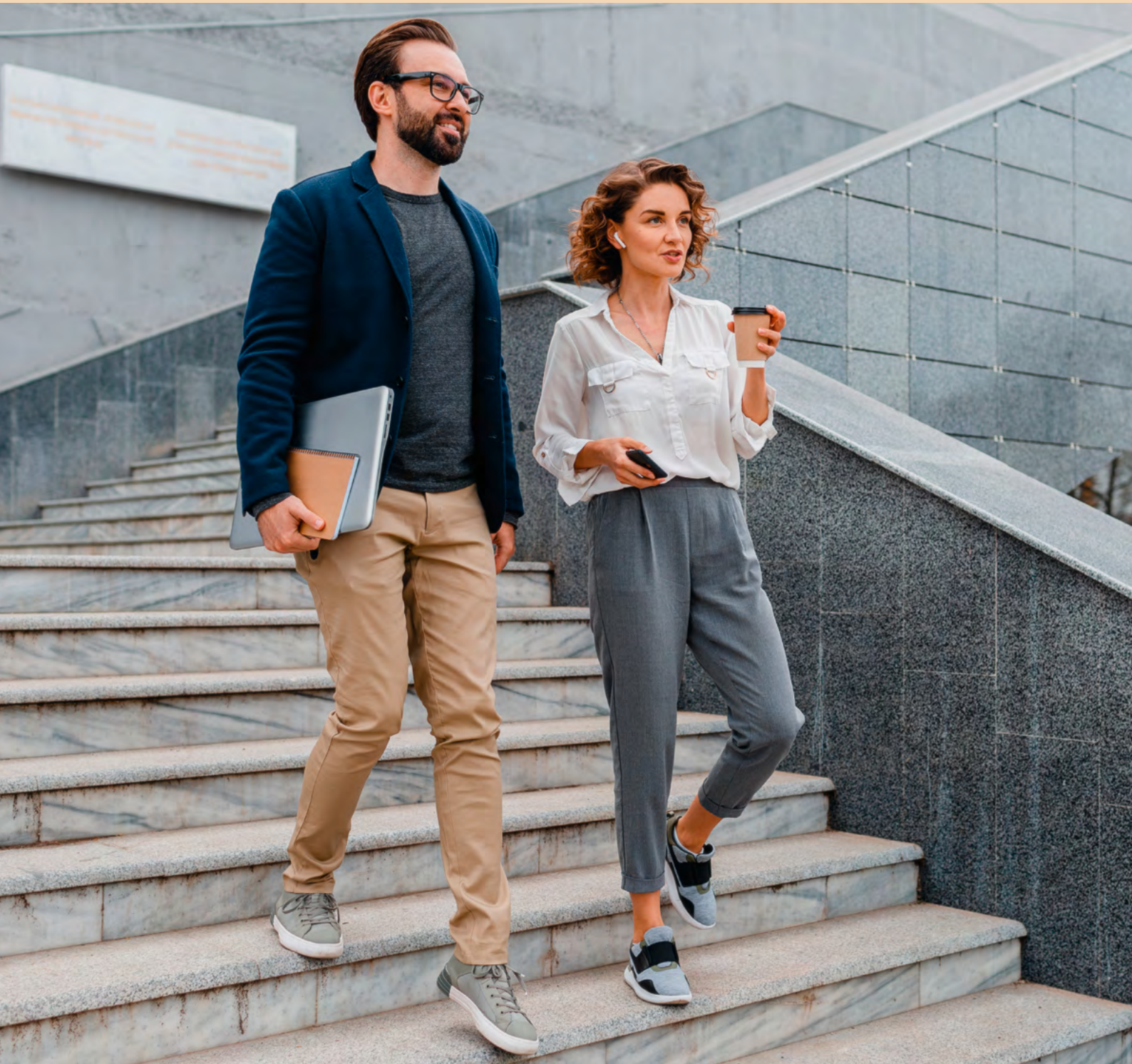
ERGO

ERGO Life Insurance SE

Health Insurance Policy Terms and Conditions No. 010

Effective from 1 June 2020



Contents

1. Key terms used in the Terms and Conditions

1.1. **Insurer** shall mean ERGO Life Insurance SE.
1.2. **Insurance Contract** shall mean a health insurance contract between the Insurer and the Policyholder.
1.3. **Policyholder** shall mean the legal person who has signed the Insurance Contract with the Insurer and is required to pay insurance premiums.
1.4. **Parties** to the Insurance Contract shall mean the Insurer and the Policyholder.
1.5. **Insured Person** shall mean the person specified by the Policyholder and indicated in the Insurance Contract, who shall be paid the insurance benefit by the Insurer in case of an insured event in the Insured Person's life.
1.6. **Insurance coverage and coverage area** shall mean the obligation of the Insurer, in case of an insured event, to pay the insurance benefit for health care services provided and purchased in the territory of the Republic of Lithuania or institutions registered in the Centre of Registers of the Republic of Lithuania. In case of critical illness insurance, the coverage area shall be specified next to the description of the insured event.
1.7. **Insurance deductible** shall mean a portion of loss/costs expressed as a fixed amount or as a percentage, by which the insurance benefit payable by the Insurer is reduced for each insured event and which is borne by the Policyholder or the Insured Person.
1.8. **Insurance benefit** shall mean the amount of money payable by the Insurer to the Insured Person and/or health care institution for health care services provided to or products purchased by the Insured Person due to an insured event in accordance with the terms and conditions of the Insurance Contract.
1.9. **Health care institution** shall mean an institution or company entitled to provide health care and pharmaceutical services in accordance with procedure prescribed by laws of the Republic of Lithuania and holding a license of a health care service provider.
1.10. **Health care service** shall mean the services provided in health care institutions, including consulting, diagnostics, treatment, prophylaxis, rehabilitation and disease prevention of the Insured Persons as well as the provision of the means that are necessary for the treatment, health improvement or recovery from the Insured Person's health disorder/condition.
1.11. **Partner** shall mean an institution or company entitled to provide health care, wellness and pharmaceutical services in accordance with procedure prescribed by laws of the Republic of Lithuania, which has concluded a cooperation/service agreement with the Insurer for providing health care services to the Insured Persons.
1.12. **Health Insurance Card** shall mean an electronic or other type of card in the form established by the Insurer provided to each Insured Person.
1.13. **Health problem** shall mean the physiological condition of the Insured Person requiring medically justified examination and treatment, of which the Insured Person has expressed a complaint.
1.14. **Diagnostics** shall mean doctor's consultations, medically justified testing and procedures for identification and assessment of disease.
1.15. **Treatment** shall mean manipulative and surgical treatment, including laser treatment, injections and infusions.
1.16. Day surgery shall mean the services provided during the Insured Person's stay in day surgery unit for up to 24 hours (or up to 48 hours, if necessary).
1.17. **Hospital services** shall mean the services provided to the Insured Person while hospitalised for more than 24 hours.
1.18. **Waiting period** shall mean a period of sixty (60) days after the effective date of the Insurance Contract for the Insured Person, when the coverage of critical illness insurance does not apply. If a critical illness is diagnosed in the period between the effective date of the Insurance Contract and the end of the waiting period, the Insured Person shall not be entitled to the insurance benefit. The waiting period clause shall not apply if another insurance contract was in force before such period, which was renewed without an interruption.
1.19. **Critical illness** shall mean an illness referred to in paragraph 3.3.13.3 of the present Terms and Conditions, confirmed by definite diagnosis and/or surgery.
1.20. **Definite diagnosis** shall mean a diagnosis based on a conclusion of a licensed specialist physician or a physicians council, confirmed by appropriate laboratory and/or instrumental medical tests, which is recorded in the Insured Person's medical documents.
1.21. **Medical supplies** shall mean the products referred to in the List of Medical Supplies (List C) approved by the Ministry of Health (e.g. hydrogel, bandages, catheters).

Other terms used in these Terms and Conditions shall be understood as they are defined in the Law on Insurance of the Republic of Lithuania and other legislation of the Republic of Lithuania.

2. Entry into an Insurance Contract

2.1. In order to enter into an Insurance Contract, the Policyholder shall submit a written application and a list of Insured Persons to the Insurer. Together with these Terms and Conditions, the application and the list of Insured Persons submitted by the Policyholder shall become an integral part of the Insurance Contract.

2.2. Having carried out the insurance risk assessment, the Insurer may refuse to conclude an Insurance Contract without specifying the reason. The submission of an application for insurance and payment of the premium shall not place the Insurer under an obligation to enter into an Insurance Contract.

2.3. If the Insurer agrees to enter into an Insurance Contract, an insurance policy confirming the conclusion of the Insurance Contract shall be issued to the Policyholder. By paying the first instalment or full insurance premium, the Policyholder confirms that the Insured Persons have been introduced to the Terms and Conditions and accept the terms of the Insurance Contract.

2.4. The Insurance Contract may be concluded with individual terms and conditions, should the Insurer and the Policyholder separately agree on the same.

3. Insured events

3.1. An insured event shall be an event referred to in the Insurance Contract, the occurrence of which puts the Insurer under the obligation to pay the insurance benefit.

3.2. An event shall be recognised as the insured event only if the physician providing the services acts within the competence of a specialist physician, described and approved by applicable legislation, and holds a licence to practice medicine issued by a competent authority, and if the services were purchased and provided during the insurance coverage period in a health care institution holding a licence to provide health care services.

3.3. Insured events:

3.3.1. Outpatient medical treatment

Coverage includes the services provided due to a health problem, injury, acute disease or monitoring and exacerbation of a chronic disease.

Physician's services:

- general practitioner consultations at a health care institution and home visits;
- consultations and tests of other specialist physicians;
- psychiatrist or medical (psychiatric) psychotherapist consultations (up to 10 sessions during the insurance period) with a diagnosis established and treatment prescribed by a psychiatrist.

Referral is not required for consulting a specialist physician.

Referral is required for ultrasound, endoscopic, radiological and clinical physiology tests.

Diagnostic tests:

Tests prescribed by a physician based on medical indications, required to diagnose and treat the illness:

- laboratory tests (clinical, biochemical, enzyme immunoassay, hormone, microbiological-bacteriological, cytological-histological, etc.);
- instrumental tests (ultrasound, radiological, endoscopic, functional, etc.).

Referral is required for ultrasound, endoscopic, radiological and clinical physiology tests.

Day surgery services, day hospital:

- An elective surgical operation must be included in the list of operations attributed to day surgery provided in the Annex to Order No. V-225 of 11 February 2016 of the Minister of Health of the Republic of Lithuania with subsequent amendments. The services must be provided during the Insured Person's stay in a day surgery unit for up to 24 hours (or up to 48 hours, if necessary). Part of the cost of the surgical operation must be compensated to the medical institution by the Compulsory Health Insurance Fund;
- Medical supplies, medicinal products and nursing equipment prescribed by a physician and used in a hospital and extra charges for supplies used during surgery, except tissue substitutes, bolts/plates/screws/staples, implants, suturing kits and prostheses.
- The difference between the amount compensated by the Compulsory Health Insurance Fund and the cost of more expensive supplies used during surgery shall be compensated, if surgery is performed in a public health care institution.
- Health care services according to treatment profiles provided in day hospital (except for injections of body fluids with or without blood components). Treatment profiles (oncology, etc.) are specified in Order No. V-730 of 14 June 2017 of the Minister of Health of the Republic of Lithuania with subsequent amendments.

Nursing services:

Services prescribed by a physician, provided in a health care institution or at the Insured Person's home:

- injections, infusions (excluding the price of medicinal substances), wound dressing, blood collection, etc.

Paragraphs describing non-insured events: 4.2.1, 4.2.2, 4.2.3.

3.3.2. Inpatient treatment in public health care institutions

Coverage includes the services provided in a national health care institution on an inpatient basis:

- comfort services (single or double ward);
- nursing services prescribed by a physician;
- medical supplies, medicinal products and nursing equipment prescribed by a physician and used in a hospital.

Paragraphs describing non-insured events: 4.2.1, 4.2.2, 4.2.3.

3.3.3. Inpatient treatment in public and private health care institutions

Coverage includes the services provided in a national and/or private health care institution on an inpatient basis:

- comfort services (single or double ward);
- consultations and diagnostic and therapeutic procedures performed by specialist physicians;
- diagnostic test prescribed by a physician;
- nursing services prescribed by a physician;
- medical supplies, medicines, nursing equipment and orthopaedic technology products prescribed by a physician and used in a hospital.

Paragraphs describing non-insured events: 4.2.1, 4.2.2, 4.2.3.

3.3.4. Medicinal products and orthopaedic technology products

Coverage includes the following products prescribed by a physician for outpatient treatment of the Insured Person and purchased in a pharmacy/online pharmacy:

- medicinal products registered in the Register of Medicinal Products of the Republic of Lithuania or the European Community;
- bearer prescription medicinal products registered in a member state of the European Union or the European Economic Area or in the manufacturer's country;
- orthopaedic technology products purchased in orthopaedic technology product stores/online stores and/or pharmacies and/or online pharmacies (medicinal body covers used for burns, splint systems for the back and upper and lower extremities, prosthetic arms and legs, special orthopaedic footwear for treatment of leg deformations (if manufactured for a specific patient), orthopaedic inserts, orthopaedic socks and assistive devices (canes, crutches, wheelchairs; elastic and compression socks).

If part of the purchase costs of the products listed in this paragraph is reimbursed by the Compulsory Health Insurance Fund (CHIF), the Insurer shall cover one hundred per cent (100%) of the non-reimbursable part of the price of medicinal products without the deductible, but within the limits of insured sum of the insurance option provided in the Insurance Contract.

Paragraphs describing non-insured events: 4.2.1, 4.2.2, 4.2.3

3.3.5. Rehabilitation

Coverage includes medically justified outpatient and/or inpatient rehabilitation services prescribed by the treating physician in case of trauma, acute disease, monitoring or exacerbation of chronic disease:

- consulting by a physiotherapist, ergotherapist, speech therapist;
- physiotherapy;
- individual and group sessions of kinesitherapy in the gym and in the water;
- water and mud treatments;
- manual therapy sessions;
- therapeutic massages.

Paragraphs describing non-insured events: 4.2.1, 4.2.2, 4.2.3.

3.3.6. Rehabilitation after hospitalization

Coverage includes medically justified outpatient and/or inpatient rehabilitation treatment prescribed by the treating physician for a disease or injury treated in a hospital, after inpatient treatment of the disease or injury, where the duration of hospitalisation was more than 24 hours:

- consulting by a physiotherapist, ergotherapist, speech therapist;
- physiotherapy;
- individual and group sessions of kinesitherapy in the gym and in the water;
- water and mud treatments;
- manual therapy sessions;
- therapeutic massages.

Rehabilitation treatment must commence within 3 months after discharge from the hospital.

Paragraphs describing non-insured events: 4.2.1, 4.2.2, 4.2.3.

3.3.7. Dental treatment, oral hygiene, prosthetics

The Insured Persons may receive treatment from dentists and dental hygienists holding a license to practice and working in licensed medical institutions in Lithuania.

Dental treatment and dental hygiene services include:

- consulting by a dentist, specialist dentist and dental hygienist;
- cleaning dental concretions and plaque;
- fluorine applications;
- endodontic, periodontal, therapeutic and surgical treatment of tooth, mouth, oral mucosa and jaw diseases, anaesthesia, X-ray examination.

Dental prosthetic services:

- consulting by a dentist or specialist dentist on dental prosthetics, implants and orthodontic treatment;
- manufacturing, restoration and repair of removable and fixed dentures;
- dental implant placement, dental implants, orthodontic treatment, braces, splints for orthodontic treatment, myorelaxing splints and cosmetic filling.

Paragraphs describing non-insured events: 4.2.1, 4.2.2, 4.2.3.

3.3.8. Preventive check-ups, prenatal care and vaccination

Preventive check-ups:

- mandatory health checks according to the type of work in accordance with procedure prescribed by the law;
- tests performed at request of the Insured Person;
- consultations and tests according to preventive programmes implemented in Lithuania or developed and approved in health care institutions;
- consultations and tests performed in order to determine the predisposition to disease or to avoid a possible disease;
- tests that are not necessary and medically justified in a particular clinical situation;
- preventive consultations and tests necessary to monitor the health condition of the Insured Person with a chronic disease or after surgery;
- psychotherapy (referral by physician is not required).

Prenatal care (services for a female Insured Person):

- comfort services (single or double ward) during prenatal, childbirth and postnatal care;
- prenatal examinations, consultations and tests prescribed by physicians for monitoring the progress of pregnancy (laboratory and instrumental);
- diagnostics of pregnancy complications (consultations and tests);
- care during childbirth (services of nurses and physicians during childbirth (including extra payment for pre-selected physician or obstetrician of the same medical institution), painkillers, labour induction medications, drips, vacuum extraction device).

Vaccination:

- physician's consultation on vaccination;
- vaccines selected by the Insured Person or prescribed by a physician and vaccination.

Paragraphs describing non-insured events: 4.2.1, 4.2.2 c) č) ė) f) g) h) i) į) y) j) k) (treatment only), l) m) n) o) p) r) s) š) t) u) ū) z) ž), 4.2.3

3.3.9. Optics

Should a condition that requires correction by spectacles or lenses be diagnosed by an ophthalmologist, the following products or services purchased in optical stores/online stores according to the physician's prescription shall be covered:

- selection and production of spectacles;
- spectacle frames purchased together with corrective lenses (glass, plastic, photochromic, progressive);
- corrective lenses (glass, plastic, photochromic, progressive);
- contact lenses;
- eye lenses used during surgery;
- surgical correction of myopia and hyperopia.

Paragraphs describing non-insured events: 4.2.1, 4.2.2, except n) surgical correction of myopia and hyperopia, 4.2.3.

3.3.10. Vitamins, food supplements, over-the-counter medicinal products

Coverage includes food supplements (according to the manufacturer's instructions for use) and vitamins (according to the manufacturer's instructions for use) and over-the-counter medicinal products registered in the Register of Medicinal Products of the Republic of Lithuania or the European Community (according to the manufacturer's instructions for use) purchased in pharmacies/online pharmacies.

Paragraphs describing non-insured events: 4.2.1, 4.2.2, 4.2.3.

3.3.11. Medical services

Physician's order/prescription/referral is not required for services listed in paragraph 3.3.11. Coverage includes services provided in health care institutions, pharmacies/online pharmacies, optical stores/online stores and orthopaedic technology product stores/online stores:

- services provided in health care institutions: medical consultations, diagnostic tests, surgery, nursing services, rehabilitation, prenatal care, prophylaxis and vaccination;
- in pharmacies/online pharmacies and orthopaedic technology product stores/online stores: medicinal products, food supplements, medical supplies, orthopaedic technology products;
- in optical stores/online stores: contact lenses, corrective lenses and frames purchased together with corrective lenses, protective glasses, spectacle selection and production services, care products for spectacle lenses (solutions for contact lenses and liquid cleaners for spectacle lenses), eye lenses used during surgery;
- dental treatment services: dental treatment, oral hygiene, prosthesis, implantation, orthodontic treatment, braces, splints for orthodontic treatment, myorelaxing splints and cosmetic filling;
- in health care institutions: physiotherapy, ergotherapy, halotherapy, kinesitherapy, water and mud treatments, manual therapy, therapeutic massages.

Paragraphs describing non-insured events: 4.2.1, 4.2.2 č) f) g) h) i) į) y) j) n) except surgical correction of myopia and hyperopia, purchase of protective glasses, contact lenses and care products for spectacle lenses o) p) r) s) š) t) except thermometers, inhalers, hearing aids and blood pressure monitors u) ū) z) ž), 4.2.3.

3.3.12. Other services

Physician's order/prescription/referral is not required for services listed in paragraph 3.3.12:

- medical consultations, diagnostic tests, surgery, nursing services, rehabilitation, prenatal care, prophylaxis and vaccination, psychotherapy, psychologist's consultations;
- medicinal products, food supplements, medical supplies, orthopaedic technology products and other products purchased in pharmacies/online pharmacies, orthopaedic technology product stores/online stores, specialised food supplement stores;
- in optical stores/online stores: contact lenses, corrective lenses and frames purchased together with corrective lenses, protective glasses, spectacle selection and production services, care products for spectacle lenses (solutions for contact lenses and liquid cleaners for spectacle lenses), eye lenses used during surgery, sunglasses;
- dental treatment services: dental treatment, oral hygiene, prosthesis, implantation, orthodontic treatment, braces, teeth whitening, aesthetic restoration, splints, trainers;
- wellness services provided in fitness centres and SPA/wellness centres: exercise, kinesitherapy, swimming pool, sauna services, manual therapy, massage, water parks and snow parks.

Paragraphs describing non-insured events: 4.2.1 a) b) d) f), 4.2.2. f) į) o) p) r) s) t) breathalysers ū) z) ž) gift cards, rent of inventory, sports equipment and sportswear, team sports training and rent of a gym for such training.

3.3.13. Critical illness insurance

A critical illness listed in paragraph 3.3.13.3 of these Terms and Conditions, diagnosed for the Insured Person for the first time in his/her life during the Insurance Contract period, confirmed by definite diagnosis and compliant with critical illness diagnosis criteria provided in the description of the illness.

3.3.13.1. Lump-sum critical illness insurance benefit

- In case of an insured event, the insurance benefit in the amount of the insured sum shall be paid to the Insured Person.
- Only one (1) insurance benefit shall be paid during the insurance period. Once the insurance benefit is paid, the insurance coverage of critical illness insurance shall be terminated for the Insured Person from the date of payment of the lump-sum insurance benefit.
- A waiting period of sixty (60) days.
- The insurance coverage shall be valid worldwide.

3.3.13.2. Critical illness treatment costs

- If any of the critical illnesses listed in paragraph 3.3.13.3 of these Terms and Conditions is diagnosed for the Insured Person during the Insurance Contract period after the waiting period, the Insurer shall reimburse the treatment costs to the Insured Person incurred in obtaining treatment for the critical illness within the limits of the insured sum set forth in the Insurance Contract. The coverage shall include the services of treatment of the critical illness listed in paragraph 3.3.13.3 of these Terms and Conditions, outpatient treatment and diagnostics, inpatient treatment, medical rehabilitation, and purchase of medicinal products and medical supplies.
- A waiting period of sixty (60) days shall apply.
- The insurance coverage shall be valid in the Republic of Lithuania, Republic of Latvia and Republic of Estonia.

3.3.13.3. List of critical illnesses

3.3.13.3.1. **Myocardial infarction**: the Insured Person is suffering from coronary obstruction. Myocardial infarction is diagnosed based on sudden and severe pain (clinical symptoms of ischaemia), new changes in the ECG (appearance of Q wave and/or ST elevation or depression) and dynamics of biochemical markers of myocardial lesions (troponin or CK-MB).

3.3.13.3.2. **Coronary artery bypass surgery**: surgery used to treat the narrowing or blockage of at least two cardiac coronary arteries (open-heart surgery), the necessity of which is based on angiography. The insurance benefit shall not be paid for coronary angioplasty or other intra-arterial treatments (closed-heart surgery).

3.3.13.3.3. **Stroke (ischaemic or haemorrhagic stroke)**: the Insured Person suffers from cerebral vascular stenosis or ischaemic lesion of the brain due to occlusion or haemorrhagic stroke due to spontaneous vascular rupture in the brain matter or above it and the sudden neurological symptoms persist for more than 24 hours.

3.3.13.3.4. **Cancer (malignant tumour)**: the Insured Person is diagnosed with one or more malignant tumours, including leukaemia and lymphoma. The diagnosis of the malignant tumour is confirmed histologically. The insurance benefit shall not be paid for the following forms of cancer: chronic lymphocytic leukaemia, stage I lymphogranulomatosis, stage I prostate cancer, localized, non-invasive tumours (carcinoma in situ), tumours histologically characterised as precancerous, cervical dysplasia CIN-1, CIN-2 and CIN-3 and all types of tumours in HIV-positive people;

3.3.13.3.5. **End-stage renal disease**: the Insured Person develops life-threatening renal failure, uremia with bilateral chronic irreversible renal function disorders and treated with regular haemodialysis or kidney transplantation. The insurance benefit shall be paid only with indication for dialysis confirmed by a physician or after renal transplant surgery.

3.3.13.3.6. **Loss of limb/limb function**: total loss of two or all limbs or their function due to illness or injury. A limb shall be considered lost if amputated above knee or elbow joint. Loss of limb function must be confirmed by a certified specialists and objective tests and persist for at least six (6) months (except irreversible nerve and brain injury).

3.3.13.3.7. **Loss of vision (blindness)**: complete and irreversible loss of vision in both eyes due to illness or injury. The diagnosis must be confirmed by an ophthalmologist and clinical and instrumental tests.

3.3.13.3.8. **Multiple sclerosis**: sensory and motor dysfunction that persists for more than three (3) months after diagnosis. The right to the insurance benefit shall arise upon diagnosis by a neurologist confirmed by clinical and instrumental tests (magnetic resonance imaging).

3.3.13.3.9. **Internal organ transplant surgery**: heart, lung, liver, pancreas, small intestine or bone marrow transplant surgery for the Insured Person, who is the recipient.

3.3.13.3.10. **Heart valve replacement/prosthesis**: replacement of one or more heart valves (aortic, mitral, tricuspid, pulmonary) by an artificial one due to stenosis and/or failure. The insurance benefit shall not be paid for valve correction or incision surgery.

3.3.13.3.11. **Aortic prosthetic surgery**: removal of a part of abdominal or thoracic aorta damaged due to illness and replacement with a transplant. The insurance benefit shall not be paid in case of branch surgery, bypass surgery or surgery, which was necessary due to injury of the aorta.

3.3.13.3.12. **Alzheimer's disease** (diagnosed before 65 years of age): irreversible loss of cognitive functions: speech, memory, thinking and decision-making ability; dependence on care; characteristic clinical symptoms and instrumental test results.
The patient should be in need of permanent (24/7) care. The diagnosis and the need of care must be confirmed by a neurologist and/or psychotherapist.

3.3.13.3.13. **Benign brain tumour**: confirmed diagnosis of benign brain tumour, defined as a benign growth of tissue within the cranial vault, extending only to the brain, soft tissue of the brain or cranial nerves. At least one of the following methods should be used for treating the tumour: surgery (complete or partial resection of the tumour), radiotherapy (radioactive irradiation), chemical therapy and stereotactic radiosurgery. If none of the above treatment methods can be used due to medical indications, the tumour has to cause permanent neurological deficit, which persists for at least three (3) months from diagnosis. The diagnosis must be confirmed by a neurologist or neurosurgeon by diagnostic imaging tests. The insurance benefit shall not be paid in the following cases: cysts, granulomas, hamartomas, malformation of brain arteries or veins, and pituitary tumours.

3.3.13.3.14. **Loss of hearing (deafness)**: complete and irreversible loss of hearing in both ears due to illness or injury. The diagnosis must be confirmed by an otorhinolaryngologist by instrumental tests (audiogram).

3.3.13.3.15. **Loss of speech**: complete and irreversible loss of the ability to speak due to physical injury or illness of the vocal cords, which persists for at least six (6) months, except in case of irreversible brain and nerve damage. The diagnosis must be confirmed by an otorhinolaryngologist and psychotherapist. The insurance benefit shall not be paid when the ability to speak is lost due to mental disorders.

3.3.13.3.16. **Third and fourth degree burns**: skin lesions to the depth of subcutaneous tissues and/or muscles caused by burns and covering at least 20 percent of the body surface. The insurance premium shall not be paid for first or second degree burns.

3.3.13.3.17. **Idiopathic Parkinson's disease** (before 65 years of age): a slowly progressing brain disease. Primary diagnosis of idiopathic Parkinson's disease, confirmed by at least two of the following clinical symptoms: muscle frigidity, tremor, bradykinesia (abnormal slowness of movement, slowness of physical and mental response). Inability to carry out at least three out of six daily activities independently without interruption for at least three (3) months: washing: ability to wash themselves in a bathtub or shower (including getting into and out of the bathtub or shower) or satisfactory washing using other means; getting dressed and undressing: ability to get dressed, undress, fasten and unfasten all parts of garments and, if necessary, supports, artificial limbs or surgical aids; eating: ability to eat on their own, if the food is prepared and served; personal hygiene: ability to maintain a satisfactory level of personal hygiene, control of defecation and urination by going to the toilet or otherwise; movement within the rooms: ability to get from one room to another on the same floor; getting into and out of bed: ability to get out of bed and sit down on a chair or in a wheelchair and to get back into bed. The diagnosis must be confirmed by a neurologist and psychotherapist. The insurance benefit shall not be paid for secondary parkinsonism (including medication or toxin-induced parkinsonism).

3.3.13.3.18. **Bacterial meningitis**: severe inflammation of meninges of the brain and/or spinal cord, which lead to severe, irreversible and permanent neurological disorders. The diagnosis has to be confirmed by: bacterial infection found in the fluid from lumbar puncture (found/determined in the cerebrospinal fluid obtained by lumbar puncture); neurologist and/or neurosurgeon and infectious disease physician based on neurological symptoms persisting at least six (6) weeks.

3.3.13.3.19. **Aplastic anaemia**: chronic persistent bone marrow failure associated with anaemia, neutropenia and thrombocytopenia, the treatment of which requires at least one of the following therapies: transfusion of blood products, allogeneic bone marrow transplantation, immunosuppressive therapy, and the use of stimulating agents. The diagnosis must be established and confirmed by laboratory tests and a haematologist. The insurance benefit shall not be paid in case of the following diagnoses: haemorrhagic anaemia, haemolytic anaemia, iron deficiency anaemia, Vitamin B12 anaemia.

3.3.12.4.20. **Active tuberculosis**: an infectious disease, which is usually associated with the lungs, i.e. pulmonary tuberculosis, as well as spinal, bone, renal, genital, cerebral, lymph node tuberculosis, etc. i.e. non-pulmonary tuberculosis. The diagnosis has to be confirmed by laboratory and instrumental tests and a pulmonologist.

3.3.13.3.21. **Crohn's disease**: a chronic and often progressive disease of the digestive tract. The diagnosis has to be confirmed by a gastroenterologist based on objective laboratory tests and instrumental tests.

3.3.13.3.22. **Hepatic failure**: liver necrosis, hepatic encephalopathy and coagulopathy caused by secondary viral infections, toxins (other than alcohol) or immune disorders. The diagnosis has to be confirmed by: clinical symptoms and objective focus (increase of ASAT, ALAT, hepatic encephalopathy, reduced hepatic synthesis function, INR>1.5); a certified specialist physician (haematologist, infectologist, etc.). The insurance benefit shall not be paid for unjustified use of medication, which resulted in the development of hepatic failure.

3.3.13.3.23. **HIV infection**: a chronic infectious disease caused by the human immunodeficiency virus (HIV), contracted during accident at work or in case of physical violence. HIV must be diagnosed for the first time during insurance period and confirmed by the Infectology Center of the respective country.

3.3.13.3.24. **Hepatitis C**: an acute or chronic infectious disease caused by hepatitis C virus, contracted during accident at work. Hepatitis C must be diagnosed for the first time and confirmed by a certified physician and objective tests.

3.3.13.3.25. **Tick-borne encephalitis**: a disease caused by an infected tick bite. The insurance benefit shall be paid in the following cases: the disease is diagnosed after a full course of vaccination against tick-borne encephalitis (upon presenting a vaccination card); the Insured Person was hospitalised for at least ten (10) days.

3.3.13.3.26. **Lyme disease**: a disease caused by an infected tick bite, which resulted in damage to at least two organ systems (skin, bones, joints and/or nerves).

Paragraphs describing non-insured events: 4.2.1, 4.2.2, 4.2.3, 4.3

4. Non-insured events

4.1. Non-insured events shall mean the events, where the Insurer is not required to pay the insurance benefit.

4.2. The Insurer shall not pay the insurance benefit:

4.2.1. For health care services, treatment and/or other services provided due to:

a) health disorders caused by injury of the Insured Person caused intentionally or due to gross negligence or the Insured Person's suicide attempt. Gross negligence shall mean failure to comply with simple, generally understandable rules of conduct or disregard and/or non-observance of safe conduct requirements undoubtedly known to the individual;

b) Health problems that occur in the course of committing or in preparation to commit a criminal offence and/or performance of other actions contrary to the law by the Insured Person. The indications of criminal conduct or preparation to commit a criminal offence or other actions or omission contrary to the law shall be proved by the following, on which the Insurer may rely in making the decision to recognise the event as a non-insured event: findings and procedural decisions of pretrial investigation authorities, bodies authorised to deal with administrative offences and/or court judgements, decisions, resolutions and rulings;

c) Health problems that occur as a result of pandemics, natural disasters (such as violent storms, cyclones, earthquakes, sea or river flooding, lightning), any form of war, military action (regardless of whether war was declared or not), state of national emergency, insurrection, riot, internal unrest reaching the level of use of military or illegal force, and participation in acts of violence; any tests and/or other services for determining whether the Insured Person has a disease for which a pandemic has been declared shall not be reimbursed;

d) Health problems that occur due to the fault of the Policyholder or the beneficiary (actions performed with direct or indirect intention). Direct intention shall mean that a person performing certain actions was aware of their hazard to health and was willing to act so; indirect intention shall mean that the person performing certain actions was aware of their hazardous nature (in this case, to health), understood that their actions may lead to negative consequences (to health) and, although they did not want them, they deliberately allowed them to occur;

e) Health problems that occur as a result of exposure to radiation or other nuclear energy (except for the consequences of radiation therapy);

f) Health problems that occur due to the Insured Person's poisoning with alcohol, drugs or toxic substances used for the purpose of intoxication, or medicinal products that were not prescribed by a physician and were taken for self-medication;

g) Health problems, where the Insured Person develops a critical illness due to failure to follow physician's instructions.

4.2.2. For health care services, treatment and/or other services:

a) prenatal care, childbirth and postnatal care, diagnosis and treatment of health problems determined or exacerbated by pregnancy or childbirth;
b) diagnosis and treatment of congenital diseases and defects, enzymopathy (including but not limited to lactase deficiency, lactose intolerance, celiac disease) and their complications, consulting and tests prescribed by a geneticist;
c) diagnosis and treatment of dependence on psychoactive substances (nicotine, drugs, alcohol, psychotropic substances);
č) activities not licensed and/or diagnostic and treatment methods not approved by the Ministry of Health of the Republic of Lithuania, non-traditional medical services (including but not limited to acupuncture, herbal treatments, homeopathy, if the physician or health care institution does not hold a licence, aromatherapy, leech therapy, music therapy, endobiogenic medicine), services provided by individuals working under a business licence or self-employment certificate;
d) more than 10 consultations of a psychiatrist or medical (psychiatric) psychotherapist during the insurance period;
e) diagnosis and treatment of sexually transmitted diseases (syphilis, gonorrhea, trichomoniasis, chlamydia, human papilloma virus, herpes genitalis, etc.), genital warts, AIDS and HIV;
ė) monitoring, diagnosis and treatment of erectile dysfunction, IVF treatments, diagnosis and treatment of conditions related to infertility and inability to conceive;
f) abortion in the absence of medical indications and childbirth at a place other than a medical facility;
g) consulting on family planning, contraception; insertion, monitoring and removal of contraceptive devices, diagnostic tests before prescribing contraception, and tests necessary to avoid complications due to the use of contraception;
h) cosmetic plastic surgery (including but not limited to eyelid lift surgery), aesthetic dermatology treatment (phototherapy, photodynamic therapy, pulsed light therapy, laser treatment, including acne, rosacea, scar and nail fungus treatment, etc.), hair loss diagnosis and treatment (including but not limited to consulting by a trichologist, trichoscopy);
i) organ and tissue transplant surgery, joint replacement surgery, bone marrow transplantation, haemodialysis;
į) cosmetic/beauty treatments (aesthetic, body contour, medical pedicure, facial cleansing, peeling, hair removal, wrapping, cream application treatments, etc.), mesotherapy, hyaluronic acid and botox injections and the use of functional and diagnostic equipment, devices and supplies directly related to these treatments;
y) supportive treatment and care in specialized inpatient facilities (permanent, long-term care of elderly or disabled individuals or patients with chronic diseases, including services provided at home, care facility, medical centre or social welfare institution);
j) therapeutic and surgical diagnosis and treatment of excess weight, obesity, eating disorders, and food intolerance tests;
k) diagnosis and treatment of warts and moles, benign growths of the skin/subcutaneous tissue/soft tissue, vascular structures, spots, and pigmentation disorders;
l) intervention therapy (sclerotherapy) of deep venous/capillary diseases and varicose veins;
m) treatment of benign tumours;
n) correction of myopic and hyperopic vision, protective glasses and sunglasses, care products for contact lenses and spectacle lenses, purchase of spectacle cases and accessories;
o) health care services and/or treatment provided by the Insured Person's spouse, parents or children, purchase or medicinal products, medical supplies and orthopaedic technology devices and provision of health care services according to a prescription or referral issued by the Insured Person;
p) services provided, purchased and/or performed during insurance coverage invalidity/suspension period;
r) health care services not covered by the Insurance Contract;
s) in case the Insured Person exceeds the insured sum limits for health care service set forth in the Insurance Contract;

š) purchase of medicinal products: anabolic steroids, weight reducing products, sexual performance enhancing products, contraceptive products, products for treatment of substance dependence, products for treatment of illnesses and health problems listed in items e) and ė) of paragraph 4.2.2, medicinal products not registered by State Medicines Control Agency of Lithuania or the European Union countries, hygiene and cosmetic products, food products;

t) purchase of first aid supplies, medical products, diagnostic and therapeutic devices (thermometers, inhalers, testers, warmers, hearing aids, scales, blood pressure monitors, breathalysers, etc.), biochemical diagnostic kits;

t) teeth whitening, veneers, dental sealant coating, splints/mouthguards (whitening splints, sports mouthguards, protective mouthguards, mouthguards for teeth grinding and snoring), trainers, dental jewellery;

ū) health care services and/or treatment, the date or circumstances whereof cannot be determined by the investigation of the event;

v) in case prescription of diagnostic tests and treatment is not medically justified for the Insured Person;

z) in case the insurance coverage provided for by the Insurance Contract is used by a person other than the Insured Person;

ž) purchase of accommodation and board, visits to water and snow parks, rent of inventory, sports equipment and sportswear, team sports training and rent of a gym for such training, purchase of gift vouchers.

4.2.3. The Insurer shall not reimburse the costs related to the issue and/or submission of medical or other documents.

4.3. Critical illness insurance benefit shall not be paid, if the cause of the Insured Person's health problems is any of the following:

4.3.1. Intentional damage to the Insured Person's health condition (including intentional injuries) or attempted suicide;

4.3.2. Involvement in war or equivalent actions, any military activity, terrorist activity and mass unrest;

4.3.3. Involvement in actions organised by national military forces, including peace-keeping missions;

4.3.4. Illegal activities, serving a sentence in a penitentiary, violation of rights or criminal offences or involvement in them, if confirmed by a court or other competent authority;

4.3.5. Radioactive poisoning, radioactive pollution, natural disaster;

4.3.6. Consumption of alcohol, drugs, toxic or other intoxicating substances, abuse of medication, and self-medication;

4.3.7. Outcome of experimental or non-traditional treatment;

4.3.8. HIV infection or AIDS (positive AIDS test), with the exception of cases referred to in paragraph 3.3.13.3.23 of these Terms and Conditions;

4.3.9. Critical illness is diagnosed not for the first time, i.e. the illness of this kind is not the first case in the Insured Person's life;

4.3.10. The Insured Person has received medical consultation and/or treatment for the same critical illness before the beginning of the insurance term;

4.3.11. The Insured Person has been previously diagnosed with the critical illness or it was suspected before the effective date of insurance coverage.

5. Object of insurance, insurance coverage and period of insurance

5.1. The object of insurance shall mean property interests related to the health of the person who is provided with insurance coverage according to these Terms and Conditions.

5.2. The beginning and end of the insurance coverage and the scope of the insurance coverage shall be specified in the Insurance Policy, individual terms and conditions of insurance, other agreements between the parties to the Insurance Contract (annexes to the Insurance Contract) and these Terms and Conditions.

5.3. The Insurance Contract shall enter into force upon signature of the Insurance Policy and payment of the first instalment or full insurance premium by the Policyholder. The Insurer shall have the right to declare the Insurance Contract effective in the absence of the above terms.

6. Insured sum

6.1. The insured sum shall mean the amount of money per Insured Person set forth in the Insurance Contract, within the limits of which the Insurer undertakes to reimburse the Insured Person or health care institution for health care services provided to the Insured Person in case of an insured event according to the scope of insurance coverage provided for by the Insurance Contract. Insured sums agreed on by the parties to the Insurance Contract shall be specified in the Insurance Policy.

6.2. The Insurance Contract may provide for distribution of the insured sums by specific insurance risk groups.

7. Insurance premiums and procedure for payment

7.1. The amounts of insurance premiums and their payment terms shall be specified in the Insurance Policy. Insurance premiums shall be paid in advance for each insurance period. All insurance premiums (regular premiums) must be paid within the time limits set forth in the Insurance Policy.

7.2. Should the Policyholder fail to pay a regular insurance premium within the time period set forth in the Insurance Policy, the Insurer shall notify the Policyholder in writing at the expense of the Policyholder. Should the Policyholder fail to pay the insurance premium within fifteen (15) days from the date of sending the notice of outstanding insurance premium, the insurance coverage shall be suspended and only be restored after the Policyholder pays all outstanding insurance premiums.

7.3. If the suspension of the insurance coverage due to failure to pay the insurance premium continues more than three (3) months, the Insurer shall have the right to unilaterally terminate the Insurance Contract. Having terminated the Insurance Contract due to failure to pay the insurance premiums, the Insurer shall have the right to demand that the Policyholder compensate for the losses incurred by the Insurer in relation to the failure to pay the insurance premium.

8. Rights and obligations of the Parties to the Insurance Contract

8.1. In order to enter into the Insurance Contract, the Policyholder shall:

- submit an application for insurance in the form set by the Insurer, the list of Insured Persons and other information necessary for the Insurer in order to conclude the Insurance Contract;
- provide full and true information to the Insurer about the Insured Person or the person to be insured and health insurance contracts concluded or to be concluded by such person;
- present applicable or related terms and conditions of the Insurance Contract to the Insured Person and inform them about the fact that their data will be processed by the Insurer for the purpose of conclusion and performance of the contract;
- pay the insurance premiums set forth in the Insurance Contract.

8.2. The Insurer shall:

a) not disclose the information about the Policyholder or the Insured Person obtained when concluding the Insurance Contract, except the cases and exceptions provided by the Insurance Contract and/or law;

b) present these Terms and Conditions and inform the Policyholder of the amounts of insurance premiums and issue an Insurance Policy;

c) perform other duties of the Insurer set forth in legislation.

8.3. If after concluding the Insurance Contract it is found that upon entering into the Insurance Contract or during its validity period, the Policyholder or the Insured Person failed to fulfil their obligation to disclose information and provided the Insurer with incomplete or false information about the Policyholder, Insured Person or the circumstances that may have a material impact on the assessment of insurance risk, likelihood of occurrence of an insured event, fees of the Insurance Contract, the amount of the insurance premium and insured sum and other circumstances essential to the Insurance Contract, the Insurer shall have the right to terminate the Insurance Contract or reduce the insurance benefit or refuse to pay it.

8.4. Notices related to the Insurance Contract must be made in writing only. Such notices shall become binding to the Insurer from their receipt.

8.5. The Policyholder and/or the Insured Person shall notify the Insurer about the changes to the correspondence address, name, surname or company name within five (5) working days by mail or e-mail.

8.6. During the Insurance Contract period, the Policyholder shall notify the Insurer in writing (e-mail or registered mail) about any changes to the information about the Policyholder or the Insured Person provided when entering into the Insurance Contract, and notify the Insurer if the Insured Person terminates employment or other contractual relationship with the Policyholder and about the unauthorised use, loss or otherwise missing health insurance card within five (5) working days.

8.7. If it is found that the Insured Person or the Policyholder gave the health insurance card to another person who used or attempted to use it, the Insurer shall have the right to refuse to pay the insurance benefit for health care services provided this way and notify the Policyholder and/or the Insured Person thereof in writing.

8.8. The Policyholder shall notify the Insurer about all and any health insurance contracts entered into with other insurance companies for the benefit of the Insured Person or the Policyholder within thirty (30) days from entering into an insurance contract with another insurance company. If the Insured Person is insured under several insurance contracts by several Insurers (double insurance), in case of an insured event, the benefit payable by the Insurer shall be reduced in proportion to the insured sums so that the total benefit does not exceed the amount of costs incurred by the Insured Person reimbursable under the Insurance Contract.

8.9. If Health Insurance Contract covers only part of the risk/insurance value, the Policyholder or the Insured Person have the right to enter into an additional insurance contract covering the remaining part of risk with the same or another Insurer. However, in these cases, the total amount of insurance under all insurance contracts must not exceed the insured value.

8.10. Underinsurance clause shall not apply according to Health Insurance Policy Terms and Conditions.

8.11. The Policyholder and/or the Insured Person must provide all available documents and information about the circumstances and consequences of the insured event necessary for the Insurer to determine the amount of the insurance benefit.

8.12. The Insured Person shall take all reasonable steps to reduce the damage to health, seek medical attention, follow the physician's instructions and avoid and refrain from any action that could undermine the course of treatment or damage the Insured Person's health.

8.13. The Insured Person may choose any health care institution in Lithuania, which has the right to provide health care services in accordance with procedure prescribed by laws of the Republic of Lithuania.

8.14. In order to determine whether an insurance benefit should be paid, the Insurer may request that the Policyholder, Insured Person or other persons provide additional evidence and information and undergo additional health checks related to the assessment of the insured event and provided health care or other services referred to in the Insurance Contract and determining the amount of the insurance benefit or perform the required tests or appoint an expert physician at their own expense.

8.15. The Insurer shall have the right to unilaterally amend the list of partners, choose the services and scope of services provided by them and impose limitations on services.

8.16. In case the Insurer pays the insurance benefit to the Insured Person or covers the invoices of health care institutions for health care services provided to the Insured Persons, where the limit of insured sums for a service set forth in the Insurance Contract is exceeded or the insurance coverage should not have been applied to the Insured Persons, the Insurer shall have the right to demand that the Insured Person compensates the losses incurred by the Insurer due to such benefits, including the amounts paid by the Insurer to health care institutions and/or the Insured Persons.

9. Procedure for calculation and payment of insurance benefits

9.1. The Insurer shall pay the insurance benefits to the partner who provided health care and/or wellness services or sold the goods to the Insured Person or the Policyholder, or to the Insured Person, if they paid the health care institution for the health services provided or the goods purchased.

9.2. The Insurer shall pay the insurance benefits not later than within thirty (30) calendar days from the date of receipt of all information relevant for determining the fact and circumstances of the insured event and the amount of the insurance benefit.

9.3. Insurance benefits shall be paid within the limits of insurance coverage set forth in the Insurance Contract.

9.4. The Policyholder or the Insured Person shall notify the Insurer about the insured event in writing immediately, but not later than within thirty (30) calendar days from the date of the event. If health care services were provided to the Insured Person by a partner and the client used the ERGO card, the Policyholder and/or the Insured Person shall be released from the obligation to notify the Insurer about the insured event and the Insurer shall deal with the partner concerning the benefit.

9.5. The Insurer shall pay the insurance benefits to partners upon providing the documents supporting the provision of health care services in accordance with procedure, scope and rates set forth in cooperation/service agreements with service providers.

9.6. If the Insured Person paid for health care services themselves, the Insurer shall pay the insurance benefit to the Insured Person upon providing the following documents or copies thereof:

9.6.1. accounting documents stating the amount of expenses, amount of provided services or purchased goods and the person who incurred the expenses (e.g. an invoice with a receipt/payment order (or any digital document) or cash receipt with the details of the service/product provider (name of the institution, institution registration number, address), payer's information (name, surname) and a detailed description of the service/product provided (name, quantity, price, date of receipt);

9.6.2. Extract or copy of the referral from the medical records, specifying the information about the nature of illness, diagnosis, prescribed tests, therapies, and treatment;

9.6.3. If medicinal products, orthopaedic technology products, orthopaedic socks, assistive devices or optical products were purchased, the Policyholder/Insured Person must provide the prescription or a copy of the medical records, specifying the nature of illness, diagnosis and prescribed treatment;

9.6.4. A completed application for compensation of health insurance expenses (standard from of the Insurer).

9.6.5. In case of a critical illness, the Policyholder/Insured Person must provide medical records or copies thereof, supporting the diagnosis of the critical illness and the findings/results of instrumental and laboratory tests and surgeries.

9.7. The Insurer may reduce or refuse to pay the insurance benefit, if the Policyholder or the Insured Person provided incorrect details or deliberately false information about provided health care services or if the Insured Person failed to meet the requirements set forth in paragraphs 8.3, 8.14 and 9.4.

9.8. If an insurance benefit had been paid for a specific service provided or medicinal product/medicinal supplies purchased for the same insured event, another benefit shall not be paid for the same service/product.

9.9. The Insurer shall have the right to reduce the insurance benefit by the amount of insurance premiums outstanding at the time of the insured event and deduct the outstanding amounts payable by the Policyholder in accordance with procedure set by the Insurer in relation to the conclusion and performance of the Insurance Contract.

10. Termination of the Insurance Contract

10.1. The Policyholder shall have the right to terminate the Insurance Contract by giving written notice to the Insurer not later than one (1) month before the intended termination date.

10.2. The Insurer may terminate the Insurance Contract unilaterally without recourse to court in the cases referred to in paragraphs 7.3 and 8.3 of these Terms and Conditions.

10.3. If the Insurance Contract is terminated on the Policyholder's initiative without violation of the terms and conditions of the Insurance Contract by the Insurer or on the Insurer's initiative in case of violation of the terms and conditions of the Insurance Contract by the Policyholder, the Insurer shall refund the portion of the insurance premium for the remaining time of insurance coverage to the Policyholder, after deduction of the costs of conclusion and performance of the Insurance Contract and the amounts paid out under such Contract. The Insurer shall have the right to deduct the costs of conclusion and performance of the Insurance Contract in the amount of 15% of the annual insurance premium.

10.4. If the Insurance Contract is terminated on the Policyholder's initiative in case of violation of the terms and conditions of the Insurance Contract by the Insurer, the Policyholder shall receive a refund of the portion of the insurance premium paid for the time period of insurance coverage after the date of termination, after deduction of the costs of conclusion and performance of the Insurance Contract, which shall be 15% of the calculated annual insurance premium.

11. Amendments to the Insurance Contract

11.1. In order to amend the Insurance Contract, the Policyholder shall present a written application (by e-mail/fax/registered mail) in the form set by the Insurer, specifying the requested amendments to the Insurance Contract not later than one (1) month before the expected date of the amendment of the Insurance Contract. If the application is delayed or Policyholder fails to specify the date of amendment, the Insurer shall amend the Insurance Contract not later than within one (1) month after the receipt of the Policyholder's application. Taking into account the changed circumstances, the Insurer may refuse to amend the terms and conditions of the Insurance Contract. The amendments to the Insurance Contract shall come into force from the date specified in the amendment to the Insurance Contract issued by the Insurer or the amended insurance policy.

11.2. Insurance options specified in the Insurance Contract shall be valid for the time period specified in the Insurance Policy and shall not be changed in the course of the Contract.

12. Liability for breaches of the Insurance Policy Terms and Conditions

12.1. If the Policyholder fails to pay the insurance premium or other payments due under the Insurance Contract within the prescribed time period, upon the request of the Insurer, the Policyholder shall be required to pay penalty interest in the amount of 0.02% of the outstanding amount for each day of delay.

12.2. If the Insurer fails to pay the insurance benefits within the prescribed time period, upon request of the Policyholder, the Insurer shall be required to pay penalty interest in the amount of 0.02% of the outstanding insurance benefits for each day of delay.

13. Procedure for transfer of rights and obligations under the Insurance Contract

13.1. On the basis of a written agreement and upon receipt of permission from the Insurance Supervisory Authority of the Republic of Lithuania, the Insurer shall have the right to transfer their rights and obligations under the Insurance Contract to another insurance company, insurance company of another Member State of the European Union or a branch of a foreign insurance company established in the Republic of Lithuania or another Member State of the European Union in accordance with procedure prescribed by laws of the Republic of Lithuania.

13.2. The Insurer's notice of the intention to transfer the rights and obligations under the Insurance Contract must specify the time period of at least two (2) months for the Policyholder to submit any written objections to the transfer of the rights and obligations under the Insurance Contract.

13.3. If the Policyholder does not agree with the transfer of the rights and obligations under the Insurance Contract, the Policyholder shall have the right to terminate the Insurance Contract within one (1) month from the date of transfer of the rights and obligations by notifying the Insurer of the termination of the Insurance Contract in writing. If the Insurance Contract is terminated on the grounds referred to in this paragraph, the Policyholder shall receive a refund of the portion of the insurance premium paid for the remaining time period of insurance coverage, after deduction of the costs of conclusion and performance of the Insurance Contract.

14. Final provisions

14.1. This Insurance Contract is governed by the laws of the Republic of Lithuania.

14.2. All disputes arising between the Insurer and the Policyholder concerning the conclusion, performance or termination of the Insurance Contract shall be resolved by mutual negotiation.

14.3. Should the Parties fail to resolve the dispute by negotiation, the dispute between the Insurer and the Policyholder may be resolved without recourse to court in accordance with the Regulations for Resolution of Disputes between Consumers and Financial Market Participants established by the Bank of Lithuania or in court in accordance with the laws of the Republic of Lithuania.

14.4. The Policyholder and the Insured Persons should refer to the supervisory authority of financial market participants, i.e. the Bank of Lithuania (address: Totorių g. 4, LT-01121 Vilnius) for resolution of a dispute without recourse to court. Information about procedure for resolution of disputes between consumers and financial market participants is available here: http://www.lb.lt/gincu_nagrinejimas.

14.5. The Insurer shall have the right to amend the Policy Terms and Conditions, based on which an Insurance Contract has been concluded, provided the interests of the Policyholder, Insured Person and beneficiary are not undermined.

14.6. The Insurer shall have the right to supplement and amend certain articles of the Policy Terms and Conditions, based on which Insurance Contracts have been concluded, in the following cases: changes to or adoption of new laws, based on which the Terms and Conditions were drawn up, or changes to the legislation directly applicable to the Insurance Contract, or objective necessity due to economic situation (e.g. hyperinflation). New Terms and Conditions must not worsen the situation of the Policyholder and/or Insured Persons in comparison with the previous version.

14.7. The Insurer shall notify the Policyholder in writing of the changes to the Terms and Conditions referred to in paragraphs 14.5 and 14.6. The changes to the Terms and Conditions shall come into force after one (1) month from the date of receipt of notice of the changes to the Terms and Conditions by the Policyholder, unless the Insurer specifies a different date. If the Policyholder does not agree with the changes to the Terms and Conditions, the Policyholder shall have the right to terminate the Insurance Contract. If the Insurance Contract is terminated on the grounds referred to in this paragraph, payments shall be subject to the provisions of paragraph 10.4.

Chief Executive Officer
Bogdan Benczak

Member of the Board
Ingrida Kirse

Health Insurance Policy Terms and Conditions No. 010
Annex 1. Life Insurance

1. Key terms used in the Annex

Insured Person shall mean the natural person specified by the Policyholder and indicated in the Insurance Contract, who shall be paid the insurance benefit by the Insurer in case of an insured event in the Insured Person's life.

Beneficiary shall mean the person indicated in the Insurance Contract or the person appointed by the Policyholder or, in cases established by law, by the Insured Person, who is entitled to receive the insurance benefit. If the Beneficiary is not appointed, in case of death of the Insured Person, the insurance benefit shall be paid to legal successors of the Insured Person. The Insured Person shall have the right to change the Beneficiary during the Contract validity period by notifying the Insurer thereof.

2. Special Life Insurance Terms and Conditions for payment of the insured sum specified in the Life Insurance Contract in case of an insured event

2.1. Key terms

Insurance area and time: 24/7 all over the world

3. General provisions

3.1. Validity of insurance

3.1.1. Signature of the Insurance Contract confirms that the Insurer and the Policyholder have expressed their will and reached an agreement, whereby the Policyholder undertakes to pay the insurance premium in a timely manner and in the amount specified in the Contract and fulfil the obligations set out in this Annex, and the Insurer undertakes to pay the insurance benefit in case of an insured event in accordance with the provisions of the Insurance Contract.

3.1.2. Insurance coverage shall apply during the insurance validity period specified in the Insurance Policy, provided the insurance premium (or the first instalment thereof) has been paid before the date specified in the insurance policy.

3.1.3. Life Insurance shall be subject to the Health Insurance Policy Terms and Conditions No. 010 to the extent they are in compliance with the provisions of Annex 1 to these Terms and Conditions.

3.2. Insured events

3.2.1. An insured event shall be the death of the Insured Person during the period of validity of the Insurance Contract (except in cases provided for in Article 4).

3.2.2. Following a judicial declaration of death of the Insured Person, it is considered an insured event if the date of death of the Insured Person established by final judicial decision falls within the insurance coverage period. If the court declares the Insured Person missing, it is not considered an insured event.

4. Non-insured events

4.1. Non-insured events, for which insurance benefit shall not be paid out:

a) Suicide of the Insured Person over the first three (3) years of insurance coverage;

b) Death of the Insured Person related to military action, war or state of emergency, internal unrest, exposure to nuclear energy or criminal activities of the Insured Person;

c) Death of the Insured Person while the insurance coverage is suspended;

d) Death of the Insured Person due to intent of the Policyholder, Insured Person or beneficiary, except for suicide of the Insured Person after the first three (3) years of insurance coverage period.

5. Object of insurance

5.1. The object of insurance is a property interest related to the life expectancy of the Insured Person.

6. Insured sum. Insurance benefit

6.1. The Policyholder may specify preferred insured sums in the application. Insured sums agreed on by the parties to the Contract shall be specified in the Insurance Policy. The Insurer may set the minimum insured sum.

6.2. In case of death of the Insured Person due to an insured event, the insured sum for that person shall be paid out.

6.3. In case of a non-insured event, insurance benefits shall not be paid out and insurance premiums shall not be refunded.

7. Procedure for determining insurance benefits

7.1. In the event of death of the Insured Person, the following documents must be presented to the Insurer:

- Notice of death of the Insured Person;
- Copy of a medical death certificate.

7.2. The Insurer must be notified of death of the Insured Person within thirty (30) days after the date of death of the Insured Person or within thirty (30) days of the effective date of court decision to declare the Insured Person dead.

7.3. In order to determine whether insurance benefits are to be paid out, the Insurer may request additional documents and/or evidence or carry out an investigation at its own expense, refer to investigation materials, reports and procedural decisions of pre-trial investigation authorities and/or court decisions, judgements, resolutions and rulings. The scope of the required information shall be defined by the Insurer. When collecting information essential for determining the fact, circumstances and consequences of an insured event and the amount of insurance benefit, the Insurer shall have the right to request that the persons claiming insurance benefits provide proof of right of inheritance, kinship and identity documents, medical reports, diagnoses, other medical documents, proof of death of the Insured Person, explanations and conclusions issued by health care institutions, law enforcement agencies and other natural and legal persons in accordance with procedure prescribed by laws of the Republic of Lithuania, and all other oral and written information that the Insurer deems necessary for the investigation of the event and determination of the amount of benefit.

7.4. If incorrect age of the Insured Person was indicated and lower insurance premiums were set as a result thereof, the insurance benefit shall be determined based on the actual age of the Insured Person and applicable insurance premiums.

7.5. If the insured sum was increased and the first instalment of insurance premium as set out in the amendment of the Insurance Contract for the increase of the insured sum was not paid, the insured sum applicable before the increase shall be paid out in case of an insured event.

8. Procedure for the payment of insurance benefits

8.1. Insurance benefits shall only be paid to beneficiaries listed in the Insurance Contract. In the event of death of an under-age or legally incapacitated Insured Person or where the beneficiary is not specified in the Insurance Contract, insurance benefits shall be paid out to legal successors of the Insured Person.

8.2. Insurance benefits shall be transferred to the account specified by the Beneficiary. In case of transfer of insurance benefits to foreign countries, the associated risks and costs (currency exchange, transfer costs, losses, delays, etc.) shall be borne by the Beneficiary.

8.3. The Insurer shall pay out the insurance benefits within thirty (30) days from the date of receipt of all information essential for determining the fact, circumstances and consequences of an insured event and the amount of benefit (including additional information from law enforcement authorities, health care institutions, etc.). In case of pending investigation by law enforcement authorities or judicial proceedings concerning the insured event, the Insurer shall have the right to postpone the decision on the insurance benefit until the end of investigation or judicial proceedings. The decision whether the information received is sufficient to recognize the event as an insured event and determine the amount of insurance benefit shall be taken by the Insurer.

8.4. The Parties may agree on the payment of insurance benefits in instalments.

9. Miscellaneous

This Annex is an integral part of the Health Insurance Policy Terms and Conditions No. 010 (effective as of 1 June 2020). The matters not covered by this Annex shall be resolved in accordance with the Health Insurance Policy Terms and Conditions No. 010 (effective as of 1 June 2020).

Chief Executive Officer
Bogdan Benczak

Member of the Board
Ingrida Kirse