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ERGO Life Insurance SE

Annex No 1 to Special Conditions of Cancer and Other Critical Illness Insurance of Children No 028-05

List of Critical Illnesses Insured and Criteria for Recognizing Insured Events

1. Cancer – invasive cancer, invasive skin cancer, non-invasive/early-stage cancer.
It shall be confirmed by a medical oncologist, haematologist or pathologist and supported by medical documentation, i.e. a histological examination shall be performed diagnosing malignant process, and meet the criteria set out in clauses 1.1 and 1.2 hereof.

1.1. Non-invasive/early-stage cancer
It is a cancer with a histologically confirmed diagnosis, characterised by malignant cell growth at the original tumour site, which does not affect the base membrane and has not spread to other tissues. In this case, 20 % of the Sum Insured shall be paid.
Such cancer includes:
- all primary carcinomas in situ according to the current AJCC classification adopted by the American Joint Committee on Cancer;
- melanoma in situ, excluding other forms of skin cancer;
- primary prostate cancer stage T1aN0M0, T1bN0M0 or T2aN0M0 – only when treated with radical prostatectomy;
- papillary or follicular thyroid cancer stage T1 (including T1aN0M0 and T1bN0M0).

The following shall not be considered non-invasive/early-stage cancer:
- benign tumour, dysplasia or precancerous disease;
- any skin cancer other than pre-invasive melanoma in situ.

1.2. Invasive cancer
Invasive skin cancer (except melanoma *in situ*) means basal cell carcinoma of the skin, squamous cell carcinoma and dermatofibrosarcoma. In this case, 10 % of the Sum Insured shall be paid.
Invasive cancer is cancer characterised by uncontrolled growth and spread of malignant cells into tissues, blood organs and the lymphatic system, including malignant lymphoma, malignant bone marrow disorders, leukaemia, malignant advanced melanoma, Hodgkin's disease and myelodysplastic syndrome. In this case, 100 % of the Sum Insured shall be paid.

The following shall not be considered invasive cancer:
- Benign tumour, dysplasia or precancerous disease;
- Basal cell and squamous cell carcinoma of the skin and dermatofibrosarcoma;
- Carcinoma in situ;
- Non-invasive malignant cancer;
- Prostate cancer – in stage lower than T2bN0M0;
- Papillary or follicular thyroid cancer – in stage lower than T2N0M0;
- True polycythemia and primary thrombocythemia, monoclonal gammopathy of undetermined origin.

2. A benign brain tumour – a non-malignant tumour located in the cerebral part of the skull, meninges or the cranial nerves.
The tumour shall be treated with at least one of the following therapies:
- complete or partial surgical removal;
- stereotactic radiosurgery;
- external beam radiotherapy.

If none of the treatments can be used for medical reasons, the tumour shall cause a permanent neurological deficit which persist for at least 3 months after the diagnosis. It shall be diagnosed by a neurologist or neurosurgeon and confirmed by imaging tests.

An Insurance Benefit shall not be paid having diagnosed:
- any cyst, granuloma, hamartoma or malformation of the cerebral arteries or veins;
- pituitary tumours;
- congenital tumours.

3. Transplantation of internal organs, tissues and bone marrow – a transplantation surgery of one or more organs performed on the Insured, when the Insured is the recipient of the following:
- a heart;
- a kidney (kidneys);
- liver (including a part of liver or transplantation of liver of a living donor);
- lungs (including transplantation of a lobe of a living donor or transplantation of one lung);
- bone marrow (transplantation of allogeneic hematopoietic stem cells performed after complete removal of bone marrow);
- small intestine;
- pancreas;
- a part or the entire face, arm, hand or leg (composite tissue allotransplantation).

A transplantation shall be vital and confirmed by a specialist of a respective field.

An Insurance Benefit shall not be paid in the following cases:
- transplantation of organs, body parts or tissues other than those listed above;
- transplantation of stem cells other than those listed above;
- transplantation for congenital defects or abnormalities.

4. Chronic renal failure – an irreversible terminal insufficiency of the function of both kidneys requiring a regular dialysis. The need for dialyses shall be confirmed by a nephrologist and renal function tests.

An Insurance Benefit shall not be paid for:
- acute reversible renal failure treated by temporary renal dialysis;
- renal failure due to congenital kidney and/or congenital urinary tract anomalies;
- renal failure due to impaired renal perfusion in the perinatal phase.

5. Paralysis of the extremities – a complete and irreversible loss of muscle function of any 2 extremities due to a trauma or an illness.
Persistent nature of the illness shall be confirmed by a neurologist, clinical data and diagnostic tests, and shall persist for more than 3 months.

An Insurance Benefit shall not be paid in the following cases:
- paralysis of the extremities caused by self-harm or psychological disorders;
- Guillain-Barre syndrome;
- paralysis due to congenital defects or abnormalities.

6. Blindness – an irreversible loss of vision of both eyes due to an illness or trauma. An irreversible condition confirmed by an ophthalmologist that cannot be treated with refractive correction, medication or surgery.
Loss of vision shall be proven when visual acuity of the better seeing eye is 3/60 or less (0,05 or less on a decimal scale) as measured after correction, or when the field of vision of the better seeing eye is less than 10° in diameter after correction.

An Insurance Benefit shall not be paid:
- for a congenital or inherited loss of vision, including due to infection during pregnancy.

7. Deafness – irreversible deafness in both ears due to an illness or trauma.
Deafness shall be confirmed by an otorhinolaryngologist with a hearing threshold of at least 90 db in the better-hearing ear after tonal threshold audiometry in all frequency ranges.

An Insurance Benefit shall not be paid:
- for a congenital or inherited deafness, including due to infection during pregnancy.

8. Coma – a loss of consciousness without responding to external stimuli or internal demands, when:
- the condition lasts for at least 96 hours and is scored 8 or less on the Glasgow Coma Scale,
- requires the use of a life support system, and
- a permanent neurological deficit[1] that persists for at least 30 days from the onset of coma.

The diagnosis shall be confirmed by a neurologist.

An Insurance Benefit shall not be paid in the following cases:
- coma has been artificially induced by medical means or medication (for medically justified reasons);
- coma has been caused by the use of alcohol or drugs, psychotropic or other psychoactive substances without a doctor's prescription;
- injury resulting from exploitation or abuse of a child by a parent, legal guardian or their spouse/cohabitant;
- coma due to complications of childbirth or congenital defects.

9. Acute viral encephalitis – a diagnosis causing a permanent neurological deficit[1] that persists for at least 3 months from the diagnosis, or complete loss or cessation of motor, cognitive and language development for 12 months in children under 6 years of age.
The diagnosis shall be confirmed by a neurologist and substantiated with typical clinical symptoms and cerebrospinal fluid tests or the results of a brain biopsy.

An Insurance Benefit shall not be paid in the following cases:
- encephalitis caused by bacterial or protozoal infections;
- myalgic or paraneoplastic encephalomyelitis.

10. Severe head injury – an injury that causes severe and permanent damage to the brain.
The suffered person is unable to perform at least 3 out of 6 daily tasks on his own (washing, dressing/undressing, eating, personal hygiene, moving around indoors, getting in and out of bed) for at least 3 months continuously, and there is no sign of improvement.
The diagnosis shall be confirmed by a neurologist or neurosurgeon, substantiated with the results of functional independence and imaging tests (CT scan, MRI).

An Insurance Benefit shall not be paid in the following cases:
- use of alcohol or drugs, psychotropic or other psychoactive substances without a doctor's prescription;
- injury resulting from child abuse or exploitation by a parent, legal guardian or their spouse/ cohabitant.

11. Loss of limbs – the loss of two or more limbs above the wrist or ankle joint as a result of an accident or medically necessary amputation. The diagnosis shall be confirmed by a surgeon or orthopaedic traumatologist.

12. Bacterial meningitis – the diagnosis that causes:
- a permanent neurological deficit[1] that persists for at least 3 months after diagnosing it; or
- in children under the age of 6 years, complete loss or cessation of motor, cognitive and speech skills for 12 months development.

The diagnosis shall be confirmed by a neurologist or an infectologist and be based on the results of a bacteriological examination when growth of pathogenic bacteria is detected in a cerebrospinal fluid sample.

An Insurance Benefit shall not be paid in the following cases:
- aseptic, viral, parasitic or non-infectious meningitis.

13. Severe asthma exacerbation – the diagnosis for which the Insured has been treated in a hospital at least twice in the last 12 months. The condition shall be confirmed by a pulmonary index score of at least 12 or an equivalent value of alternative scores.
The diagnosis shall be confirmed by a pulmonologist and be based on typical clinical signs and laboratory test results.

An Insurance Benefit shall not be paid in the following cases:
- asthma due to gastroesophageal reflux disease (GERD);
- drug-induced asthma;
- asthma as a result of a respiratory infection.

14. Insulin-dependent diabetes mellitus (type I) – a diagnosis characterised by the inability of the pancreas to produce enough insulin, with the need for lifelong use of exogenous insulin.
The diagnosis shall be confirmed by an endocrinologist and supported by typical clinical features and laboratory test results.
The conducted laboratory tests shall demonstrate at least one of the following results:
- pancreatic autoantibodies;
- insulin and C-peptide levels consistent with a diagnosis of type 1 diabetes mellitus.

An Insurance Benefit shall not be paid in the following cases:
- when the Insured suffers from diseases of the exocrine system (e.g. cystic fibrosis, hereditary haemochromatosis or chronic pancreatitis);
- endocrine disorders of glucose regulation (e.g. Cushing's syndrome);
- drug-induced diabetes;
- type II diabetes mellitus.

[1] Neurological deficit
Symptoms of neurological impairment as determined by clinical examination. Symptoms include numbness, hyperaesthesia (hypersensitivity), paralysis, local weakness, dysarthria (impaired speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficult walking, incoordination, tremor, convulsions, lethargy, dementia, delirium and coma.

An Insurance Benefit shall not be paid in the following cases:
- Abnormalities visible on CT or MRI scans or other neuro-visual examinations which are not obviously related to clinical symptoms;
- neurological signs occurring without pathological symptoms, e.g. sudden reflexes without other symptoms;
- symptoms of psychological or psychiatric origin.