from liability only for a period that is reasonable taking into account the influence of the Force Majeure on the fulfilment of the Insurance Contract.

8.4.4. If a Party to the Insurance Contract cannot or is not be able to fulfil any of its obligations under the Insurance Contract due to Force Majeure, it must, not later than 14 calendar days after the occurrence of the Force Majeure, notify the other Party to the Insurance Contract in writing of the circumstances which prevent it from fulfilling its obligations, together with an indication of the obligations it cannot or will not fulfil.

8.4.5. These provisions do not exclude the right of the other Party to the Insurance Contract to terminate or suspend the fulfilment of the Contract or to demand payment of interest.

9. PERSONAL DATA PROTECTION

9.1. The Insurer's processing of data of Policyholders, Insured, Beneficiaries and other persons (hereinafter referred to as Data Subjects) is described in the Privacy Policy adopted by the Insurer, which is available at the Insurer's website https://www.compensa.lt/privatumo-politika/.

9.2. If the Data Subject considers that his/her personal data are being processed by the Insurer in breach of the legislation governing the processing and protection of personal data, or wishes to exercise the rights of Data Subjects, he/she should first directly contact the Insurer's Data Protection Officer by e-mail dpo@compensa.lt. If the Data Subject is not satisfied with the solution proposed by the Insurer or considers that the Insurer has not taken sufficient action in response to the Data Subject's request, he/she shall have the right to lodge a complaint with the State Data Protection Inspectorate or to apply to the court.

LIST OF CRITICAL ILLNESSES

1. **Loss of speech** is a total and irreversible loss of the ability to speak due to injury and/or illness (except in cases of mental illness), which cannot be corrected by any method of treatment and which persists for 6 months after diagnosis by a competent doctor.

2. **Limb Loss** is a final diagnosis by a competent doctor of a Health Disorder resulting in the permanent and irreversible loss of two or more limbs or all of their functions, where the latter persists for 3 (three) months after the final diagnosis. Insurance Benefit shall not be paid in the following cases:

2.1. Guillain-Barré syndrome.

2.2. For the loss of limbs or their functions due to stroke.

3. **Deafness** is a final diagnosis of irreversible (not correctable by surgery, hearing aids or other means) hearing loss in both ears, confirmed by an audiogram by an otorhinolaryngologist, due to a threshold of at least 90 db in all frequencies.

4. **Burn** is a burn to the body which, as certified by a competent physician, destroys all the layers of the skin (burns of grade 3 or 4) and which covers at least 20% of the body surface area.

5. **Blindness** is the total and irreversible loss of sight in both eyes due to injury and/or disease, which

cannot be corrected by any medical treatment, and which persists for 6 months after the diagnosis by an ophthalmologist.

6. **Myocardial infarction** is irreversible damage and necrosis of myocardial cells caused by acute myocardial ischaemia, as certified by a competent doctor. The Insurance Benefit is payable only in the event of a type 1 myocardial infarction and if the diagnosis of myocardial infarction is based on all of the criteria listed below:

6.1. Clinical signs of myocardial infarction (pain).

6.2. New electrocardiographic abnormalities characteristic of myocardial infarction - ST elevation.

6.3. Serum concentrations of a marker of myocardial damage (cardiac-specific high-sensitivity troponin I or T, or CK-MB mass) are increased to levels typical of myocardial infarction.

7. **Stroke** is a permanent and irreversible neurological deficit that has persisted for at least 3 months after an acute ischaemic or haemorrhagic disorder of the cerebral circulation, as certified by a neurologist, based on imaging studies showing new-onset changes characteristic of stroke. Insurance Benefit shall be rejected in the following cases:

7.1. When the stroke is due to direct and/or post-surgical indirect damage to the brain or blood vessels as a result of trauma and/or surgery.

7.2. When incidental findings are detected without clearly associated clinical symptoms of stroke ('silent stroke').

8. **Oncological disease** is a malignant oncological disease confirmed by a medical oncologist with a specified stage of the disease, based on histological and imaging tests. No Insurance Benefit is payable if the following is found:

8.1. Any pre-cancerous condition.

8.2. Cervical dysplasia, cervical intraepithelial neoplasia (any stage of CIN).

8.3. Any non-invasive tumour (carcinoma in situ or Tis according to TNM classification).

8.4. Stage I prostate cancer.

8.5. Stage I bladder cancer.

8.6. Stage I thyroid cancer.

8.7. Stage I lymphogranulomatosis.

8.8. Stage I breast cancer (except when systemic treatment is recommended by a panel of doctors).

8.9. Chronic lymphocytic leukaemia.

8.10. Skin cancer, excluding malignant invasive melanoma from Clark's stage III onwards or melanoma of any stage with metastases.

8.11. Cutaneous lymphoma, unless the disease needs to be treated with chemotherapy or radiotherapy.

8.12. Tumours of uncertain or unknown course.

Staging is based on the latest version of the TNM classification.

9. **Kidney failure** means a complete chronic and irreversible impairment of the function of both kidneys, as certified by a nephrologist, and as determined by him/her to require treatment of this impairment by permanent dialysis or transplantation of the kidney/kidneys.

10. **Multiple sclerosis** is a definitive diagnosis of multiple sclerosis in case of neurological deficit based on the results of a magnetic resonance imaging study of at least two (2) foci and the relevant McDonald's criteria and confirmed by a neurologist.

11. **Coronary artery bypass surgery** is a surgery for narrowing or blockage of two or more blood vessels in the heart, using a bypass as an autologous graft.

12. **Heart valve surgery** is a surgery to replace or restore the function of one or more heart valves. Catheter-based stricture of the bicuspid valve is not an insured event.

13. **Aortic surgery** is a surgery (including minimally invasive procedures) for disease-related dilatation (aneurysm) or dissection (dislocation) of the thoracic or abdominal aorta. Non-insurable events include:

13.1. Aortic branch surgery.

13.2. Aortic surgery for congenital (genetic) connective tissue diseases.

14. **Organ transplantation** is a surgery actually performed on the Insured as a recipient (including the Insured as a recipient being placed on an official waiting list for surgery in accordance with the final diagnosis of a specialist in the relevant field), which involves the transplantation of one or more of the organs/body parts/cells listed below, as there is no other applicable treatment:

14.1. Bone marrow (except autologous).

14.2. Heart, kidney/kidneys, small intestine, and pancreas.

14.3. Liver and lung (partial or whole organ).

14.4. Face, arms, hands, legs, and feet (partial or whole organ).

No Insurance Benefit is payable for transplantation of other cells, organs, body parts or tissues (including fingers, corneas, skin, and hair).

15. **Parkinson's disease** is a diagnosis of primary parkinsonism confirmed by a neurologist. No Insurance Benefit shall be paid for secondary parkinsonism (e.g. drug-induced parkinsonism, Malignant Neuroleptic Syndrome, other environmental factors, Poencephalitic Parkinsonism, Vascular Parkinsonism, Lewy Body Disease, etc.). The Insurance Benefit shall be paid only if the Insured's age at the time of diagnosis is under 60 years.

16. **Alzheimer's disease** is a diagnosis of Alzheimer's disease confirmed by imaging and instrumental tests by a neurologist, requiring 24-hour care. The insurance shall not be paid for the Alzheimer's dimension. The Insurance Benefit shall be paid only if the Insured's age at the time of diagnosis is under 60 years.

17. **Benign brain tumour** is a final diagnosis of a benign brain tumour (including the meninges or cranial nerves) confirmed by imaging studies by a neurologist and a neurosurgeon, with local treatment or with a tumour causing a persistent neurological deficit that persists for at least three (3) months from the date of the final diagnosis. No Insurance Benefit shall be paid for cysts, granulomas, hamartomas or brain malformations, and

pituitary tumour.

18. **Bacterial meningitis** is a final diagnosis confirmed by a neurologist's examination of a fluid puncture of the cerebrospinal fluid, due to inflammation of the meninges caused by a bacterial infection, with persistent neurological deficits that persist for at least 6 weeks from the confirmation of the final diagnosis. No Insurance Benefit shall be paid for bacterial meningitis in the case of HIV infection.
19. **Aplastic anaemia** is a final diagnosis of chronic persistent bone marrow failure, characterised by anaemia, neutropenia and thrombocytopenia, confirmed by laboratory tests by a haematologist. No Insurance Benefit shall be paid for drug-induced aplastic anaemia.
20. **Tuberculosis** is a final diagnosis of a chronic infectious disease caused by a tuberculosis mycobacterium that has damaged the lungs, confirmed by laboratory tests (molecular tests or sputum culture and microscopy) and instrumental tests by a pulmonologist.
21. **Crohn's disease** is a final diagnosis of chronic relapsing and remitting granulomatous inflammation of the gastrointestinal tract, confirmed by the gastroenterologist's laboratory findings and histological examination.
22. **Liver failure** is a final diagnosis of chronic liver failure, confirmed by laboratory and instrumental tests by a gastroenterologist, resulting in hepatic impairment, hepatic encephalopathy (cerebral impairment), or coagulopathy (coagulation disorder). No Insurance Benefit shall be paid for liver failure caused by medication and alcohol consumption.
23. **HIV infection** means a final diagnosis of human immunodeficiency virus (HIV) confirmed by an Infectious disease specialist following a positive screening test result with repeated laboratory immunoblot testing (including, if necessary, HIV antigen and neutralisation reactions, HIV RNA/DNA detection or viral isolation testing in culture).
24. **Hepatitis C** is a final diagnosis of chronic hepatitis C virus infection causing inflammation of the liver, confirmed by laboratory tests carried out by a gastroenterologist, following an accident at work.
25. **Tick-borne encephalitis** means a final diagnosis of tick-borne encephalitis caused by an infected tick bite, confirmed by an Infectious disease specialist and which required inpatient treatment for at least 10 days. The Insurance Benefit shall be paid only if the vaccination passport provided proves that a full vaccination was given prior to the illness and that the maintenance vaccination schedule was followed.
26. **Viral encephalitis** means a final diagnosis of viral encephalitis confirmed by inpatient examination by a neurologist or an Infectious disease specialist for immunological/serological indicators and positive results for lesions in the fluid, with a permanent neurological deficit that persists for at least three (3) months from the confirmation of the final diagnosis. Insurance Benefit shall be rejected in the following cases:

26.1. If the encephalitis was caused by the HIV virus.
26.2. If the encephalitis was caused by tick bites, bacteria, protozoa or parasites.
26.3. In the case of encephalomyelitis.
26.4. In the case of viral meningitis or meningoencephalitis.

27. **Lyme disease** is a final diagnosis confirmed by an Infectious disease specialist and caused by an infected tick bite (injury) leading to Lyme borreliosis and resulting in permanent neurological deficit (neuroborreliosis).
28. **COVID19** - the Insured is admitted to the intensive care unit of the intensive department as a result of a diagnosis of COVID-19 infection and/or its sequelae.

Deividas Raipa
Chairman of the Board

Felix Nagode
Member of the Board