Effective from 01/01/2021

ERGO

ERGO Life Insurance SE

Personal Health Insurance Policy Terms and Conditions No. 23

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I. General

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 a natural person of full age or a legal person who either applied to the Insurer with a request to conclude an Insurance Contract or who was offered by the Insurer to conclude an Insurance Contract or who concluded an Insurance Contract with the Insurer and undertook to pay the 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. One Insurance Contract may have only one Insured Person.
1.6. **Object of insurance** shall mean property interests related to the health of the person who is provided with insurance coverage according to these Policy Terms and Conditions.
1.7. **Insurance coverage and coverage area** shall mean the obligation of the Insurer, in case of and 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 Hospitalization Insurance and Serious Illness Insurance, coverage area is specified next to the description of the insured event in paragraphs 3.3.2 and 3.3.3 of these Policy Terms and Conditions.
1.8. **Insurance deductible** shall mean a portion of loss/costs expressed as a fixed amount or percentage, by which the insurance premium payable by the Insurer is reduced for each insured event and which is borne by the Policyholder or the Insured Person.
1.9. **Insurance premium** shall mean the amount of money payable by the Insurer to the Insured Person 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.
1.10. **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 provider.
1.11. **Outpatient health care institution** shall mean a health care institution entitled to provide outpatient health care services in accordance with procedure prescribed by laws of the Republic of Lithuania.
1.12. **Inpatient health care institution** shall mean a health care institution entitled to provide inpatient health care services in accordance with procedure prescribed by laws of the Republic of Lithuania.
1.13. **Insurance risk** shall mean the likely threat to the object of insurance.
1.14. **Application for a Personal Health Insurance Offer ("Application")** shall mean a document in the form established by the Insurer, submitted to the Insurer by the Policyholder who intends to conclude an Insurance Contract.
1.15. **Insurance Policy** shall mean a document issued by the Insurer confirming the conclusion of the Insurance Contract.
1.16. **Insured sum** shall mean the amount of money specified in the Insurance Contract or calculated in accordance with procedure prescribed by the Insurance Contract, which represents the maximum amount of insurance benefit and/or insurance benefits under the Insurance Contract, except the cases provided in the Insurance Contract. Insured sums agreed on by the Parties to the Insurance Contract shall be specified in the Insurance Policy.
1.17. **Health care services** shall mean the services provided in health care institutions, including consulting, diagnostics, treatment, prophylaxis, rehabilitation and prevention of the Insured Person as well as the provision of the means that are necessary for the treatment, improvement or recovery from the Insured Person's health problem/condition.
1.18. **Diagnostics** shall mean doctor's consultations, medically justified testing and procedures for identification and assessment of disease.
1.19. **Treatment** shall mean surgical treatment, including laser treatment, injections (administering only) and infusions (administering only).
1.20. **Day surgery** shall mean the services provided during the Insured Person's stay in a day surgery unit for up to 24 hours (or up 48 hours, if necessary).
1.21. **Hospital services** shall mean the services provided to the Insured Person while hospitalised for more than 24 hours.
1.22. **Waiting period** shall mean a period of three (3) months after the effective date of the Insurance Contract for the Insured Person, when the coverage of Serious Illness Insurance does not apply. If a serious illness is diagnosed in the period from the effective date of the Insurance Contract to 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 interruption.

1.23. **Health problem** shall mean a change in the Insured Person's health or physiological condition as a result of acute illness and/or injury, which requires diagnostics and treatment.

1.24. **Medical supplies** shall mean the products referred to in the List of Medical Supplies (List C) approved by the Ministry of Health of the Republic of Lithuania (e.g. hydrogel, bandages, catheters).

1.25. **Serious illness** shall mean a serious illness listed in paragraph 3.3.3.5 of these Terms and Conditions, diagnosed for the Insured Person for the first time during the Insurance Contract period, confirmed by definite diagnosis and compliant with serious illness diagnosis criteria provided in the description of the serious illness.

1.26. **Diagnosis code** shall mean a diagnosis based on the International Classification of Diseases ICD-10.

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 complete the Application for a Personal Health Insurance Offer, providing full and accurate answers to the questions and other information requested by the Insurer, which can have material impact on the probability of occurrence of the insured event and on insured risk. The submission of the Application shall not place the Insurer under an obligation to enter into an Insurance Contract.

2.2. Having carried out the insurance risk assessment, the Insurer may refuse to enter into an Insurance Contract without specifying the reason. If the insurance premium under the submitted Application was paid before the risk assessment and the Insurer's refusal to enter into an Insurance Contract, the premium shall be refunded to the payer. If an insured event provided for in these Policy Terms and Conditions occurs during this period, the Insurer shall not be required to pay the insurance benefit.

2.3. If the Insurer agrees to enter into a contract, the Policyholder shall be given a notice of payment, under which the first insurance premium must be paid before the Policy takes effect. Once the insurance premium is paid, the Insurance Contract shall take effect not earlier than ten (10) days from the date of submitting the Application.

2.4. The Insurance Contract may be concluded with individual terms and conditions, if the Insurer agrees that such terms and conditions be included in the Insurance Contract.

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 treatment**

Insurance coverage includes the services provided due to a health problem, including exacerbation of chronic diseases, if the disease is diagnosed during the insurance coverage period.

Insurance coverage does not include health problems and chronic diseases which were diagnosed before the effective date of the Insurance Contract.

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 5 sessions during the insurance period) with a diagnosis established and treatment prescribed by a psychiatrist.

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 (applicable only with insurance option III):
- 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;
- 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.

3.3.2. **Inpatient treatment**

Insurance coverage includes the services provided in a state inpatient health care institution:
- Comfort services (single or double ward);
- Medical supplies, medicinal products and nursing equipment prescribed by a physician and used in a hospital.

The insurance coverage shall be valid in the Republic of Lithuania, Republic of Latvia and Republic of Estonia.

3.3.3. **Treatment of serious illnesses**

If any of the serious illnesses listed in paragraph 3.3.3.5 of these Policy Terms and Conditions is diagnosed for the Insured Person during the Insurance Contract period after the waiting period of three (3) months, the Insurer shall reimburse the treatment costs to the Insured Person incurred in obtaining treatment for the serious illness within the limits of the insured sum set forth in the Insurance Contract. The insurance coverage shall include the services of treatment of the serious illness listed in paragraph 3.3.3.5 of these Policy Terms and Conditions, outpatient treatment and diagnostics, inpatient treatment, medical rehabilitation, and purchase of medicinal products and medical supplies.

The insurance coverage shall be valid in the Republic of Lithuania, Republic of Latvia and Republic of Estonia.

Upon diagnosis of a serious illness, insurance coverage for services specified in paragraphs 3.3.3.1., 3.3.3.2., 3.3.3.3 and 3.3.3.4. shall be valid for 12 months after the date of diagnosis of serious illness.

3.3.3.1. **Outpatient treatment of serious illnesses**

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 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.

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.

3.3.3.2. **Inpatient treatment of serious illnesses**

If hospitalisation be necessary, insurance coverage includes additional treatment services in an inpatient health care institution.
Additional and treatment services in a state and/or private hospital:
a) Comfort services (single or double ward);
b) Consultations, diagnostic and therapeutic procedures performed by specialist physicians;
c) Diagnostic tests prescribed by a physician;
d) Nursing services prescribed by a physician;
e) Medical supplies, orthopaedic technology products and nursing equipment prescribed by a physician;
f) Medicinal products prescribed by a physician and used in the hospital;
g) Surgical treatment services.

3.3.3.3. **Medicinal products and orthopaedic technology products for treatment of serious illnesses**

Coverage includes the following products prescribed by a physician for outpatient and/or inpatient 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 and/or pharmacies/online pharmacies (medicinal body covers used for burns, splint systems for the back/spine 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 (purchased and/or rented canes, crutches, wheelchairs; and 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.

3.3.3.4. **Rehabilitation treatment of serious illnesses**

Insurance coverage includes medically justified outpatient and/or inpatient rehabilitation services prescribed by the treating physician in case of serious illness:
- Consulting by a physiotherapist, ergotherapist, speech therapist;

- Physiotherapy;
- Individual and group sessions of kinesitherapy indoors and in the water;
- Water and mud treatments;
- Manual therapy sessions;
- Therapeutic massage.

3.3.3.5. **List of serious illnesses**

- Malignant neoplasm according to ICD-10: C00-C97; D00-D09.
  Malignant neoplasms characterised by uncontrolled and/or unstoppable growth and division of malignant cells, their invasion/spread to normal tissues and destruction of healthy tissues.

  The diagnosis has to be confirmed by:
  - Histological tests;
  - Oncologist's, hematologist-oncologist's report.

  Exceptions:
  - Neoplasms which are histologically characterized as precancerous;
  - Cervical dysplasia CIN-1, CIN-2 and CIN-3;
  - Localised, non-invasive neoplasms (carcinoma in situ);
  - Any neoplasms if the Insured Person is infected with HIV.

- Myocardial infarction according to ICD-10: I21.0-I21.4, I21.9.
  Acute irreversible damage to heart muscle tissue (necrosis) due to insufficient blood flow.

  Diagnosis has to be confirmed by at least two of the following symptoms:
  - Typical episodes of the illness;
  - New ECG changes characteristic to myocardial infarction;
  - Increase in biochemical markers (troponin I and T, creatine kinase, creatine kinase MB fraction, myoglobin);
  - Cardiologist's report.

- Stroke (cerebral infarction) according to ICD-10: I60-166.
  Acute cerebrovascular incident, usually due to occlusion or rupture of cerebral blood vessels or intracranial and/or intracerebral haemorrhage, resulting in neurological symptoms that last longer than twenty-four (24) hours.

  The diagnosis has to be confirmed by:
  - Cerebral lesions characteristic to stroke and confirmed by computed tomography of the brain or nuclear magnetic resonance imaging test;
  - Permanent neurological deficit after at least 6 weeks following the incident;
  - Neurologist's report.

  Exceptions:
  - Transient cerebrovascular disorders;
  - Cerebral damage due to injury, infection, vasculitis and inflammation;
  - Neurological symptoms of migraine.

- Renal failure according to ICD-10: N17; N18; N19.
  Acute and chronic damage to kidney tissue caused by a variety of materials and (or) factors resulting in renal circulatory disorders and significantly reduced or completely failing glomerular filtration, which requires regular hemodialysis or kidney transplant.

  The diagnosis has to be confirmed by:
  - Nephrologist's report and instructions to perform constant or regular hemodialysis;
  - Abnormalities in blood and urine tests;
  - Kidney puncture biopsy.

- Multiple sclerosis according to ICD-10: G35.

Multiple sclerosis is a demyelinating, inflammatory and relapsing-progressive disease of the central nervous system, causing its significant dysfunction.

Diagnosis has to be confirmed by at least three of the following symptoms:
- Neurologist's report following an outpatient examination;
- Neurological symptoms: sensory and motor dysfunction lasting longer than three (3) months;
- At least two documented clinical episodes at least one (1) month apart;
- Nuclear magnetic resonance imaging and cerebrospinal fluid test results.

- Parkinson disease according to ICD-10: G20.
  Progressive neurodegenerative disease caused by insufficient dopamine levels, resulting in motor system disorders.

  The diagnosis has to be confirmed by:
  - Neurologist's report following an outpatient examination;
  - Symptoms of disease progression;
  - Person's inability (with or without assistance) to carry out at least three out of six daily activities without interruption for at least six (6) months:

    I. 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;
    II. Dressing: getting dressed and undressed: ability to get dressed, undress, fasten and unfasten parts of garments and artificial limbs or surgical aids;
    III. Getting in and out of bed: ability to move from the bed to a chair or wheelchair and to get back into bed;
    IV. Movement: ability to get from one room to another on the same level;
    V. Toilet: ability to use the toilet or otherwise defecate or urinate, ability to maintain a satisfactory level of personal hygiene;
    VI. Eating: ability to eat on their own, if the food is prepared and placed in an accessible location.

  Exceptions:
  - If the cause of disease is chronic alcoholism or drug overdose.

- Alzheimer disease according to ICD-10: G30.0-G30.1; G30.8-G30.9.
  Chronic neurodegenerative disease that affects the brain nuclei and brain structure, resulting in impaired memory, thinking, and behavioural changes.

  The diagnosis has to be confirmed by:
  - Cognitive changes confirmed by clinical evaluation and neuropsychological tests, indicative of the need of constant care and lasting at least six (6) months;
  - Neurologist's report.

  Exceptions:
  - Dementia syndrome caused by neurological, psychiatric or other systemic conditions.

- Bacterial meningitis according to ICD-10: G00.0-G00.3; G00.8-G00.9.
  Severe inflammation of meninges of the brain and/or spinal cord caused by bacterial infection, resulting in severe, irreversible and permanent neurological disorders.

  The diagnosis has to be confirmed by:
  - Bacterial infection found by blood and cerebrospinal fluid tests;
  - Neurological symptoms lasting for at least six (6) weeks;
  - Neurologist's and/or neurosurgeon's report.

- Aplastic anaemia according to ICD-10: D60-D61.
  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;
  - Use of agents stimulating bone marrow activity;
  - Use of immunosuppressive agents;
  - Bone marrow transplantation.

  The diagnosis has to be confirmed by:
  - Blood and blood marrow laboratory tests;
  - Hematologist's report.

- Active tuberculosis according to ICD-10: A15- A19.
  An infectious disease, where tuberculosis bacteria spread through blood and the lymphatic system in the whole body and can damage any organ or system (lungs, spine, femurs, kidneys, genitals, brain, etc.).

  The diagnosis has to be confirmed by:
  - Laboratory and radiological tests;
  - Phthisiatrist's report.

- Crohn disease according to ICD-10: K50.
  Chronic autoimmune, relapsing, segmental, progressing granulomatous inflammation of the gastrointestinal tract.

  The diagnosis has to be confirmed by:
  - Gastroenterologist's report;
  - Instrumental tests (endoscopic tests);
  - Histological test report.

- Hepatic failure according to ICD-10: K72.0; K71.1; K71.2.
  Liver failure due to liver necrosis caused by acute viral infection, toxins, drugs or immune disorders.

  The diagnosis has to be confirmed by:
  - Clinical symptoms characteristic to liver failure;
  - Objective laboratory findings;
  - Gastroenterologist's/hepatologist's or treating physician's report.

  Exceptions:
  - Hepatic failure cause by alcohol or unjustified (when not prescribed by a physician) use of drugs.

- Coronary artery bypass surgery
  Surgical operation intended to correct the narrowing or occlusion of several coronary arteries using vascular grafts.

  The need for surgery has to be confirmed by:
  - Coronary occlusion found by angiography;
  - Necessity of surgical operation prescribed by a cardiologist and/or cardiac surgeon.

  Exceptions:
  - Angioplasty, stenting;
  - Arterial catheterisation;
  - Laser cardiovascular treatment.

- Heart valve surgery
  Damaged heart valve replacement surgery (in case of stenosis of the opening, valve failure).

The need for surgery has to be confirmed by:
- Cardiac ultrasound findings;
- Cardiologist's or cardiac surgeon's report on medical necessity of such surgery.

Exceptions:
- Valvular plastic and/or corrective surgery.

- Transplantation of major organs/bone marrow

The diagnosis has to be confirmed by:
- Human bone marrow transplantation using the hematopoietic system cells with prior complete removal of bone marrow;
- Transplantation of one of the human organs (heart, lungs, liver, kidney, pancreas), where it is necessary due to irreversible failure of the respective organ.

Exceptions:
- Stem cell transplantation

3.3.4. **Rehabilitation after inpatient treatment of injury**

Insurance coverage includes medically justified outpatient and/or inpatient rehabilitation treatment prescribed by the treating physician after inpatient treatment of the injury, where the duration of hospitalisation was more than 24 hours. Coverage applies for the services, if the injury is diagnosed during the insurance coverage period.
Coverage does not apply for injuries which were diagnosed before the effective date of the Insurance Contract.

Coverage includes the following rehabilitation services:
- Consulting by a physiotherapist, ergotherapist, speech therapist;
- Physiotherapy;
- Individual and group sessions of kinesitherapy indoors and in the water;
- Water and mud treatments;
- Manual therapy sessions;
- Therapeutic massage.

3.3.5. **Dental treatment, oral hygiene**

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

Dental treatment and dental hygiene services:
- 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.

3.3.6. **Preventive check-ups and vaccination**

Preventive check-ups:
- Mandatory health checks according to the type of work in accordance with procedure prescribed by the laws;
- Tests performed at request of the Insured Person;
- Consultations and tests according to preventive programmes implemented in Lithuania or developed and approved in a health care institution;
- 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.

Vaccination:

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

4. Non-insured events

4.1. The Insurer shall not pay the insurance benefit:

4.1.1. **For health care services and/or treatment provided due to:**

a) Health problems 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 that occurred during insurance coverage invalidity period;

h) Services provided, purchased and/or performed during insurance coverage invalidity/suspension period;

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

j) Health care services not covered by the Insurance Contract;

k) In case the Insured Person exceeds the insured sum limits for health care service set forth in the Insurance Contract;

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

m) Diagnosis and treatment of dependence on psychoactive substances (nicotine, drugs, alcohol, psychotropic substances);

n) 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;

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

p) In case prescription of diagnostic tests and treatment is not medically justified for the Insured Person.

4.1.2. **For health care services and/or treatment including:**

a) 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 have a licence, aromatherapy, leech therapy, music therapy, endobiogenic medicine), services provided by individuals working under a business licence or self-employment certificate;
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) Organ and tissue transplant surgery, joint replacement surgery, bone marrow transplantation, haemodialysis;
d) Correction of myopia and hyperopia or laser vision correction;
e) Prenatal care, childbirth and postnatal care, diagnosis and treatment of health problems determined or exacerbated by pregnancy or childbirth;
f) Abortion in the absence of medical indications and/or childbirth at a place other than a medical facility;
g) Diagnosis and treatment of sexually transmitted diseases (syphilis, gonorrhea, trichomoniasis, chlamydia, human papilloma virus, herpes genitalis, etc.), genital warts, AIDS and HIV;
h) Monitoring, diagnosis and treatment of erectile dysfunction, IVF treatments, diagnosis and treatment of conditions related to infertility and inability to conceive;
i) Diagnosis and treatment of warts and moles, benign growths of the skin/subcutaneous tissue/soft tissue, vascular structures, spots, and pigmentation disorders;
j) Treatment of benign tumours;
k) Intervention therapy (sclerotherapy) of deep venous/capillary diseases and varicose veins;
l) Therapeutic and surgical diagnosis and treatment of excess weight, obesity, eating disorders, and food intolerance tests;
m) 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;
n) 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);
o) 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;
p) 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 f) and g) of paragraph 4.2.2, medicinal products not registered by State Medicines Control Agency of the Republic of Lithuania or the European Union countries, hygiene and cosmetic products, food products;
q) 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);
r) 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;
s) More than five (5) consultations of a psychiatrist or medical (psychiatric) psychotherapist (in case of serious illnesses, more than ten (10)) during the insurance period;
t) Cosmetic filling, prosthesis, implantation, orthodontic treatment, splints, braces, trainers, teeth whitening, veneers, dental sealant coating, dental jewellery;
u) Accommodation and board expenses.

5. Insurance premiums and procedure for payment

5.1. The insurance premium shall be calculated taking into account the information provided by the Insured Person in the Application concerning their health condition, sport and/or leisure activities, selected insurance option, insurance risks indicated in the Insurance Contract, insured sums and other characteristics describing specific insurance risks.

5.2. 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. The first or single insurance premium must be paid before the effective date of the Insurance Contract. All other insurance premiums (regular premiums) must be paid within the time limits set forth in the Insurance Policy.

5.3. The date of payment of insurance premium shall be the date when the premium is credited to the Insurer's bank account. If the payment order does not indicate the Insurance Contract for which the insurance premium is paid, the date of payment of insurance premium shall be the date when the Insurer assigns the insurance premium to the respective Insurance Contract.

5.4. If the Policyholder fails to pay the insurance premium or part thereof within the time limit prescribed by the Insurance Contract, the Insurer shall notify the Policyholder in writing, stating that in case of failure to pay the insurance premium of part thereof within thirty (30) calendar days from the date of the notice, the Insurance Contract shall be terminated.

5.5. If the Policyholder fails to pay the first or single insurance premium, the Insurance Contract shall not take effect from the effective date indicated in the Insurance Contract. If the insurance premium is paid with a delay, but not later than within thirty (30) calendar days from the effective date indicated in the Insurance Contract, the Insurance Contract shall take effect on the day following the payment of insurance premium. The Insurance Contract validity period specified in the Insurance Contract shall not be extended.

6. Insurance Contract validity period

6.1. Insurance Contract validity period shall be specified in the Insurance Contract.

6.2. The Insurance Contract shall take effect upon payment of the first or single insurance premium and issue of the Policy.

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

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

a) submit the Application in the form established by the Insurer and other information necessary to the Insurer for concluding an Insurance Contract;
b) provide full and true information to the Insurer about the Insured Person and health insurance contracts concluded or to be concluded by such person;
c) 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;
d) pay the insurance premiums set forth in the Insurance Contract;
e) fulfil other obligations of the Policyholder laid down in legislation applicable in the Republic of Lithuania and the Insurance Contract.

7.2. 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/or exceptions provided by the Insurance Contract or laws;
b) present these Policy Terms and Conditions and inform the Policyholder of the amounts of insurance premiums and issue an Insurance Policy;

c) fulfil other obligations of the Insurer laid down in the Insurance Contract.

7.3. The Insurer provides insurance coverage assuming that the Policyholder and the Insured Person answered all questions provided in the Application, in particular those concerning existing or previous illnesses, health problems and ailments, fully and accurately.

7.4. 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 intentionally or negligently 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, taking into account the circumstances of failure to provide information, shall have the right to declare the Insurance Contract null and void, or demand that it be terminated, or offer the Policyholder to change it and, should the Policyholder refuse, terminate it, or reduce the insurance benefit, or refuse to pay the insurance benefit.

7.5. If, after the conclusion of the Insurance Contract, it is found that the Policyholder knowingly provided the Insurer with false information about the circumstances, the Insurer shall have the right to request that the Insurance Contract be recognized null and void, except where the circumstances concealed by the Policyholder disappeared before the insured event or had no influence on the insured event.

7.6. If after concluding the Insurance Contract it is found that the Policyholder failed to provide required information due to negligence, the Insurer shall not later than within two (2) months after becoming aware of these circumstances offer the Policyholder to change the Insurance Contract. If the Policyholder refuses to do so or fails to respond to the offer within one (1) month, the Insurer shall have the right to demand that the Insurance Contract be terminated.

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

7.8. If the legislation applicable in the Republic of Lithuania and/or the Insurance Contract require that information must be provided in writing, this requirement shall be deemed met if, upon agreement by the Parties to the Insurance Contract, information to the Policyholder/Insured Person is provided by mail, e-mail or other telecommunication means, which allow to have proof of providing the information.

7.9. The Policyholder shall notify the Insurer about the changes to the correspondence address, first name, surname or company name within five (5) working days. Otherwise, the Policyholder shall be required to compensate for the costs involved, if the notice is sent by registered mail to the address last known to the Insurer, where the Policyholder failed to notify the Insurer of its change.

7.10. Before entering into the Insurance Contract and during the Insurance Contract validity period, the Policyholder shall notify the Insurer by e-mail about any changes to the information about the Policyholder or the Insured Person provided when entering into the Insurance Contract and the increase in risk within five (5) working days.

7.11. 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.

7.12. The Insured Person shall take all reasonable steps to reduce the damage to health and avoid and refrain from any action that could undermine the course of treatment or damage the Insured Person's health.

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

7.14. 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 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. Procedure for determining and payment of insurance benefits

8.1. Insurance benefits shall be paid within the limits of the insured sum specified in the Insurance Contract.

8.2. Upon payment of the insurance benefit, the insured sum shall be reduced by the amount of the insurance benefit paid.

8.3. 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.

8.4. In order to receive an insurance benefit, the following documents or copies thereof must be provided to the Insurer:

8.4.1. 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));

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

8.4.3. If medicinal products, medical supplies, orthopaedic technology products, orthopaedic socks or assistive devices 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;

8.4.4. A completed application for compensation of health insurance expenses. Application for compensation of health insurance expenses shall be a document in the form established by the Insurer, which is submitted to the Insurer in order to receive an insurance benefit. The most convenient way to submit the application for compensation of health insurance expenses is via the ERGO Lietuva mobile app, which can be downloaded for free from the App Store or Google Play.

8.5. 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 Policyholder and/or Insured Person failed to meet the requirements set forth in paragraphs 7.1, 7.4 and 8.3.

8.6. If the Insured Person is insured under several insurance contracts by different insurers, in case of an insured event, the benefit payable by the Insurer shall be reduced proportionately.

8.7. 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.

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

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

8.10. 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 prescribed by the Insurer in relation to the conclusion and performance of the Insurance Contract.

9. Procedure for providing information

9.1. All notices, statements, claims and/or requests related to the Insurance Contract and obligations arising therefrom shall be provided to ERGO Life Insurance SE in writing to the registered address or by electronic means using our customer self-service portal on the website www.ergo.lt or to the provided e-mail address.

9.2. ERGO Life Insurance SE can provide notices, information and damage reports to the postal address and/or e-mail address or telephone specified in the Insurance Contract by the Policyholder and/or the Insured Person.

9.3. We shall notify the Policyholder of the changes to ERGO Life Insurance SE contact details, Policy Terms and Conditions and requirements applicable to the Insurance Contract by posting on our website www.ergo.lt and/or by sending information about said changes to the last known address or email address of the Policyholder.

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 5.4 and 7.4 of these Terms and Conditions.

10.3. In case of violation of the terms and conditions of the Insurance Contract by the Policyholder, insurance premiums shall not be refunded.

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 not exceed 25% of the calculated annual insurance premium.

10.5. 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, 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 insurance benefits paid and the costs of conclusion and performance of the Insurance Contract, which shall not exceed 25% of the calculated annual insurance premium.

11. Amendments to the Insurance Contract

11.1. In order to amend the Insurance Contract, the Policyholder shall notify the Insurer in writing (by e-mail/fax/registered mail), stating 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 insurance risk and other circumstances relevant to the Insurance Contract, 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 Contract.

11.2. When amending the terms and conditions of the contract, the Insurer may request information about the health condition, leisure activities and other risk factors of the Insured Persons.

12. Liability for breaches of the Insurance Contract

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 the Insurer 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 Members 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 legislation applicable in the Republic of Lithuania.

14.4. The Policyholder and the Insured Persons have the right refer to the supervisory authority of financial market participants, i.e. the Bank of Lithuania, for dispute settlement without recourse to court. Information about procedure for resolution of disputes between consumers and financial market participants is available on 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 Policy 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 Policy Terms and Conditions must not impair the situation of the Policyholder and/or Insured Persons in comparison with the previous version.

14.7. The Insurer shall notify the Policyholder of the changes to the Policy Terms and Conditions in writing. The changes to the Policy Terms and Conditions shall come into force after one (1) month from the date of receipt of notice of the changes to the Policy 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 10.5.

Chief Executive Officer
Bogdan Benczak

Member of the Board
Ingrida Kirse

Annex 1 to Health Insurance Policy Terms and Conditions No. 23

Information on the processing of personal data

1. Data Subject shall mean a natural person, who is the Policyholder, Insured Person, beneficiary or payer of insurance premiums.

2. The Insurer shall process personal data received from the Data Subject:

   2.1. for the purposes of conclusion and administration of the Health Insurance Contract, risk assessment, investigation of insured events, calculation of insurance benefits, according to Article 6(1)(a) and (b) and Article 9(2)(a) of the Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC (General Data Protection Regulation) ("Regulation (EU) 2016/679") for a period of ten (10) years after the end of the contractual relationship;

   2.2. for direct marketing purposes with consent of the Data Subject;

   2.3. for the purpose of recording telephone conversations to obtain evidence of conclusion and performance of Insurance Contracts for a period of ten (10) years after the end of the contractual relationship.

3. If the Data Subject fails to provide necessary personal data to the Insurer, insurance services cannot be provided and the Insurer shall have the right to refuse to conclude and/or terminate the Insurance Contract in accordance with the Policy Terms and Conditions.

4. Personal data of the Data Subject may be provided to and received from:

   4.1. Doctors, hospitals, and other medical, health care, and care institutions in the Republic of Lithuania and other countries, National Health Insurance Fund under the Ministry of Health and territorial health insurance funds, State Social Insurance Fund Board (SODRA), offices authorised to assess disability and working capacity in accordance with legislation, forensic experts, law enforcement agencies, and other natural and legal persons for the purpose of assessing the circumstances of the insured events and calculating insurance benefits.

5. The Insurer may provide personal data of the Data Subject to:

   5.1. Courts, law enforcement and other authorities in cases provided for in laws;

   5.2. Reinsurers for the purpose of reinsurance in both the Republic of Lithuania and other countries;

   5.3. Data Processors, i.e. companies that provide the Insurer with customer service and other value added (administrative) services, document scanning, management and storage of archived documents/ archives, and maintenance and servicing of information systems of the Insurer;

   5.4. Companies whose activities are related to debt recovery for the purpose of collecting outstanding insurance premiums from the Policyholder;

   5.5. Other data recipients with consent of the Data Subject or at their request.

6. Data Subject shall be informed of their right to request that the Insurer give them access to their personal data, rectify and delete such data or limit the processing of their data, as well as the right to object to the processing of their data and the right to data portability. The above rights shall be exercised in accordance with procedure prescribed by Regulation (EU) 2016/679 (with the exceptions provided for in the Regulation (EU) 2016/679).

7. Where personal data are processed in accordance with Article 6(1)(a) and Article 9(2)(a) of the Regulation (EU) 2016/679, Data Subject may withdraw their consent at any time.

8. Data Subject shall have the right to refer to the Data Protection Officer (by e-mail to asmensduomenys@ergo.lt or by phone 1887) regarding any issues related to the processing of their personal data and exercise of their rights under the Regulation (EU) 2016/679.

9. The Insurer may use profiling of personal data of the Data Subject for the purposes stated in paragraph 2 of this Annex. More details about profiling are available in the ERGO Privacy Policy.

10. Should the Data Subject believe that their rights provided for in the Regulation (EU) 2016/679 have been infringed, they may lodge a complaint with the supervisory authority, i.e. the State Data Protection Inspectorate, according to Article 77(1) of the Regulation (EU) 2016/679, and exercise their right to an effective judicial remedy under Article 79 of the Regulation (EU) 2016/679.

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