ERGO Life Insurance SE

Health Insurance Regulations No. 010

Valid since 1 November 2016

1. Main concepts used in the Regulations

1.1. **The Insurer** shall mean ERGO Life Insurance SE.

1.2. **Insurance agreement** shall mean health insurance agreement signed by the Insurer and the Policyholder.

1.3. **The Policyholder** shall mean an adult natural person or a legal person, who has entered into an insurance agreement with the Insurer and who must pay insurance premiums.

1.4. **Parties to the Insurance agreement** shall mean the Insurer and the Policyholder.

1.5. **The Insured** shall mean a person indicated by the Policyholder and named in the Insurance agreement, in the event of an insured event having occurred in the life of whom the Insurer shall have to pay an insurance benefit. There may be several insured persons in one insurance agreement.

1.6. **Insurance coverage** shall mean the Insurer's commitment to pay an insurance benefit for health care services provided/ acquired in the territory of the Republic of Lithuania in case of an insured event.

1.7. **Beneficiary** shall mean a person indicated in the insurance agreement, who acquires the right to an insurance benefit in cases provided for in the insurance agreement. The Policyholder may appoint and replace persons entitled to insurance benefits under the insurance agreement. In cases provided by laws beneficiaries may be appointed or replaced only upon the Insured's consent.

1.8. **Insurance benefit** shall mean an amount of money which the Insurer must pay to the Insured and/or a health care institution according to insurance agreement conditions for health care services provided to the Insured due to an insured event or for acquired goods.

1.9. **Health care institution** shall mean an institution or a company entitled to provide health care, wellness and pharmaceutical services in the procedure prescribed by laws of the Republic of Lithuania.

1.10. **Health care service** shall mean a qualified personal health care, wellness or pharmaceutical services provided in a health care institution.

1.11. **Partner** shall mean an institution or a company entitled in the procedure prescribed by laws of the Republic of Lithuania to provide health care, wellness, pharmaceutical services and ministrations, with which the Insurer has a concluded cooperation (service) agreement for the provision of health care services to the Insured.

1.12. **Health insurance card** (booklet) shall mean a card (booklet) of the form established by the Insurer issued to each Insured.

1.13. **Health disorder** shall mean physiological condition of the Insured, which requires medical testing and treatment, and which the Insured has complained about.

Other concepts used in these Insurance Regulations shall be interpreted as defined in the Law on Insurance of the Republic of Lithuania and other legislation 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 application in a form set by the Insurer and a list of insured persons. Having concluded an insurance agreement, the application submitted by the Policyholder and the list of insured persons shall form an integral part of the insurance agreement along with these Insurance Regulations.

2.2. Having assessed the risk of insurance, the Insurer may refuse to conclude an insurance agreement, without indicating any reasons therefor. The submission of the application and the payment of an insurance premium does not obligate the Insurer to conclude an insurance agreement. If the insurance premium was paid according to the submitted application before the assessment of the risk insured 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 Regulations 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 the issuance of an insurance certificate.

2.4. The insurance agreement may be concluded laying down therein individual insurance conditions, if the Insurer and the Policyholder separately agreed on such conditions.

3. Insured event

3.1. An insured event shall mean an incident specified in the insurance agreement, upon occurrence of which the Insurer shall have to pay an insurance benefit.

3.2. An event shall be declared an insured event only in case the doctor providing the services acts within the limits of competence of doc-

tor's specialty described and approved in applicable legislation and has a valid medical practice license issued by a competent state authority, when services have been acquired and provided during the insurance coverage period.

3.3. Description of insured events is presented in Annex 1 to these Insurance Regulations.

4. Non-insured events

4.1. Non-insured events shall mean events when the Insurer does not have to pay an insurance benefit (unless agreed otherwise when concluding an insurance agreement).

4.2. The Insurer shall not pay an insurance benefit:

4.2.1. for provided health care services, and/or other services for:

a) health disorders 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 of a failure to comply with well-known safe behaviour requirements;

b) health disorders 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;

c) health disorders 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);

d) health disorders having occurred at the fault of the Policyholder or 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;

e) health disorders having occurred due to radiation or other nuclear energy effects (excluding the effects of radiation therapy);

f) health disorders suffered by the Insured from the use of alcohol, drugs, toxic substances or medicines used for intoxication purposes;

g) health disorders having occurred during non-validity (suspension) of insurance coverage.

4.2.2. for the provided health care services, treatment and/or other services:

a) pregnancy care, childbirth and post-natal care, treatment of health disorders resulting from pregnancy or childbirth, unless the insurance agreement establishes otherwise;

b) surgical treatment of chronic diseases, congenital diseases with genetic risk factors, treatment of abnormalities and their complications;

c) treatment of persons suffering from addictions to psychoactive substances (nicotine, drugs, alcohol, psychotropic substances);

č) engaging in unlicensed activities and/or applying non-approved diagnostic and treatment methods, services, also non-traditional medical services;

d) psychotherapeutic treatment of more than 10 sessions;

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

ė) monitoring, diagnosis and treatment of potency problems, artificial insemination procedures, examination and treatment of conditions related to infertility and inability to conceive;

f) abortion in the absence of any medical indications and giving birth in non-medical institution;

g) 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;

h) cosmetic - plastic surgeries, cosmetology / beauty procedures (aesthetic, improvement of body lines, anti-cellulite procedures, body scrub, wraps, etc.), aesthetic dermatology treatment (phototherapy, photodynamic therapy, pulsed light therapy, laser treatments, including acne and nail fungus treatment) and the use of functional, diagnostic equipment, devices and instruments directly related to these procedures;

i) organ and tissue transplant operations; bone marrow transplantation, haemodialysis procedures;

y) maintenance treatment and care in specialised inpatient care facilities (permanent, long-lasting care of elderly, disabled persons or patients suffering from chronic diseases, including services provided at home, in a nursing care institution, medical centre or social welfare institution);

j) therapeutic and surgical treatment of obesity, food intolerance tests;

k) treatment of warts and moles, benign skin formations, vascular lesions, spots, treatment of pigmentation disorders (unless the insurance agreement establishes otherwise);

l) intervention therapy (sclerotherapy) of venous / capillary disease (unless the insurance agreement establishes otherwise);

m) manipulation therapy of benign tumours;

n) correction of vision, joint replacement surgery;

o) health care services and/or treatment performed by spouse, parents or children of the Insured;

p) services provided, acquired and/or performed during non-validity (suspension) of insurance coverage;

r) health care services unprovided for in the insurance agreement;

s) if the Insured exceeded the limits of sums insured for the health care service of the insurance option provided for in the insurance agreement;

š) purchase of medicines: anabolic steroids, weight loss drugs, drugs to increase potency, treat various addictions, also, measures for treating diseases listed in subparagraphs e and ė of paragraph 4.2.2, medicines unregistered with the State Medicines Control Agency of Lithuania and in European Union countries; food supplements (unless the insurance agreement establishes otherwise); hygiene and cosmetics;

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

u) purchase of care products for eyeglass frames, goggles and sunglasses, contact lenses and spectacle lenses (unless the agreement establishes otherwise);

ū) health care services and/or treatment, the date and circumstances whereof cannot be determined having inspected the event;

v) when the prescription of diagnostic tests and therapies to the Insured is not medically justified;

z) when someone other than the Insured uses insurance coverage established in the insurance agreement;

ž) acquisition of drugs, medical aids or orthopaedic instruments and provision of health care services on the basis of a prescription or a referral issued by the Insured himself.

4.2.3. The Insurer shall not cover costs related to the issuance and/or presentation of medical and other documents.

5. Object of insurance and insurance coverage

5.1. Object of insurance is the property interest related to health of a person who is provided with insurance coverage according to these Insurance Regulations.

5.2. Start and end of the insurance coverage and its scope shall be indicated in the insurance certificate, individual insurance conditions and other agreements of parties to the insurance agreement (annexes to the insurance agreement), also, in these Insurance Regulations.

6. Sum insured

6.1. The sum insured means the amount of money planned for one Insured under the insurance agreement, within the limits of which the Insurer undertakes to pay to the Insured or a health care institution for health care services provided to the Insured in case of an insured event within the scope of the insurance coverage established in the insurance agreement. Sums insured whereon the parties to the insurance agreement have agreed shall be indicated in the insurance certificate.

6.2. The insurance agreement may set forth the sums insured for separate insurance periods and the allocation of sums insured by specific insurance risk groups.

7. Insurance premiums and their payment procedure

7.1. Insurance premium amounts and their payment deadlines are laid down in the insurance certificate. Insurance premiums shall be paid in advance for each insurance period. The first and single premium shall be paid immediately after signing an insurance agreement. All other insurance premiums (regular premiums) shall be paid within the deadlines set in the insurance certificate.

7.2. 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.

7.3. If the Policyholder fails to pay a regular insurance premium within the time set in the insurance agreement, the Insurer shall inform the Policyholder thereof in writing at the Policyholder's expense. If an insurance premium is not paid within 15 days from the day of sending a notice on unpaid insurance premium to the Policyholder, insurance coverage shall be suspended and shall be restored only after the Policyholder pays all insurance premiums unpaid within the set deadlines.

7.4. If suspension of the insurance coverage due to non-payment of an insurance premium lasts longer than 3 months, the Insurer shall have the right to unilaterally terminate the insurance agreement. The Insurer having terminated the insurance agreement due to non-payment of insurance premiums shall have the right to request the Policyholder to reimburse to the Insurer losses related to non-payment of insurance premiums.

8. Insurance agreement validity terms

8.1. Insurance term shall be entered in the insurance policy. The insurance agreement shall take effect in presence of all the following conditions: the Policyholder has an issued insurance certificate, and the first or a single insurance premium has been paid. The Insurer shall also have the right to declare the entry into force of an insurance agreement in the absence of all the listed conditions.

8.2. Insurance coverage shall take effect having paid the first or a single insurance premium, but no earlier than the signing of the insurance agreement and no earlier than the start of insurance indicated in the insurance certificate. If the Insurer agrees, the insurance coverage may also start earlier than that.

9. Rights and duties of parties to the insurance agreement

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

- present an application for insurance in the form set by the Insurer, a list of insured persons and other information necessary for the Insurer to conclude an insurance agreement;
- provide to the Insurer comprehensive, true information on the person being insured or the Insured person, also, on the concluded or planned to be concluded agreements on the insurance of health of this person;
- familiarize the Insured with insurance agreement conditions applicable to the Insured or related to him;
- pay additional insurance agreement service fees established in the insurance agreement (Annex 2 to these insurance regulations).

9.2. 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;

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 by legal acts.

9.3. Should it be determined after concluding an insurance agreement that the Policyholder or the Insured failed to perform its duty to disclose information when concluding an insurance agreement or during its validity, or 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 have the right to terminate the insurance agreement or to reduce insurance benefit, or to refuse to pay it altogether.

9.4. Notices related to the insurance agreement shall be submitted in writing. Such notices shall take effect in respect of the Insurer from the moment of their receipt.

9.5. The Policyholder shall inform the Insurer about the change of correspondence address, its name, surname or title within five 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.

9.6. The Policyholder shall during the validity period of the insurance agreement inform the Insurer about any change of information on the Policyholder or the Insured indicated when concluding an insurance agreement in writing within five working days.

9.7. The Policyholder and/or the Insured must immediately/ no later than within 7 days notify the Insurer about illegitimately used, misplaced or otherwise lost health insurance card (booklet).

9.8. Having determined that the Insured or the Policyholder handed over his health insurance card (booklet) to another person, who used or tried to use it, the Insurer shall have the right to refuse to pay an insurance benefit for health care services provided under such circumstances, having informed the Policyholder and/or the Insured about that in writing.

9.9. When employees of the Policyholder are covered by the insurance agreement, the Policyholder shall immediately inform the Insurer in writing where the Insured has terminated employment or other contractual relations with the Policyholder, and return a health insurance card (booklet) within the term indicated by the Insurer.

9.10. The Policyholder shall inform the Insurer about all health insurance agreement concluded for the benefit of the Insured or the Policyholder with other insurance companies within 30 days from the day of conclusion of an insurance agreement with another insurance company.

9.11. The Policyholder and/or the Insured must 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.

9.12. The Insured must 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.

9.13. 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 of the Republic of Lithuania.

9.14. 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, provided health care or other services provided for in the insurance agreement, the setting of insurance benefit amount, or perform the necessary tests at its own expense, or appoint a medical expert.

9.15. If the Insurer pays an insurance benefit to the Insured or pays bills of health care institutions for health care services provided by health care institutions to the insured persons, when the limit of sums insured provided for in the insurance agreement was exceeded for the service, or when insurance coverage did not have to be applied to the insured persons, the Insurer shall have the right to request the Policyholder or the Insured to compensate losses incurred by the Insurer due to the payment of such benefits, including amounts of money, which the Insurer paid to health care institutions and/ or the insured persons.

9.16. Upon the Policyholder's written request and the payment of a fee of additional insurance agreement services according to a price list of additional services (Annex No 2 to the Insurance Regulations), a duplicate insurance certificate may be issued. According to a written application of the Policyholder, the Insurer may also provide other additional insurance agreement administration services. The Policyholder or the Insured shall pay for these services fees set by the Insurer.

10. Procedure of determining insurance benefits

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

10.2. 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. If a partner provided health care services to the Insured, the Policyholder and/or the Insured shall be relieved from obligation to report an insured event to the Insurer.

10.3. The Insurer shall calculate and pay insurance benefits:

10.3.1. for health care services provided by partners – according to partner rates;

10.3.2. outpatient services provided by health care institutions with whom the Insurer does not have concluded cooperation (service) agreements for the provision of health care services to the Insured shall be covered without exceeding base prices of personal health care services approved by the Ministry of Health four times.

10.4. The Insurer shall pay insurance benefits to partners having presented documents substantiating the provision of health care services in accordance with the procedure and to the scope provided for in cooperation (service) agreements with service providers and according to rates laid down therein.

10.5. If the Insured paid for health care services at its own expense, the Insurer shall pay to the Insured an insurance benefit having presented the following documents of their copies:

10.5.1. 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);

10.5.2. referral/ extract or a copy from medical records, indicating information on the nature of the disease, the diagnosis, prescribed tests, procedures and treatment;

10.5.3. in case of purchasing medicines, medical aids, orthopaedic technical products, compression stockings, mobility aids or optical goods– a prescription or a copy of medical records indicating information on the nature of disease, diagnosis and prescribed treatment;

10.5.4. a completed application to compensate health insurance costs (a standard form of the Insurer);

10.5.5. a completed sheet from a health insurance booklet, if the Insured has been issued a booklet.

10.6. Costs related to the issuance and submission of documents substantiating the provided health care services shall be covered by a person applying for an insurance benefit.

10.7. If treatment or prescription of diagnostic tests is not medically justified, the Insurer may refuse to pay an insurance benefit and/or may reduce it.

10.8. 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 9.3., 9.14. and 10.2. hereof.

10.9. 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.

10.10. 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.

11. Procedure of payment of insurance benefits

11.1. The Insurer shall pay insurance benefits to the partner who has provided health care services to the Insured or the Policyholder, or to the Insured, if he paid for the provided health care services to a health care institution.

11.2. 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 amount of an insurance benefit was received.

11.3. 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.

12. Termination of the insurance agreement

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

12.2. The Insurer may terminate the insurance agreement unilaterally in out of court procedure in cases laid down in paragraphs 7.4. and 9.3. hereof.

12.3. When the insurance agreement is terminated at the initiative of the Policyholder without the Insurer having breached conditions of the insurance agreement or at the initiative of the Insurer with the Policyholder having breached conditions of the insurance agreement, the Insurer shall return to the Policyholder a part of the insurance premium for the remaining validity period of insurance coverage having deducted costs of conclusion and execution of the insurance agreement and amounts paid according to the agreement. The Insurer shall have the right to deduct annual costs of conclusion and execution of the insurance agreement of 15%.

12.4. 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 premium 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 account for 15% of the calculated annual insurance premiums amount.

13. Amending insurance agreement

13.1. In order to amend the insurance agreement, the Policyholder shall present to the Insurer an application on the desired amendments to the insurance agreement in writing (by e-mail/ fax/ registered mail) in the form set by the Insurer no later than one 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 one month from the day of receipt of the Policyholder's applications. Having assessed the changed circumstances, 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.

14. Liability for breaching insurance regulations

14.1. 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.

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

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

15.1. The Insurer shall have the right to assign his rights and duties under the insurance agreement to another insurance company, insurance company of another member state of the European Union or 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, on the basis of a written agreement and having received a permission of an insurance supervisory authority of the Republic of Lithuania.

15.2. The Insurer notice on the intension to assign rights and obligations under the insurance agreement shall indicate a deadline of at least 2 (two) 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.

15.3. 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.

16. Final provisions

16.1. The insurance agreement is subject to legislation of the Republic of Lithuania.

16.2. All disputes arising between the Insurer and the Policyholder in relation to the conclusion, execution or termination of the insurance agreement shall be solved by negotiation.

16.3. 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 rules on settlement of disputes between consumers and financial market participants laid down by the Bank of Lithuania, or in court pursuant to laws of the Republic of Lithuania.

16.4. The Policyholder and the insured shall have the right to refer to institution supervising financial market participants - the Bank of Lithuania. Information on the procedure of settlement of disputes between consumers and financial market participants is available online at: http://www.lb.lt/gincu_nagrinejimas.

16.5. The Insurer shall have the right to amend insurance regulations on the basis whereof the insurance agreement has already been concluded, if this does not lead to the breach of interests of the Policyholder, the Insured or the Beneficiary.

16.6. The Insurer shall also have the right to supplement and amend certain Articles of the insurance regulations on the basis of which insurance agreements have already been concluded in the following cases: upon the change or adoption of new legal norms pursuant to which insurance regulations were compiled and when legal norms directly applicable to the insurance agreement change, or in presence of an objective necessity due to an economic situation (for example, in case of hyperinflation). New provisions of the insurance regulations shall not deteriorate the position of the Policyholder and/or the Insured, compared to their previous version.

16.7. The Insurer shall inform the Policyholder about amendments to the insurance regulations provided for in paragraphs 16.5 and 16.6 in writing. These amendments to the insurance regulations shall take effect in one month after the day when the Policyholder received a notice on amendments to the insurance regulations, unless the Insurer indicates a different period of time. If the Policyholder does not agree with amendments to the insurance regulations, he may terminate the insurance agreement. When terminating the insurance agreement on this basis, insurance benefits shall be subject to provisions of paragraph 12.4 of the regulations.

Director General
Dr. Kęstutis Bagdonavičius

Member of the Board
Ingrida Kirse

Annex No. 1
To Health Insurance Regulations No. 010

Valid since 1 November 2016

Insured events (health insurance programmes)

The following insured events may be indicated in the insurance agreement (health insurance programmes):

1. Outpatient treatment (except for outpatient rehabilitation)

- Doctor's services;
- Diagnostic tests;
- Day surgery services;
- Day-patient facilities;
- Nurse's services.

2. Inpatient treatment in state health care institutions (except for rehabilitation treatment)

Additional services in public hospital:

- Single or double ward;
- Nurse's services;
- Premiums for medical aid and nursing instruments;
- Premiums for medicines.

3. Inpatient treatment in state and private treatment institutions (except for rehabilitation treatment)

Additional and treatment services in state/ private hospital:

- Single or double ward;
- Services of specialists physicians;
- Diagnostic tests;
- Nurse's services
- Medical aids and nursing instruments;
- Medicines;
- Surgical treatment services.

4. Drugs, medical aids and orthopaedic technical measures

- Medicines;
- Medical aids and orthopaedic technical measures.

5. Non-prescription drugs, food supplements, vitamins

- Non-prescription drugs;
- Food supplements;
- Vitamins.

6. Rehabilitation treatment

- Kinesiotherapist, occupational therapist, speech therapist consultation;
- Physical therapy procedures;
- Kinesiotherapy sessions;
- Water and mud treatments;
- Manual therapy sessions;
- Massages.

7. Rehabilitation treatment after hospital treatment

- Consultations of a kinesiotherapist, occupational therapist and speech therapist;
- Physical therapy procedures;
- Kinesiotherapy sessions;
- Water and mud treatments;
- Manual therapy sessions;
- Massages.

8. Dentistry, oral hygiene, prosthetics

Dental and oral hygiene services:

- Consultations of a dentist and dental hygienist;
- Removal of concretions, plaque;
- Fluoride applications;
- Endodontic, periodontal, therapeutic and surgical dental treatment, anaesthesia, X-ray examination.

Dental prosthetics service (optional clause):

- Dentist consultations on prosthetic / implant, orthodontic treatment;
- Production, restoration and repair of fixed and removable bridge;
- Teeth implantation, dental implants, orthodontic treatment, braces.

9. Preventive health check

- Mandatory health check;
- Tests performed at the Insured's request;
- Doctors' consultations and treatment, except for outpatient rehabilitation.

10. Vaccination

- Doctor's advice on vaccination;
- Vaccines selected by the Insured or prescribed by a doctor, and vaccination.

11. Optics

- Selection and production of glasses;
- One pair of eyeglass lenses per insurance year;
- Contact lenses.

12. Wellness services

- Physical education classes;
- Kinesiotherapy sessions;
- Water treatments;
- Manual therapy sessions;
- Massages.

13. Prenatal care

- Prenatal examination, medical consultations, studies to monitor the course of pregnancy;
- Diagnosis and treatment of pregnancy complications;
- Natal care;
- Single or double ward.

14. Other medical services

- Services provided in health care institutions: medical consultations, diagnostic tests, surgeries, nursing, rehabilitation therapy, prophylaxis, vaccination;
- Medications: medicines, food supplements, medical aids, orthopaedic technical products;
- Eyeglass and contact lenses, eyeglass frames, safety goggles, services of selection and production of eyeglasses, eyeglass lens care products (solutions for contact lenses and liquid cleaners of eyeglasses).
- Dental services: dental treatment, oral hygiene, prosthetics, implants, orthodontic treatment.
- Wellness services: physical education classes, kinesitherapy classes, water procedures, manual therapy sessions, massages.

15. Other medical services plus

- Services provided in healthcare institutions: medical consultations, diagnostic tests, surgeries, nursing, rehabilitation treatment, prophylaxis, vaccination;
- Drugs: medicines, food supplements, medical aids, orthopaedic technical products and other goods purchased in pharmacies;
- Glass and contact lenses, eyeglass frames, safety goggles, services of selection and production of eyeglasses, eyeglass lens care products (solutions for contact lenses and liquid cleaners of eyeglasses), sunglasses;
- Dental services: dental treatment, oral hygiene, prosthetics, implants, orthodontic treatment, teeth whitening, aesthetic filling;
- Wellness services: physical education classes, kinesitherapy classes, water procedures, manual therapy sessions, massages.

Insured events (health insurance programmes) and insurance benefit conditions whereon the Policyholder and the Insurer have agreed upon shall be laid down in individual agreement conditions.

Director General
Dr. Kęstutis Bagdonavičius

Member of the Board
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Annex No. 2
To Health Insurance Regulations No. 010

Valid since 1 November 2016

Price list of additional insurance agreement services

Additional issuance of copy of an insurance certificate	4 EUR
Issuance of a duplicate insurance certificate	4 EUR
Replacement of an insurance card (booklet) (when it is lost or damaged)	3 EUR

If several services need to be paid for at a time, only the most expensive service shall be paid for.

Director General
Dr. Kęstutis Bagdonavičius

Member of the Board
Ingrida Kirse