ERGO Life Insurance SE

Annex 3 to Health Insurance Rules No. 010

Effective as of 1 January 2017

Critical Illness Insurance

1. Key Terms Used in the Annex

Insured event means a Critical Illness with which the insured person is diagnosed for the first time in his/her life and specified in Paragraph 4.2 of this Annex which is evidenced by a final diagnosis and meets the criteria of diagnosing with critical illness specified in this Annex.

Waiting period means a period of 60 (sixty) days from the moment of coming into force of the insurance agreement in respect of the insured person during which the insurance cover of critical illness risk is invalid. If a person is diagnosed with a critical illness during the period from the moment of entry into force of the insurance agreement to the end of the waiting period, the insured person is not entitled to an insurance benefit. The waiting period shall not be applicable, if an insurance agreement is extended for another insurance period without any break.

Critical illness means an illness specified in Paragraph 4.2 and confirmed by a final diagnosis and/or surgery.

Final diagnosis means a diagnosis based on the conclusion drawn by a certified specialist physician or a medical consilium evidenced by appropriate laboratory and/or instrumental medical tests and recorded in medical records of the insured person.

2. Special Terms and Conditions of Critical Illness Insurance, where in case of occurrence of an insurance event an insurance benefit of critical illness specified in the agreement is paid out

2.1. Key Terms and Definitions

Insurance territory and time means 24 (twenty-four) hours a day anywhere in the world.

Survival period means a period of 30 (thirty) days after the date of detection of the insured event which is given to see, whether the insured person will survive. In case where an insured person fails to survive during the given period, the insurance benefit is not paid out.

2.2. Insurance Benefit

2.2.1. In case of an insured event the insured person is paid an insurance benefit in the amount of insurance.

2.2.2. Only 1 (one) insurance benefit shall be paid during the period of insurance. If an insurance benefit is paid out, insurance cover for the insured person in terms of critical illness insurance shall be terminated.

2.2.3. In the event where no insured event occurs up to the expiry of the insurance contract, insurance benefit is not paid out.

2.2.4. In case where the insured person dies during the survival period, insurance cover to such insured person expires and the insurance contribution made for this insured person is not repaid.

3. Special Terms and Conditions for Critical Illness Insurance where the costs for treatment of critical illness are paid upon the occurrence of an insurance event

3.1. Key Terms and Definitions

Insurance territory and time means 24 (twenty-four) hours a day in the Republic of Lithuania, Republic of Latvia, and Republic of Estonia.

When the type of insurance cover is chosen where the costs for treatment of critical illness are paid and the costs incurred by the insured person on treatment of the critical illness specified in Paragraph 4.2 of this Annex intended for out-patient treatment and diagnostics, in-patient treatment, medical rehabilitation, acquisition of medicines and medical aid items are reimbursed.

3.2. Insurance Benefit

3.2.1. In case where the insured person is diagnosed with any of the critical diseases specified in Paragraph 4.2 of this Annex during the validity of the insurance contract and after the expiry of the waiting period, the insurer shall repay the costs of treatment which accumulated due to the received treatment services intended for treatment of critical diseases to the insured person without exceeding the insurance amount established in the insurance contract.

3.2.2. In the event of occurrence of an insured event during the period of insurance contract where the insured person dies, the insurance cover to such insured person expires and the insurance contribution made for this insured person is not repaid.

4. General Provisions

General provisions shall apply to all types of insurance benefits specified in this Annex to the extent to which they do not conflict with the special and extraordinary rules established in the insurance contract having chosen a corresponding type of critical illness insurance.

4.1. Insurance Validity

4.1.1. The signing of the insurance contract confirms that expressing their will the Insurer and the Policyholder reached an agreement on the basis of which the Policyholder assumes the obligation to make payments of the established amount as specified in the contract at appropriate times, to also fulfil the obligations discussed in this Annex; the Insurer, on its part, assumes the obligation to pay to the Insured Person the insurance benefit in the amount established in the insurance contract in the event of occurrence of an insured event in accordance with the provisions of the insurance contract.

4.1.2. The insurance contract is valid for the period specified in the insurance policy, if the insurance premium (or its first instalment) is paid before the date specified in the insurance policy.

4.2. Cases in which insurance benefits are paid

Insurance benefits are paid upon the occurrence of an insured event – where the insured person becomes ill with any of the below listed critical illness during the insurance validity:

4.2.1. **Myocardial infarction** – The insured person is ill with coronary obstruction. The diagnosis of myocardial infarction is established on the basis of sudden and acute pain (symptoms of clinical ischemia, new changes in Electro-Cardiogram (ECG) (Q-wave formation and/or ST elevation or depression), and dynamics of biochemical markers of myocardial infarction (troponin or CK-MB);

4.2.2. **Aortocoronary shunting (bypass surgery)** – Surgery for the reason of narrowing or blockage of at least two coronary bloodvessels (with the opening of thorax), the necessity of which is based on angiography. No insurance benefit is paid for the coronary angioplasty or other methods of intra-arterial treatment (without opening thorax);

4.2.3. **Stroke (ischemic and haemorrhagic stroke** – Intracranial blood vessel stenosis occurs in an insured person or ischemic brain damage due to occlusion or due to spontaneous tearing of a blood vessel in the brain substance or above it, haemorrhagic stroke and neurological symptoms which occur suddenly and prevail for more than 24 hours;

4.2.4. **Cancer (malignant tumour)** – One or a few malignant tumours are found in an insured person, including leukaemia, lymphoma. Diagnosis of malignant tumour is confirmed histologically. No insurance benefit is paid for the following forms of cancer: chronic lymphocyticlleucemia, limphogranulomatosis, stage I, prostate cancer, cancer of unknown primary origin (carcinoma in situ) and all types of tumours to HIV-positive persons;

4.2.5. **End-stage renal disease/kidney failure** – The insured person shows the signs of dangerous kidney failure, uraemia, which manifests in chronic irreversible functional disorders of both kidneys, and is treated by performing regular haemodialysis or kidney transplantation. Insurance benefit is paid solely when a physician confirms the indication for dialysis or after a kidney transplant surgery;

4.2.6. **Limb loss/loss of limb functions** – complete loss of two or all limbs or their functions due to illness or trauma. Limb loss shall be considered when a limb above a knee or elbow is lost. Loss of limb functions must be confirmed by a certified specialist and objective conclusions of tests and shall not take less than 6 months (except for irreversible impairment of nerves or brain).

4.2.7. **Loss of vision (blindness)** – complete or irreversible loss of vision of both eyes due to illness or trauma. Diagnosis must be confirmed by a physician ophthalmologist and based on the methods of clinical and instrumental tests;

4.2.8. **Multiple sclerosis** – Sensory and motor dysfunctions which last more than 3 (three) months from the moment an illness is diagnosed. The right to the insurance benefit is obtained after the neurologist establishes the diagnosis confirmed by clinical and instrumental tests (magnetic resonance imaging);

4.2.9. **Internal organ transplant surgery** – Transplantation of heart, lungs, liver, pancreas, small intestine, bone marrow performed to the insured person when s/he is a recipient;

4.2.10. **Heart valve replacement (prosthesis)** – Replacement of one of two heart valves (aorta, mitral, tricuspid, pulmonary) with artificial valves due to stenosis and/or insufficiency. Insurance benefit is not paid for valve correction or incision surgeries;

4.2.11. **Aortic prosthesis surgery** – Removal or replacement with a transplant of part of abdominal or thoracic aorta impaired due to illness. Insurance benefit is not paid, a surgery of aortic arch branches is performed, shunting is conducted or a surgery was necessary due to traumatic impairment of aorta;

4.2.12. **Alzheimer's disease (established before the age of 65)** – Irreversibly lost cognitive functions:

- Language problems, memory loss, thinking, decision-making ability, dependence on care;
- Typical clinical symptoms and results of instrumental tests.

In case of illness, 24-hour continuous care is required. Diagnosis and the need for care must be confirmed by a neurologist and/or psychotherapist.

4.2.13. **Benign brain tumour** – Diagnosis of benign brain tumour is proven which is defined as benign growth of tissues within the skull reaching to brain, soft tissues of brain or cranial nerves. To cure the tumour at least one of the following methods must be applied:

- surgery (complete or partial resection of tumour);
- radiotherapy (radioactive irradiation);
- chemical therapy;
- stereotactic radiosurgery.

If it is impossible to use any of the aforementioned treatment methods for medical indications, the tumour must cause permanent neurological deficit lasting no less than for 3 months from the moment of diagnosis establishment. Diagnosis must be confirmed by a neurologist or neurosurgeon by means of imaging diagnostic tests.

Insurance benefit is not paid in the following cases:

- malformation of a cyst, granuloma, hamartoma or brain arteries or veins;
- pituitary tumours;

4.2.14. **Hearing loss (deafness)** – Complete and irreversible loss of hearing in both ears due to an illness or trauma. Diagnosis must be confirmed by an otolaryngologist by means of instrumental tests (audiogram);

4.2.15. **Loss of speech** – Complete and irreversible loss of ability to speak due to physical injury or illness of vocal chords which lasts for no less than 6 months except for irreversible nerve and brain impairment. Diagnosis must be confirmed by an otolaryngologist or psychotherapist. Insurance benefit is not paid, where speech is lost due to psychiatric disorders;

4.2.16. **Third and fourth degree burns** – Burns which cause skin injuries and extend into subcutaneous tissues and/or muscles which cover at least 20% of the body surface.

Insurance benefit is not paid for the first and second degree burns.

4.2.17. **Idiopathic Parkinson's disease (before the age of 65)** – Slowly progressive brain disease. Initial diagnosis of idiopathic Parkinson's disease which is confirmed by at least two of the clinical phenomena listed below:

- Muscle frigidity;
- Tremor;
- bradykinesia (pathological slowness of movements, slowness of physical and mental rebound effects).

Inability to perform at least 3 out of 6 activities of daily living independently without a break for at least 3 months:

- washing – ability to wash oneself in a bath or shower (including getting in a bath or shower and out of it) or satisfactorily washing by any other means;
- getting dressed and undressed – ability to put on clothes, to take them off, to button up/zip up and unbutton and unzip all parts of clothes and where needed, all supports, artificial limbs or surgical aids;
- eating – ability to have a meal independently, if food is prepared and served;
- personal hygiene – ability to maintain the satisfactory level of personal hygiene after a toiler or ability to control bowel movement and urination;
- moving indoors – ability to get from one room to another on the same floor;
- getting in bed and out of it – ability to get out of bed and sit down on a chair or a wheelchair and to get in bed.

Diagnosis must be confirmed by a neurologist and psychotherapist.

Insurance benefit is not paid for secondary Parkinsonism (including Parkinsonism caused by medicines or toxins).

4.2.18. **Bacterial meningitis** – Severe head and/or spinal brain inflammation caused by an infection due to which severe, irreversible and permanent neurological disorders occur.

Diagnosis is confirmed by the following:

- Bacterial infection (found/identified in cerebral spinal fluid obtained during lumbar puncture);
- Diagnosis established by a neurologist and/or neurosurgeon and a physician of infectious diseases showing neurological symptoms and lasting at least 6 weeks.

4.2.19. **Aplastic anaemia –** Chronic persisting insufficiency of bone marrow activity related to anaemia, neutropenia and thrombocytopenia the removal of which requires at least one of the following therapies:

- transfusion of blood products;
- allogeneic bone marrow transplantation;
- immunosuppressive therapy;
- use of stimulating agents;

Diagnosis shall be established and confirmed by:

- laboratory tests;
- physician haematologist.

Insurance benefit is not paid, where the following is diagnosed:

- haemorrhagic anaemia;
- haemolytic anaemia;
- iron deficiency anaemia;
- vitamin B12 anaemia.

4.2.20. **Active tuberculosis** – Infectious disease which is most often related to lungs – pulmonary tuberculosis, also – with spinal, bone, genital, brain, lymphatic nodes, etc. – non-pulmonary tuberculosis.

Diagnosis is confirmed by the following:

- Laboratory and instrumental tests;
- pulmonologist.

4.2.21. **Chron's disease** – Chronic and often a progressive gastrointestinal disease. Diagnosis is confirmed by a physician gastroenterologist based the conclusions of objective laboratory tests and the results of instrumental tests.

4.2.22. **Hepatic insufficiency/liver failure** – Hepatic necrosis which is caused by hepatic encephalopathy and coagulopathy or secondary viral infections, toxins (except for alcohol) or impairment of the immune system.

Diagnosis is confirmed by the following:

- Clinics or objective disease focus (increase in ASAT, ALAT, hepatic encephalopathy, impaired liver synthesis function, INR>1.5);
- Certified physician (haematologist, infectologist, etc.).

Insurance benefit is not paid due to unreasonable use of medicines which caused the development of hepatic insufficiency.

4.2.23. **HIV infection** – A chronic infectious disease which is caused by human immunodeficiency virus (HIV) which is received from blood transfusion/blood products or after an accident at work or in case of physical violence.

HIV must be diagnosed for the first time during the period of insurance and must be confirmed by a centre of infectious diseases of a corresponding country.

4.2.24. **Hepatitis C** – An acute or chronic infectious disease which is caused by the hepatitis C virus and which is received from blood transfusion or blood products or after an accident at work.

Hepatitis C must be diagnosed for the first time and approved by a certified physician and substantiated by objective tests.

4.2.25. **Tick-borne meningoencephalitis** – A disease caused by a bite of an infected tick.

Insurance benefit is paid, when:

- The disease is detected after a complete course of vaccination against tick-borne meningoencephalitis (upon presentation of a vaccination card);
- The insured person received in-patient treatment for at least 10 (ten) days.

4.2.26. **Lyme disease** – A disease caused by a bite of an infected tick due to which no less than two organ systems' lesion (skin, bone and articulation).

4.3. Obligations of the Policyholder and the Insured Person having declared an insured event

The Policyholder and the Insured Person shall fulfil the following obligations after an insured event is declared:

4.3.1. Notify the insurer of a possible insured event immediately, as soon as it becomes practicable, however no later than within 30 (thirty) days from the date of declaration of a possible insured event;

4.3.2. Address for medical aid immediately, as soon as it become practicable, and to follow a physician's instructions;

4.3.3. After the confirmation of a final diagnosis, provide the insurer with the following:

4.3.4. Notification about having got a critical illness;

4.3.5. Medical records proving the diagnosis of a critical illness which contain the indication of an accurate final diagnosis and the date of establishment of a final diagnosis;

4.3.6. Other documents and information requested for by the insurer.

4.4. Procedure of establishment and payment of insurance benefits

4.4.1. Having made a claim for an insurance benefit, the following documents must be provided the costs of preparation and receipt of which shall be paid by the recipient of the benefit:

Notification about having got a critical illness;

Medical documentation or its copies confirming the diagnosis of critical illness and providing the results of performed instrumental and laboratory tests and surgeries;

4.4.2. The insurer may request that the insured person conduct additional health checks, also demand additional certificates or explanations. The costs of preparation and receipt of documents shall be paid by the insurer.

4.4.3. The insurer has the right to check the details provided by the insured person about his/her health condition in medical institutions in which the insured person was examined and/or treated.

4.4.4. Decision about payment of an insurance benefit shall be made by the insurer within 30 (thirty) days from the moment when all documents required for receiving all necessary documents to make a decision are received.

4.4.5. Insurance benefit shall be paid in accordance with the terms and conditions of Paragraph 2.2 or 3.2 of this Annex, subject to the type of critical illness insurance specified in the insurance policy. If the insurance policy does not specify the method of payment of insurance benefit, insurance benefit is paid out in accordance with the provisions of Paragraph 3.2 of this Annex.

4.5. Insurance benefit payment restrictions

Insurance benefit is not paid, if the reason for health disorders of the insured person is the following:

4.5.1. Deliberate impairment of health condition of the insured person (including deliberate injuries) or attempt to commit suicide;

4.5.2. Participation in war or actions considered equivalent to it, in the activities of any military formation, terrorist acts, also in mass upheaval;

4.5.3. Participation in organised actions of national military forces, including peace keeping missions;

4.5.4. Unlawful activity, execution of sentence in a confinement institution, infringements on rights or performance of criminal activities (or participation in them), if this has been recognised by the court or any other competent institution;

4.5.6. Radiation poisoning, radioactive pollution, natural disaster;

4.5.7. Abusive consumption of alcohol, drugs, toxic or other intoxicating substances or medicaments, self-treatment;

4.5.8. Result of experimental or non-conventional treatment;

4.5.9. HIV infection or AIDS (AIDS positive test), except for the cases specified in Paragraph 4.2.23 of this Annex;

4.5.10. The insured person that has insurance cover against critical illness got ill without following the instructions of the physician.

5. Exceptions

Insurance benefit is not paid, if:

5.5. The case of critical illness is not diagnosed for the first time, i.e. it is not the first case of this kind in the life of the insured person;

5.6. The insured person received a medical consultation and/or treatment from any of critical illness before the start of the insurance period;

5.7. The insured person has already been diagnosed with a critical disease in his life or the insured person knew about any circumstances speaking of a possible becoming ill with a critical illness before the entry into force of the insurance cover.

5.8. The insured person dies during the survival period.

6. Other provisions

This Annex is an integral part of Health Insurance Rules No. 010 (in effect as of 1 November 2016). Any questions not discussed in this Annex are resolved by application of Health Insurance Rules No. 010 (in effect as of 1 November 2016).

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