ERGO Life Insurance SE

ERGO

Personal Health Insurance Rules No. 23

Approved by Order No SE 19/v of CEO of ERGO Life Insurance SE of 30 March 2017
Valid from 03-04-2017.

I. General part

1. Main terms used in the rules

1.1. **Insurer** – ERGO Life Insurance SE.

1.2. **Policyholder** – adult natural or legal person, who either addressed the Insurer for concluding an insurance agreement or who was offered to conclude an insurance agreement by the Insurer, or who entered into the insurance agreement with the Insurer and committed to paying insurance premiums.

1.3. **Insured** shall mean a person indicated by the Policyholder and named in the insurance agreement, an insured event having happened in the life of whom shall be subject to a pay-out of an insurance benefit. There shall be one insured in one insurance agreement.

1.4. **Outpatient health care institution** shall mean a health care facility, which has the right to provide outpatient health care services in accordance with the procedure prescribed by legal acts valid in the Republic of Lithuania.

1.5. **Inpatient health care institution** shall mean a health care facility, which has the right to provide inpatient health care services in accordance with the procedure prescribed by legal acts valid in the Republic of Lithuania.

1.6. **Insurance coverage** shall mean an Insurer's commitment to pay an insurance benefit in case of an insured event.

1.7. **Insurance risk** shall mean the likely risk threatening the object of insurance.

1.8. **Insured event** shall mean an incident specified in the insurance agreement upon the occurrence of which the Insurer shall pay an insurance benefit. If the treatment of the Insured is continued for a disease or accident, which has no causal relationship to the health problem treated up until now, it shall be treated to be a separate insured event.

1.9. **Non-insured event** shall mean an event (health care services, treatment), upon occurrence of which the Insurer shall not have to pay an insurance benefit.

1.10. **Insurance application** a document in the form set by the Insurer, which the Policyholder planning to enter into the insurance agreement presents to the Insurer.

1.11. **Insurance rules** shall mean Personal Health Insurance Rules No. 23.

1.12. **Insurance agreement** shall mean a health insurance agreement signed by the Insurer and the Policyholder. The insurance agreement shall comprise:

- 1.12.1. insurance application;
- 1.12.2. insurance certificate;
- 1.12.3. insurance rules;
- 1.12.4. amendments, supplements and/or individual insurance agreement conditions agreed by the Insurer and the Policyholder in writing.

1.13. **Insurance certificate** shall mean a document issued by the Insurer certifying the conclusion of an insurance agreement.

1.14. **Sum insured** shall mean the amount of money indicated in the insurance agreement or calculated in accordance with the procedure laid down in the insurance agreement, which may not be exceeded by an insurance benefit and/or insurance benefits under an insurance agreement, except for cases laid down in the insurance agreement. Sums insured for which parties to the insurance agreement agreed upon shall be indicated in the insurance certificate.

1.15. **Insurance premium** shall mean the amount of money, which the Insurer shall pay to the Insured and/or a health care institution for health care services provided to the Insured according to insurance agreement conditions.

1.16. **Request for compensation of health insurance expenses** shall mean a document in the form set by the Insurer presented to the Insurer in request of an insurance benefit.

1.17. **Health care service** shall mean a qualified personal health care, pharmaceutical service provided in an outpatient and / or inpatient health care institution or a pharmacy.

1.18. **Pharmaceutical service** shall mean drugs, medical products, orthopaedic technical products, orthopaedic stockings and mobility aids for treating a disease.

1.19. **Treatment** shall mean medical consultations, diagnostic tests and medical procedures for treating a disease.

1.20. **Health problem** shall mean the change in health or physiological condition of the Insured (in cases of an acute illness, exacerbation of a chronic disease and/or a trauma), which requires the application of diagnostic and treatment.

1.21. **Alternative medicine** shall mean disease diagnosis and treatment in non-traditional ways, including, but not limited to biopuncture (electro-acupuncture) diagnostics, food intolerance test, hydro-colonotherapy, acupuncture, homeopathy and leach treatment.

1.22. **Preventive services** shall mean chronic disease monitoring, tests done at the wish of the Insured, and preventive health check-ups depending on the nature of work.

Other terms used in the insurance agreement shall be interpreted as defined in the Law on Insurance and other valid legal acts of the Republic of Lithuania.

2. Concluding insurance agreement

2.1. In order to conclude an insurance agreement, the Policyholder shall submit to the Insurer an insurance application, answering therein questions presented by the Insurer in the insurance application comprehensively and correctly, and providing other information requested by the Insurer, which can have a material impact on the likelihood of occurrence of an insured event and the insurance risk. The submission of an insurance application shall not obligate the Insurer to conclude an insurance agreement.

2.2. Having assessed the risk of insurance, the Insurer may refuse to conclude an insurance agreement, without indicating any reasons therefor. If the insurance premium was paid according to the submitted insurance application before the assessment of the insurance risk and the refusal of the Insurer to conclude an insurance agreement, such a premium shall be returned to the person having paid it. If an insured event provided for in these Rules happens during this period of time, the Insurer shall not have to pay an insurance benefit.

2.3. Upon the Insurer's consent to conclude an insurance agreement, the Policyholder shall be issued an insurance certificate confirming the conclusion of an insurance agreement. The day of conclusion of an insurance agreement shall be the day of issuance of the insurance certificate.

2.4. The insurance agreement may be concluded laying down therein individual insurance conditions, if the Policyholder agrees to such conditions being a part of the insurance agreement.

3. Object of insurance and insurance territory

3.1. Object of insurance shall be a moral interest related to health of a person who is provided with insurance coverage according to these Insurance Rules.

3.2. The Insurer shall assume an obligation to compensate those expenses of the Insured that are not covered from compulsory health insurance fund budget.

3.3. The insurance coverage shall be valid in the territory of the Republic of Lithuania, unless these rules and/or the insurance agreement establishes otherwise.

4. Non-insured events

4.1. The Insurer shall not pay an insurance benefit:

4.1.1. **for the provided health care services, and/or other services for:**

4.1.1.1. health problems that were caused to the Insured by him having injured himself intentionally or by gross negligence, or when trying to commit a suicide. Gross negligence is non-compliance with simple commonly understandable rules of behaviour or ignorance and/ or a failure to comply with well-known safe behaviour requirements;

4.1.1.2. health problems that occurred when the Insured was committing a crime or preparing to commit a crime and/or due to other actions in conflict with law. Signs of criminal acts or preparation to commit them, or actions or omission in conflict with law are proved by and the Insurer may use the following as a basis for making a decision on declaring an event to be non-insured: conclusions of pre-trial investigation authorities and bodies authorized to examine cases of administrative offenses, procedural decisions and/or court resolutions, decisions, judgements and rulings;

4.1.1.3. health problems that occurred as a result of pandemics and impact of natural disasters (such as a violent storm, cyclones, earthquakes, sea or river floods, lightning), war of any form, actions of military nature (regardless of whether or not a war was declared), introduction of the state of emergency, rebellion, riots, internal unrest having reached the scope of exertion of military or illegal power, also for participation in acts of violence;

4.1.1.4. health problems having occurred at the fault of the Policyholder or the insurance beneficiary (offenses committed with direct or indirect intent); direct intent shall mean cases, when, conducting certain actions, a person realized their dangerous nature to health and wanted to act that way; indirect intent shall mean that cases, when, conducting certain actions, a person realized their dangerous nature (in this case - to health), he knew that his actions were likely to result in adverse consequences (to health), and, even though unwillingly, he consciously allowed them to happen;

4.1.1.5. health problems having occurred due to radiation or other nuclear energy effects (excluding the effects of radiation therapy);

4.1.1.6. health problems suffered by the Insured from the use of alcohol, drugs, toxic substances used for intoxication purposes, or medicines that were not prescribed by a doctor;

4.1.1.7. health problems having occurred during non-validity of insurance coverage;

4.1.1.8. congenital health problems and their complications;

4.1.1.9. costs associated with the issuance and/or presentation of medical and other documents;

4.1.2. **for the provided health care services and/or treatment:**

4.1.2.1. when a service was provided by a spouse, parents or children of the Insured;

4.1.2.2. unprovided for in the insurance agreement;

4.1.2.3. when the Insured exceeded the limits of the sums insured for the health care service of the insurance option provided for in the insurance agreement;

4.1.2.4. the date and circumstances whereof cannot be determined having investigated the event;

4.1.2.5. when the prescription of diagnostic tests and treatment are not medically justified;

4.1.2.6. according to a prescription or referral issued by the Insured himself;

4.1.2.7. joint replacement surgeries and joint prostheses, prosthetic systems;

4.1.2.8. surgeries for the correction of vision;

4.1.2.9. pregnancy care, childbirth and post-natal care, treatment of health disorders resulting from pregnancy or childbirth;

4.1.2.10. abortion in the absence of any medical indications and/ or giving birth in non-medical institution;

4.1.2.11. treatment of sexually transmitted diseases (syphilis, gonorrhoea, trichomoniasis, chlamydia, human papilloma virus, herpes genitalis, etc.), genital warts, AIDS and HIV diagnosis and treatment;

4.1.2.12. diagnosis and treatment of potency problems, artificial insemination procedures;

4.1.2.13. diagnosis and treatment of warts and moles, benign skin formations, vascular lesions, spots, and pigmentation disorders;

4.1.2.14. surgical treatment of benign tumours;

4.1.2.15. sclerotherapy procedures and surgical treatment of varicose veins;

4.1.2.16. therapeutic and surgical treatment of obesity;

4.1.2.17. cosmetic - plastic surgeries, cosmetology / beauty procedures (aesthetic, improvement of body lines, anti-cellulite procedures, body scrub, wraps, etc.), and the use of functional, diagnostic equipment, devices and instruments directly related to these procedures;

4.1.2.18. services provided in a health care institution and / or by a health care professional, who do not hold a valid license issued by the State Health Care Accreditation Agency under the Ministry of Health of the Republic of Lithuania, the Lithuanian Dental Chamber or the State Medicines Control Agency under the Lithuanian Ministry of Health;

4.1.2.19. applying methods of alternative medicine treatment;

4.1.2.20. acquisition of medical aids, diagnostic and therapeutic devices (thermometers, inhalers, testers, warmers, hearing aids, scales and blood pressure meters, glucometers, etc.);

4.1.2.21. medicinal products unregistered in the Republic of Lithuania or the Community Register of Medicinal Products;

4.1.2.22. weight loss drugs, drugs to increase potency, treat various addictions, steroids, nutritional supplements, hygiene, cosmetics and contraceptives;

4.1.2.23. medicinal products acquired in places other than pharmacies.

4.2. Other non-insured events are indicated in special insurance conditions to these insurance rules.

5. Insurance premiums and their payment procedure

5.1. Insurance premium currency, amounts and their payment deadlines shall be indicated in the insurance certificate. Insurance premiums shall be paid in advance for each insurance period. The first and single premium shall be paid before the effective date of the insurance agreement. All other insurance premiums (regular premiums) shall be paid within the deadlines set in the insurance certificate. The Policyholder shall pay insurance premiums in the official currency of the Republic of Lithuania.

5.2. The date of payment of an insurance premium shall be considered the day when the premium is credited to the Insurer's bank account. If a payment transfer does not allow determining the insurance agreement on the basis whereof an insurance premium is paid, the date of payment of an insurance premium shall be the date when the Insurer attributed this insurance premium to a respective insurance agreement.

5.3. If the Policyholder fails to pay a regular insurance premium or its part within the time set in the insurance agreement, the Insurer shall inform the Policyholder thereof indicating that should he fail to pay the insurance premium or a part thereof within 30 calendar days from the day of sending the notice to the Policyholder, the insurance agreement shall terminate.

5.4. If the Policyholder fails to pay the first or single insurance premium, the insurance agreement shall not take effect from the effective date indicated in the insurance agreement. If an insurance premium is paid late in such a case, but no later than within 30 calendar days from its effective date provided for in the insurance agreement, the insurance agreement shall take effect on the day following the payment of the insurance premium, but the period of validity of the insurance agreement indicated therein shall not be extended.

6. Insurance agreement validity terms

6.1. The term of validity of the insurance agreement shall be entered in the insurance certificate.

6.2. The insurance agreement shall take effect in presence of all the below conditions: the Policyholder has been issued an insurance certificate and the first or a single insurance premium has been paid.

7. Rights and duties of parties to the insurance agreement

7.1. When concluding an insurance agreement, the Policyholder must:

a) present an application for insurance in the form set by the Insurer and other information necessary for the Insurer to conclude an insurance agreement;

b) provide to the Insurer with comprehensive, true information on the insured person, also, on the concluded or planned to be concluded agreements on the insurance of health of this person;

c) familiarize the Insured with insurance agreement conditions applicable to the Insured or related to him;

d) pay insurance premiums laid down in the insurance agreement;

e) perform other duties of the Policyholder provided for in legal acts valid in the Republic of Lithuania and the insurance agreement.

7.2. The Insurer undertakes:

a) not to publish information on the Policyholder or the Insured received when concluding an insurance agreement, except for cases and/or exceptions established in the insurance agreement or laws valid in the Republic of Lithuania;

b) to familiarize the Policyholder with these insurance rules, insurance premium amounts, and issue an insurance certificate having concluded an insurance agreement;

c) to perform other duties of the Insurer provided for in legal acts valid in the Republic of Lithuania and the insurance agreement.

7.3. The Insurer shall insure believing that the Policyholder and the Insured answered all the question related to the existing or former illnesses, health problems and ailments presented in the insurance application correctly and in detail.

7.4. Should it be determined after concluding an insurance agreement that the Policyholder or the Insured failed to perform their duty to disclose information when concluding an insurance agreement or during its validity, or intentionally or due to gross negligence provided to the Insurer incomplete, untrue information about the Policyholder, the Insured or about circumstances that may have essential effect on the evaluation of the insurance risk, the likelihood of occurrence of an insured event, the setting of insurance agreement fees, insurance premiums or the sum insured, or determining other circumstances important for insurance agreement, the Insurer shall, considering the circumstances of non-disclosure of information, have the right declare the insurance agreement invalid, or to request to terminate it, and should the Policyholder disagree with its termination, - to terminate it, or to reduce an insurance benefit, or to refuse to pay it altogether.

7.5. The Insurer shall have the right to request the insured person to check his health in the health care institution specified by the Insurer and present the Insurer with the check-up results.

7.6. Insurance agreement-related notices shall be presented in writing only. Such notices shall take effect in respect of the Insurer from the moment of their receipt.

7.7. In cases when a written submission of information is provided for in laws valid in the Republic of Lithuania and/or the insurance agreement, this requirement shall be considered fulfilled if, upon the agreement of the parties to the insurance agreement, information to the Policyholder (the Insured) was presented by mail, e-mail or other telecommunications terminal equipment allowing to prove the fact of the submission of information.

7.8. The Policyholder shall inform the Insurer about the change of correspondence address, his name, surname or title within 5 working days. Otherwise, the Policyholder shall cover related expenses, if a notice addressed thereto was sent by registered mail to the address known to the Insurer about the change whereof the Policyholder failed to notify.

7.9. The Policyholder shall inform the Insurer before concluding an insurance agreement or during the validity period of the insurance agreement about any change of information of the Policyholder or the Insured indicated when concluding the insurance agreement, or the increase of risk in writing within 5 working days.

7.10. The Policyholder and/or the Insured shall present all available documents and information about the circumstances and consequence of the insured event necessary for the Insurer to determine the insurance benefit amount.

7.11. The Insured shall take all measures available thereto to reduce damage done to health and to avoid and refrain from any actions that could undermine the course of treatment or health of the Insured.

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

7.13. In order to determine whether insurance benefits must be paid, the Insurer may ask the Policyholder, the Insured or other persons to furnish additional evidence and information related to the assessment of the insured event, the provided health care services or other services

provided for in the insurance agreement, the setting of the insurance benefit amount, or perform the necessary investigations at its own expense, or appoint a medical expert.

8. Procedure of determining insurance benefit amounts

8.1. Insurance benefits shall be paid within the limits of insurance coverage established in the insurance agreement.

8.2. Having paid an insurance benefit, the sum insured shall be reduced by the paid insurance benefit amount.

8.3. The Policyholder or the Insured shall report the insured event immediately, but no later than within 30 calendar days from the day of the event.

8.4. The following documents or their copies shall be submitted to the Insurer for the payment of an insurance benefit:

- Financial documents - an invoice with a cash receipt/ payment transfer or a cash income order receipt/ cash acceptance receipt, which shall contain service/ product supplier's details (name of the institution, company code and address), data of the payer (name, surname, personal code) and detailed description of the provided service/ product (name, quantity, price, date of receipt);
- referral/ extract or a copy from medical records, indicating information on the nature of the disease, the diagnosis, prescribed tests, procedures and treatment;
- in case of purchasing medicines, medical aids, orthopaedic technical products, compression stockings, mobility aids– a prescription or a copy of medical records indicating information on the nature of disease, diagnosis and prescribed treatment;
- a completed application for the compensation of health insurance expenses.

8.5. When reporting an insured event, the Policyholder and/or the Insured shall present to the Insurer documents substantiating the provision of health care services and the payment therefor, or copies of such documents.

8.6. The Insurer may reduce or refuse to pay an insurance benefit, if the Policyholder or the Insured presented incorrect data or false information about the provided health care services or if the Insured has failed to fulfil requirements laid down in paragraphs 7.1., 7.5. and 8.3.

8.7. If the Insured is insured under several insurance agreements by different insurers, the insurance benefit paid by the Insurer in case of an insured event shall be reduced proportionately.

8.8. If an insurance benefit was already paid for the same insured event for the same service or acquired medicine/ medical aid, another benefit shall not be paid.

9. Procedure of payment of insurance benefits

9.1. The Insurer shall pay insurance benefits no later than within 30 calendar days from the day when all information important in determining the fact, circumstances and consequences of the insured event and the insurance benefit amount was received.

9.2. The Insurer shall have the right to reduce an insurance benefit by the amount of insurance premiums unpaid until the insured event and to deduct amounts unpaid by the Policyholder related to the conclusion and execution of the insurance agreement in the procedure prescribed by the Insurer.

10. Termination of the insurance agreement

10.1. The Policyholder shall have the right to terminate the insurance agreement having warned the Insurer in writing no later than 1 month before the planned date of termination of the insurance agreement.

10.2. The Insurer may terminate the insurance agreement unilaterally in out of court procedure in cases laid down in paragraphs 5.3. and 7.4. hereof.

10.3. When the insurance agreement is terminated at the initiative of the Policyholder or the Insurer with the Policyholder having breached conditions of the insurance agreement, insurance premiums shall not be returned.

10.4. When the insurance agreement is terminated at the Policyholder's initiative with the Insurer having breached conditions of the insurance agreement, the share of the paid insurance premiums shall be returned to the Policyholder for the insurance coverage period remaining after the termination day, having deducted costs of conclusion and execution of the insurance agreement, which shall not exceed 25% of the calculated annual insurance premiums amount.

10.5. When the insurance agreement is terminated at the initiative of the Policyholder without the Insurer having breached conditions of the insurance agreement, the Policyholder shall be repaid the share of the paid insurance premium for the validity period of insurance coverage remaining after the termination day, having deducted the paid insurance benefits and costs of conclusion and execution of the insurance agreement, which shall not exceed 25% of the calculated annual insurance premiums amount.

11. Amending insurance agreement

11.1. In order to amend the insurance agreement, the Policyholder shall inform the Insurer of the desired amendments to the insurance agreement in writing (by e-mail/ fax/ registered mail) no later than 1 month before the planned date of amendment of the insurance agreement. If the Policyholder breaches this deadline or fails to indicate it, the Insurer shall amend the insurance agreement no later than within 1 month from the day of receipt of the Policyholder's request. Having assessed the insurance risk and other circumstances important for the insurance agreement, the Insurer may refuse to amend insurance agreement conditions. Amendments to the insurance agreement shall take effect on the day indicated in the amendment to the insurance agreement issued by the Insurer or in the amended insurance certificate.

11.2. When amending agreement conditions, the Insurer may request information on health condition of the insured persons, their leisure interests and other risk factors.

12. Liability for breaching insurance agreement

12.1. If the Policyholder fails to pay an insurance premium or other payments according to the insurance agreement within the set period of time, the Policyholder shall, at the Insurer's request, pay to the Insurer interest of 0.02 % of the outstanding amount for each day of delay.

12.2. If the Insurer fails to pay insurance benefits within the set period of time, he shall, at the Policyholder's request, pay interest of 0.02 % of the unpaid insurance benefits amount for each day of delay.

13. Procedure of assigning rights and duties under the insurance agreement

13.1. The Insurer shall have the right to assign his rights and duties under the insurance agreement to another insurance company, insurance company of another European Union member state or a branch of a foreign insurance company established in the Republic of Lithuania or another European Union member state in the procedure prescribed by laws of the Republic of Lithuania or another European Union member state, on the basis of a written agreement and having received a permission of an insurance supervisory authority of the Republic of Lithuania in accordance with the procedure laid down by laws of the Republic of Lithuania.

13.2. The Insurer's notice on the intension to assign rights and obligations under the insurance agreement shall indicate a deadline of at least 2 months during which the Policyholder shall have the right to express to the Insurer its objections on the intension to assign rights and duties under the insurance agreement.

13.3. Disagreeing with the assignment of rights and duties under the insurance agreement, the Policyholder shall have the right to terminate the insurance agreement within one month from the day of assignment of rights and duties, having informed the Insurer about the termination of the insurance agreement in writing. Having terminated the insurance agreement on the basis indicated in this paragraph, the Policyholder shall be returned the share of the insurance premium for the remaining insurance coverage period, having deducted costs of conclusion and execution of the insurance agreement.

II. Special insurance conditions

1.1. **Insurance conditions for outpatient treatment service expenses**

1.1.1. **Explanations of terms**

Outpatient treatment service shall mean treatment in an outpatient health care institution.

1.1.2. **Insured events**

Insured event shall mean expenses for a health impairment of the insured person for medically-justified outpatient treatment services in Lithuania.

1.1.3. **Non-insured events**

The Insurer shall not pay insurance benefits for the following provided health care services and/or treatment:

a) advice on family planning and contraception-related issues; insertion, control and removal of contraceptives, diagnostic tests before prescribing contraceptives and tests in order to avoid complications from the use of these measures;
b) immunotherapy, psychotherapeutic treatment;
c) immunologic - immunoenzymatic tests for the detection of antibodies-antigens (except for the thyroid gland hormone antibodies);
d) diagnosis and treatment of osteoporosis;
e) genetic and cytogenetic, allergen-specific IgE (food, inhaled), sex hormone tests;
f) tests of medicines, narcotic substances and heavy metals;
g) somnography examination, trichogram;
h) treatment of diseases included in the list of severe diseases;
i) services of specialized doctors not specified in the insurance agreement;
j) rehabilitative therapy services (physiotherapy, physical therapy, occupational therapy, massages);
k) day care and day surgery services, unless the insurance agreement establishes otherwise.

1.2. **Special conditions for insurance of inpatient service expenses**

1.2.1. **Explanation of terms**

Inpatient treatment service shall mean a health care service provided at the state inpatient health care institution, when the insured person needs medical aid lasting for more than 24 (twenty four) hours.

1.2.2. **Insured events**

Insured event shall mean expenses for a health impairment of the insured person for medically-justified inpatient treatment services in Lithuania, Latvia or Estonia.

1.2.3. **Insurance benefit and its payment**

Costs of pharmaceutical services shall be compensated, once the insured person submits a discharge summary issued by a physician who treated him in the inpatient health care institution.

1.2.4. **Non-insured events**

The Insurer shall not pay insurance benefits for the following provided health care services and/ or treatment:

a) if the inpatient treatment service was provided in the first 3 insurance agreement validity months (excluding the cases of renewed insurance agreements);
b) organ transplantation, bone marrow transplantation;
c) supportive treatment and care in specialized inpatient institutions (permanent, long-term care for the elderly, disabled persons and patients with chronic diseases);
d) diagnosis and treatment of diseases included in the list of severe diseases;
e) rehabilitation (physiotherapy, physical therapy, occupational therapy, massages) and sanatorium (anti-recurrence) treatment services, day care and day surgery services.

1.3. **Special conditions for insurance of serious disease treatment expenses**

1.3.1. **Explanation of terms**

Serious disease shall mean one or several diseases and/or surgeries mentioned in paragraph 15.3.4 carried out according to the medical indications corresponding to the criteria for diagnosing serious diseases referred to in this article. Health care services related to the treatment of serious diseases shall be provided in an outpatient and/ or inpatient health care institution or pharmacy.

Diagnosis code shall mean a diagnosis determined according to the International Classification of DiseasesTLK-10.

1.3.2. **Insured event** shall mean expenses incurred by the insured for medically-justified health care services for the treatment of serious diseases in Lithuania, Latvia or Estonia.

1.3.3. **Validity period of the insurance coverage**

Insurance coverage shall be valid for 12 months from the day of an insured event.

1.3.4. **List of severe diseases:**

1.3.4.1. **Malignant tumour (cancer)** (according to the ICD-10 classification: C00-C97; D00-D09)

Malignant tumours are characterized by uncontrolled and (or) unstoppable malignant cell proliferation, invasion and spreading (penetration) into normal tissue and destruction of healthy tissue.

Diagnosis is confirmed by:

- histological tests;
- conclusion by an oncologist; haematologist-oncologist.

Exceptions:

- tumours, which in histological terms are characterized as a precancerous stage
- cervical dysplasia CIN-1, CIN-2 and CIN-3;
- localized, non-invasive tumours (carcinoma in situ);
- any tumours if the insured person is infected with HIV.

1.3.4.2. **Myocardial infarction** (according to the ICD-10 classification: I21.0-I21.4, I21.9)

This is an acute irreversible damage to cardiac muscle tissue (necrosis) due to insufficient blood flow.

The diagnosis is confirmed by at least two of the following symptoms:

- typical episodes of the disease;
- new changes in the electrocardiogram typical of myocardial infarction;
- increased levels of biochemical markers (troponin I and T, creatine kinase, creatine kinase MB fraction, myoglobin;
- cardiologist's opinion.

1.3.4.3. **Stroke (cerebral infarction)** (according to the ICD-10 classification: I60-166)

This is an acute cerebrovascular disorder, usually due to cerebral vascular blockage or rupture of blood vessels of the brain or cerebral and/or subarachnoid haemorrhage, causing neurological symptoms that last longer than 24 (twenty four) hours.

Diagnosis is confirmed by:

- changes in the brain characteristic to stroke and confirmed by computed tomography or nuclear magnetic resonance imaging of the brain;
- permanent neurological deficit until at least 6 weeks after the event;
- neurologist's opinion.

Exceptions:

- transient cerebral circulatory disorders;
- brain damage due to trauma, infection, vasculitis and inflammation;
- neurological symptoms due to migraine.

1.3.4.4. **Renal failure** (according to the ICD-10 classification: N17; N18; N19)

Acute and chronic kidney tissue damage induced by a variety of substances and/or factors, which results in renal blood disorders, significantly reduced or completely stopped renal glomerular urine filtration requiring regular haemodialysis or kidney transplantation.

Diagnosis is confirmed by:

- nephrologist's opinion and instructions for regular or continuous haemodialysis;
- abnormalities in blood and urine tests;
- renal puncture biopsy.

1.3.4.5. **Multiple sclerosis** (according to the ICD-10 classification: G35)

Multiple sclerosis is a relapsing and progressing demyelinising, inflammatory disease of the central nervous system, which clearly interferes with its functions.

The diagnosis is confirmed by at least three of the following symptoms:

- neurologist's opinion after inpatient examination;
- neurological symptoms: sensory and motor dysfunction lasting longer than for 3 months;
- at least two documented clinical episodes, with at least one month interval;
- conclusions on nuclear magnetic resonance and cerebrospinal fluid tests.

1.3.4.6. **Parkinson's disease** (according to the ICD-10 classification: G20)

This is a progressing neurodegenerative disease determined by insufficient dopamine levels that causes disorders of the motor system.

Diagnosis is confirmed by:

- neurologist's opinion after inpatient examination;
- signs of disease progression;
- personal inability (with or without assistance) to perform at least three of the six daily activities for a long period of time, but not less than six months:

  I. washing: the ability to take a bath or a shower or a bath (including entry and exit) or to wash satisfactorily in any other way;

  II. dressing: the ability to dress and undress clothes, to button and unbutton various clothing items, limb or other surgical prosthetic aids;

  III. locomotion: the ability to move from a bed to a chair or wheelchair and back;

  IV. movement: the ability to move from one room to the other on a level surface;

  V. toilet: the ability to use the toilet or otherwise ensure emptying of the bowel or bladder, maintaining a satisfactory level of personal hygiene;

  VI. eating: the ability to eat independently, if the food is prepared

  VII. and placed in an accessible place;

Exceptions:

- if the disease is caused by chronic alcoholism or overdose of medication.

1.3.4.7. **Alzheimer's disease** (according to the ICD-10 classification: G30.0- G30.1; G30.8-G30.9)

This is a chronic neurodegenerative disease that affects the brain nuclei and the brain structure, which worsens memory and thinking, changes in behaviour.

Diagnosis is confirmed by:

- cognitive changes confirmed by clinical assessment and neuropsychological tests, stating what the need for regular care and lasting for at least 6 months;
- neurologist's opinion.

Exceptions:

- dementia syndrome due to neurological, psychiatric or other systemic diseases.

1.3.4.8. **Bacterial meningitis** (according to the ICD-10 classification: G00.0-G00.3; G00.8-G00.9)

This is a severe head or spinal cord sheathing inflammation caused by bacterial infection, leading to serious, irreversible and permanent neurological defects.

Diagnosis is confirmed by:

- bacterial infection found in blood and CSF;
- neurological symptoms lasting for at least 6 weeks;
- neurologist and (or) neurosurgeon's opinion.

1.3.4.9. **Aplastic anaemia** (according to the ICD-10 classification: D60-D61)

This is a chronic bone marrow failure accompanied by anaemia, neutropenia and thrombocytopenia; to eliminate it at least one of the following treatment methods is required:

- transfusion of blood products;
- use of substances promoting bone marrow activity;
- use of immunosuppressive substances;
- bone marrow transplantation.

Diagnosis is confirmed by:

- laboratory tests of blood and bone marrow;
- haematologist's opinion.

1.3.4.10. **Active tuberculosis** (according to the ICD-10 classification: A15- A19)

This is an infectious disease, when TB bacilli with the blood and via the lymphatic system spread throughout the body and damage any organ or system (lungs, spine, hips, kidneys, sex organs, brain, etc.).

Diagnosis is confirmed by:

- Laboratory and X-ray tests;

- Phthisiologist's opinion.

1.3.4.11. **Crohn's disease** (according to the ICD-10 classification: K50)

This is a chronic, relapsing, segmented, progressive autoimmune granulomatous inflammation of the digestive tract.

Diagnosis is confirmed by:

- gastroenterologist's opinion;
- instrumental examination (endoscopic tests);
- histopathological findings.

1.3.4.12. **Hepatic insufficiency** (according to the ICD-10 classification: K72.0; K71.1; K71.2)

This is liver failure due to hepatic necrosis after acute viral infections, toxins, drugs or immune system damage.

Diagnosis is confirmed by:

- clinical symptoms associated with liver failure;
- objective laboratory data;
- gastroenterologist's (hepatologist's) or general practitioner's opinion.

Exceptions:

- liver failure caused by alcohol or unreasonable (not prescribed by a physician) use of medicines.

1.3.4.13. **Coronary artery bypass surgery**

The surgery, which corrects stenosis or occlusion of several coronary arteries by using arterial grafts.

The need for surgery is confirmed by:

- coronary occlusion, found during angiography;
- the need for operation confirmed by a cardiologist and/or cardio surgeon.

Exceptions:

- angioplasty, stenting;
- arterial catheterization;
- arterial laser treatment.

1.3.4.14. **Heart valve surgeries**

Surgeries for the replacement of damaged heart valves (due to stenosis, valve failure).

The need for surgery is confirmed by:

- cardiac ultrasound test;
- the medical need for operation confirmed by a cardiologist and/or cardio surgeon.

Exceptions:

- heart valve plastic and/or correction surgeries.

1.3.4.15. **Transplantation of major organs/bone marrow**

Diagnosis is confirmed by:

- operation for bone marrow transplantation, using the cells of haematopoietic system with prior complete removal of bone marrow;
- transplantation of one of the following human organs: the heart, lungs, liver, kidney, pancreas due to irreversible failure of the organ concerned.

Exceptions:

- stem cell transplantation.

1.3.5. **Non-insured events**

The insurer shall not pay the insurance benefits for the provision of health care services and/or treatment:

15.3.5.1. if a severe disease is diagnosed during the first six months of the insurance agreement effectiveness (excluding the cases with renewed insurance agreements);

15.3.5.2. if the severe disease does not meet the criteria for acknowledgement

15.3.5.3. as a severe disease and an insured event set out in paragraph 15.3.4.

1.4. **Special conditions for insurance of costs of treatment after accidents**

1.4.1. **Explanation of terms:**

Accident shall mean an event where the insured person's body is suddenly affected from outside without his will, causing damage to his health.

Rehabilitation treatment service shall mean continuing treatment of accident consequences in an outpatient and/or inpatient health care institution that helps the patient to recover working capacity.

Dental treatment service shall mean dental x-ray examination of teeth damaged during an accident, seal rehabilitation, surgical dentistry, prosthetics, dental treatment in an outpatient and/or inpatient health care institution.

1.4.2. **Insured events**

1.4.2.1. the insured person's costs for medically reasonable dental services in Lithuania due to traumatic injury of teeth;

1.4.2.2. the insured person's costs for medically reasonable rehabilitation services of trauma consequences.

1.4.3. **Obligations of the Policyholder and the Insured**

15.4.3.1. in case of an accident, to immediately, but no later than within 48 hours refer to a physical (a health care institution).

1.4.4. **Insurance benefit and its payment**

Rehabilitative treatment costs are reimbursed only after treating trauma consequences in an inpatient health care institution.

1.4.5. **Non-insured events:**

1.4.5.1. The insurer shall not pay insurance benefits for medical costs related to accidents where the insured person:

a) used alcohol or other intoxicating substances after the accident before medical examination or avoided a check for intoxication with alcohol or other intoxicating substances. In these rules intoxication with alcohol or other intoxicating substances shall be understood in accordance with the procedure set out in laws of the Republic of Lithuania;

b) serves in an army or another similar formation, participates in a peacekeeping mission;

c) participates in air, land or water vehicle competitions as a motor vehicle driver, co-driver or a passenger, including their workouts, which are aimed at high speed;

d) participates in any sports competitions, trainings, unless the insurance agreement establishes otherwise;

   Officially organized sports competitions and training shall be those, which are held by sports organizations, sports clubs, sports schools, sports centres, sports facilities, sports federations, associations, societies and other physical culture and sports organizations and institutions that have the rights of legal persons and creates conditions for practicing physical culture and sports, train athletes, organize sports competitions and other physical culture and sports events. The provisions of this paragraph shall not apply to sports activities, which are not held by sports organizations and are the form of leisure of the insured;

e) used air transport means without motor, motor airplanes, light aircraft, engaged in extreme life-threatening sports or activities, or in extreme entertainment (mountain climbing, parachuting, bungee jumping, surfing, kite surfing, scuba diving, mountain biking, rock climbing, auto-motor sports, etc.), unless the insurance agreement establishes otherwise;

f) being under the influence of alcohol and/or narcotic substances, strong medications, toxic, psychotropic or other intoxicating substances, which causes actions of third parties impairing health of the insured.

1.4.5.2. The insurer shall not pay insurance benefits for medical services related to:

a) chronic, congenital or degenerative diseases, mental disorders (affective states, mental illness or other mental disorders) or impaired consciousness, apoplexy, epilepsy or other convulsive seizures, affecting the entire body of the insured;

b) health disorders resulting from treatment, surgery or other medical procedures. If surgery or treatment was necessary because of an accident, it shall be treated an insured event;

c) pathological bone fractures; damage to intervertebral discs, hernia; stomach or abdominal hernia;

d) fracture of osteosynthesis structures and dislocation, joint prostheses fracture and dislocation; dental injury due to internal injuries (in the process of chewing, biting, eating);

e) dental aesthetic surgical treatment, oral hygiene, tooth whitening, laminating, jaw bone integrity recovery; injury of facial soft tissues.

1.5. **Special conditions for insurance of dental treatment costs**

1.5.1. **Explanation of terms**

Dental treatment service shall mean general endodontal, periodontal and surgical treatment of dental diseases, treatment of carious teeth damage and its complications, dental fillings, x-ray examination in an outpatient health care institution in Lithuania.

1.5.2. **Insured event**

Insured event shall mean expenses of dental treatment services of the insured.

1.5.3. **Non-insured events**

1.5.3.1. The insurer shall not pay insurance benefits for provision of the following dental services:

a) fluoride application, covering teeth in sealants;

b) teeth whitening, laminating (veneering);

c) prosthesis, implantation, orthodontic treatment, moulds (healing, whitening, for bruxism).

1.6. **Special prevention and vaccination insurance conditions**

1.6.1. **Explanations of terms**

Prevention service shall mean a compulsory health check-up, medical tests performed at the insured's request, medical consultations and procedures, except for outpatient rehabilitation.

Vaccination service shall mean medical advice on vaccination and vaccines, vaccines prescribed by physician or chosen by the insured, and vaccination.

1.6.2. **Insured events**

Insured event shall mean costs of prevention and/or vaccination services of the insured.

14. Final provisions

14.1. The insurance agreement is governed by laws of the Republic of Lithuania.

14.2. All disagreement between the Insurer and the Policyholder in respect of the conclusion, execution or termination of the insurance agreement shall be solved by mutual negotiations.

14.3. In case of a failure to resolve disagreements by negotiation, a dispute between the Insurer and the Policyholder may be solved in out of court procedure pursuant to the rules of settlement of disputes between consumers and financial market participants established by the Bank of Lithuania in accordance with legal acts valid in the Republic of Lithuania.

14.4. The Policyholder and the Insured shall have the right to refer to the authority supervising participants in the financial market - the Bank of Lithuania for dispute examination in out of court procedure. Information on the procedure of resolution of disputes between consumers and financial market participants is available online at http://www.lb.lt/gincu_nagrinejimas.

14.5. The Insurer shall have the right to change insurance rules on the basis whereof insurance agreements have already been concluded, if interests of the Policyholder, the Insured and the beneficiary are not breached as a result of that.

14.6. The Insurer shall also have the right to supplement and amend certain articles of the insurance rules on the basis whereof insurance agreements have already been concluded in the following cases: in case of a change of legal acts or having adopted new legal norms on the basis whereof the insurance rules were drawn up, or in case of a change of legal norms directly applicable to the insurance agreement, or in presence of an objective necessity due to an economic situation (for example, in case of hyperinflation). New provisions of insurance rules shall not deteriorate the condition of the Policyholder and/or the Insured compared to the previous version of the rules.

14.7. The Insurer shall inform the Policyholder about amendments to the insurance rules in writing. Amendments to the insurance rules shall take effect in 1 month from the day when the Policyholder received a notice on the change of the insurance rules, unless the Insurer provides for a different term. If the Policyholder disagrees with amendments to the insurance rules, he may terminate the insurance agreement. When terminating the insurance agreement on this basis, benefits shall be subject to provisions of paragraph 10.5 of the rules.

Chief Executive Officer
Dr. Kęstutis Bagdonavičius

Member of the Board
Ingrida Kirse