ERGO Life Insurance SE

Individual Health Insurance Rules No. 22

Approved by ERGO Life Insurance SE CEO's Order No SE 29/v of 15 July 2014.
Effective from 15 July 2014

1. Definitions Used in the Rules

1.1. **"Insurer"** means ERGO Life Insurance SE.

1.2. **"Policyholder"** means a natural person of full age or a legal person who applied to the insurer regarding conclusion of 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 must pay insurance premiums.

1.3. **"Insured person"** means a person specified by a policyholder and nominated in an insurance contract to whom, upon occurrence of an insured event in his life, the insurer must pay an insurance benefit. One person may be insured under one insurance contract.

1.4. **"Outpatient health care institution"** means a health care institution entitled to provide with personal outpatient health care services according to the procedures set out in the laws of the Republic of Lithuania.

1.5. **"Inpatient health care institution"** means a health care institution entitled to provide with personal inpatient health care services according to the procedures set out in the laws of the Republic of Lithuania.

1.6. **"Insurance cover"** means the insurer's commitment to pay an insurance benefit upon occurrence of an insured event.

1.7. **"Insurance risk"** means a possible danger threatening the insurance object.

1.8. **"Insured event"** means an event specified in the insurance contract upon occurrence of which the insurer must pay the insurance benefit. If treatment of the insured person is continued due to a disease or an accident that has no causal relationship with the health disorder that was treated before, it shall be assessed as a separate insured event.

1.9. **"Non-insured event"** means an event (heath care services, treatment) where the insurer is not under an obligation to pay insurance benefits.

1.10. **"Application for insurance"** means the document in the form prescribed by the insurer, which the policyholder intending to conclude an insurance contract shall provide to the insurer.

1.11. **"Insurance rules"** means Individual Health Insurance Rules No 22.

1.12. **"Insurance contract"** means a health insurance contract concluded between the insurer and the policyholder. The integral parts of the insurance contract:

1.12.1. application for insurance;

1.12.2. insurance policy;

1.12.3. insurance rules;

1.12.4. amendments, modifications of an insurance contract and/or individual conditions of an insurance contract agreed in writing between the insurer and the policyholder.

1.13. **"Insurance policy"** means the document issued by the insurer certifying the conclusion of the insurance contract.

1.14. **"Sum insured"** means the sum of money specified in the insurance contract or calculated according to the method specified in the insurance contract which the insurance benefit may not exceed, except for the cases provided for in the insurance contract. Sums insured, which the parties of the insurance contract have agreed upon, shall be specified in the insurance policy.

1.15. **"Insurance benefit"** means an amount of money which the insurer must pay to the insured person and/or a health care institution under the insurance contract conditions upon occurrence of an insured event for services provided to the insured person.

1.16. **"Application for reimbursement of health insurance costs"** means the document in the form prescribed by the insurer, which is submitted to the insurer in order to receive the insurance benefit.

1.17. **"Health care services"** means qualified individual health care and pharmaceutical services provided at an outpatient and/or inpatient health care institution, pharmacy.

1.18. **"Pharmaceutical services"** means medicinal products, medical aid equipment, orthopaedic technical products, orthopaedic socks and compensatory equipment for the disease treatment.

1.19. **"Treatment"** means physician's consultations, diagnostic tests, medical procedures intended for the disease treatment.

1.20. **"Health disorder"** means change of the insured person's health or physiological condition (in the case of an acute disease, exacerbation of a chronic disease and/or trauma), which requires application of diagnostics and treatment.

1.21. **"Alternative medicine"** means diagnosis and treatment in non-traditional ways, including, but not limited to biopuncture (electroacupuncture) diagnostics, food intolerance test, hydro-colon therapy, acupuncture, homeopathy, leech therapy.

1.22. **"Preventive services"** means chronic disease monitoring, tests carried out at the request of the insured person, preventive health examination according to the job nature.

Other terms used in these insurance rules are interpreted as they have been defined in the Law on Insurance of the Republic of Lithuania and other legal acts of the Republic of Lithuania.

2. Conclusion of an Insurance Contract

2.1. A policyholder, in order to conclude an insurance contract, shall submit to the insurer the application for insurance, where he shall answer comprehensively and truthfully to the questions asked in the application by the insurer, and provide other information requested by the insurer related to the insurance object and insurance risk. Submission of an application for insurance does not obligate the insurer to conclude an insurance contract.

2.2. The insurer, after assessing the insurance risk, may refuse to conclude an insurance contract without giving any reasons. If the insurance premium has been paid prior to the insurance risk assessment and the insurer's refusal to conclude an insurance contract, such premium is returned to the person who paid it. If during this period an insured event specified in these insurance rules occurs, the insurer is not required to pay the insurance benefit.

2.3. If the insurer agrees to conclude an insurance contract, an insurance policy shall be issued to the policyholder certifying the conclusion

of the insurance contract. The insurance contract date is the insurance policy issuing date.

2.4. The insurance contract may be concluded by setting individual insurance conditions, if the insurer and the policyholder have agreed separately upon such conditions following risk assessment.

3. Insurance Object and Insurance Cover

3.1. Insurance object means property interests related to a person's health provided with insurance cover according to these insurance rules.

3.2. The insurer undertakes the obligation to compensate for such insured person's costs, which are not compensated from the budget of the Compulsory Health Insurance Fund.

3.3. The beginning, the end and the scope of insurance cover is specified in the insurance policy, the individual terms of insurance and these insurance rules.

4. Non-Insured Events

4.1. The insurer shall not pay any insurance benefits:

4.1.1. for health care services and/or treatment provided in relation to:

4.1.1.1. health disorders that were caused when the insured person injured himself intentionally or by gross negligence, or attempted to commit suicide. Gross negligence shall be deemed failure to comply with simple rules of conduct understandable to everyone or ignoring and/or failure to comply with the requirements of safe behaviour certainly known to the person;

4.1.1.2. health disorders resulting from committing a criminal offence or preparation to commit it and/or committing other acts contrary to the law by the insured person. Indications of a criminal offence or preparations to commit it or other acts or omissions contrary to the law are proven and the insurer may substantiate his decision to recognise the event a non-insured event by the following: conclusions, procedural decisions of pre-trial investigating authorities and bodies authorized to hear administrative cases and/or court judgments, decisions, resolutions and rulings;

4.1.1.3. health disorders resulting from the effect of pandemics, natural disasters (such as violent storms, cyclones, earthquakes, tides and floods, lightning), any form of war, military actions (regardless of whether war was declared or not), the state of national emergency, insurrection, riot, internal unrest which reaches the level of use of military or illegal force by participation in acts of violence;

4.1.1.4. health disorders which occurred through the intent of the policyholder or the beneficiary (offences committed with a specific or general intent); a specific intent - a person performing certain actions understood their dangerous nature to health and wanted to act in that way; general intent - a person performing certain actions understood their dangerous nature (in this case to health), envisaged that his actions may have negative consequences (to health) and although he did not want them, but deliberately allowed them to occur;

4.1.1.5. health disorders resulting from exposure to radiation or other effects of nuclear power (excluding the consequences of radiation therapy);

4.1.1.6. health disorders resulting from the effect of alcohol, drugs or toxic substances used by the insured for intoxication purposes, or medicines that were not prescribed by a physician;

4.1.1.7. health disorders which occur during the time period, when insurance cover is not effective;

4.1.1.8. congenital health disorders and their complications;

4.1.1.9. the costs related to issuing and/or submission of medical and other documents;

4.1.2. for the provision of health care services and/or treatment:

4.1.2.1. when services have been provided by the insured person's spouse, parents or children;

4.1.2.2. not included in the insurance contract;

4.1.2.3. where the insured person has exceeded the limits of sum insured for health care services of the insurance option set out in the insurance contract;

4.1.2.4. the date and circumstances of which may not be detected during investigation of the event;

4.1.2.5. when appointment of diagnostic tests and treatment to the insured person is not medically substantiated;

4.1.2.6. under prescription or referral issued by the insured person himself;

4.1.2.7. joint replacement surgery, joint endoprostheses, prosthetic systems;

4.1.2.8. vision correction surgery;

4.1.2.9. pregnancy care, childbirth and postpartum care, treatment of health disorders resulting from pregnancy or childbirth;

4.1.2.10. termination of pregnancy in the absence of medical indications and childbirth outside a medical facility;

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

4.1.2.12. diagnosis and treatment of infertility and potency disorders, in vitro fertilization;

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

4.1.2.14. surgical treatment of benign tumours;

4.1.2.15. sclerotherapy procedures and surgical treatment of varicose veins;

4.1.2.16. therapeutic and surgical treatment of obesity;

4.1.2.17. prophylaxis and vaccination services;

4.1.2.18. cosmetic-plastic surgery, cosmetic/beauty treatments (aesthetic, development of body lines, anti-cellulite, body scrub, wrapping etc.), as well as the use of functional, diagnostic equipment, devices and instruments directly related to these treatments;

4.1.2.19. provided in a health care institution and/or by a health care specialist, which/who does not hold a valid licence issued by the State Health Care Accreditation Agency under the Ministry of Health, Lithuanian Dental Chamber or the State Medicines Control Agency under the Ministry of Health of the Republic of Lithuania;

4.1.2.20. applying alternative medical treatment methods;

4.1.2.21. purchase of first aid means, diagnostic and therapeutic devices (thermometers, inhalers, testers, warmers, hearing aids, scales and blood pressure measuring devices, glucometers etc.);

4.1.2.22. purchase of medicinal products not registered in the register of medicinal products of the Republic of Lithuania or the Community;

4.1.2.23. purchase of weight-reducing, potency increasing medicinal products, medicinal products for treatment of various addictions, anabolic steroids, food supplements, hygiene, cosmetic and contraceptive means;

4.1.2.24. medical products purchased not in pharmacies.

4.2. Other non-insured events are specified in the special insurance conditions.

5. Insurance Premiums and Procedures of their Payment

5.1. Insurance premium currency, their amounts and payment terms are specified in the insurance policy. Insurance premiums are paid in advance for each period of insurance. A first or a single premium must be paid before the insurance contract effective date. All other insurance premiums (regular premiums) must be paid within the time limits specified in the insurance policy. The policyholder shall pay insurance premiums in the national currency. Premiums are converted into the currency of the insurance contract at the exchange rate set by the Bank of Lithuania on the day of issuing the invoice or other payment document. If the premium is paid with delay, the insurer is entitled to request the policyholder to compensate the difference that occurred due to the change of currency exchange rate. The difference shall be compensated immediately.

5.2. Insurance premium payment date is deemed the date when the premium is credited to the insurer's bank account. If it is impossible to determine according to the payment order in relation to which insurance contract the insurance premium was paid, the insurance premium payment date will be the date on which the insurer attributes that premium to the relevant insurance contract.

5.3. If a policyholder fails to pay an insurance premium or its part in the time specified in the insurance contract (except when effectiveness of an insurance contract is related to the payment of an insurance premium or its part), the insurer shall notify the policyholder about this in writing stating that the insurance contract will terminate, if a policyholder does not pay an insurance premium or its part within 30 days after the dispatch of the notification.

6. Duration of the Insurance Contract

6.1. The insurance period is specified in the insurance policy. The insurance contract shall enter into force if all the following conditions have been met: an insurance certificate has been issued to the policyholder, a first or a single premium has been paid. The insurer has the right to declare the contract in force also in the absence of all the listed conditions.

6.2. The insurance cover is valid subject to payment of a first or a single premium, but not before the insurance contract is concluded, and not before the beginning of insurance referred to in the insurance policy. With the insurer's consent, the insurance cover can begin earlier.

7. Rights and Obligations of the Insurance Contract Parties

7.1. The policyholder entering into the insurance contract shall:

a) submit an insurance application of the form established by the insurer and other information required by the insurer for concluding the insurance contract;

b) provide the insurer with comprehensive, true information about the person to be insured or already insured, health insurance contracts of this person concluded or to be concluded;

c) familiarize the insured person with the insurance contract conditions applicable or related to him;

d) pay the insurance premiums set out in the insurance contract;

e) pay additional fees set out in the insurance contract.

7.2. The insurer undertakes:

a) not to disclose information about a policyholder or an insured person received during conclusion of an insurance contract, except for the cases and/or exceptions provided in the insurance contract or the law;

b) familiarise a policyholder with these insurance rules, insurance premium rates and issue an insurance policy, when an insurance contract is concluded;

c) perform other statutory obligations of the insurer.

7.3. The insurer insures believing that a policyholder and an insured person answered comprehensively and truthfully to all questions presented in the insurance application, particularly to the questions related to existing and previous diseases, health disorders and ailments.

7.4. If it is found after concluding an insurance contract that a policyholder or an insured person failed to meet their obligation to disclose information during concluding of an insurance contract or during its validity period, and intentionally or negligently provided the insurer with incomplete, untrue information about a policyholder, an insured person or the circumstances that may have a material impact on the insurance risk assessment, probability of occurrence of an insured event, for determining of the insurance contract fees, insurance premiums and sum insured, or other significant circumstances of the insurance contract, the insurer has the right to terminate the insurance contract or reduce the insurance benefit or refuse to pay it.

7.5. The insurer is entitled to request the insured person to undergo health examination in the health care institution indicated by the insurer and submit the examination results to the insurer.

7.6. Any notices related to an insurance contract shall be submitted in writing. Such communications shall be effective to the insurer from the moment of their receipt.

7.7. A policyholder must notify the insurer within five business days about the change of his correspondence address and/or name. Otherwise the policyholder will have to bear the related costs, if a message addressed to him is sent by registered mail to the address known to the insurer, when a policyholder fails to inform about the change of the address.

7.8. Prior to concluding an insurance contract and during its effectiveness period, a policyholder must notify the insurer in writing within five business days about the change of any information about the policyholder or the insured person specified during concluding of the insurance contract, also about increase of risk.

7.9. A policyholder shall inform the insurer about all health insurance contracts concluded with another insurance company in favour of the insured person or the policyholder within 30 days from the date of concluding the insurance contract with another insurance company.

7.10. The policyholder and/or the insured person must submit to the insurer all documents and information about the circumstances and the consequences of the insured event necessary for the insurer to determine the amount of insurance benefit.

7.11. The insured person must take any available steps to reduce the damage to health and avoid and refrain from any actions which could impair the course of treatment or the insured person's health.

7.12. The insured person may choose any health care institution in Lithuania, which has the right to provide health care services according to the laws of the Republic of Lithuania.

7.13. In order to determine whether insurance benefits shall be paid, the insurer may request from the policyholder, the insured person or other parties additional evidence and information related to the assessment of the insured event, provided health care and other services specified in the insurance contract, determination of the amount of insurance benefit, or perform the necessary investigation at his own expense, or to appoint a medical expert.

8. Procedure for Determining of Insurance Benefits

8.1. Insurance benefits are paid within the insurance coverage limits set out in the insurance contract.

8.2. When the insurance benefit has been paid, the sum insured shall be reduced by the amount of the insurance benefit paid out.

8.3. The policyholder or the insured must notify about the insured event in writing immediately, but no later than within 30 calendar days from the date of the event.

8.4. The insurer shall pay insurance benefits upon submission of the following documents or copies thereof:

- Financial documents: an invoice with a cash register receipt/ payment order or a cash income slip/money receipt, which must have the details (the name, identification number, address) of the service/goods provider, details of the payer (name, surname, personal number) and a detailed description of services/goods (name, quantity, price, date of receipt);
- Referral/extract or a copy of medical records containing information about the nature of disease, diagnosis, appointed tests, procedures, treatment;
- A prescription or a copy of medical records, which contain information about the nature of disease, diagnosis, treatment, if medicinal products, medical aid equipment, orthopaedic technical products, orthopaedic socks and compensatory equipment have been purchased;
- A completed request for reimbursement of health insurance costs.

8.5. A policyholder and/or an insured person notifying about an insured event shall submit to the insurer documents or copies of the documents confirming provision of health care services and payment for them.

8.6. The insurer may reduce or refuse to pay an insurance benefit, if a policyholder or an insured person has submitted false information or deliberately misleading information about the health care services provided, or if a policyholder and/or an insured person has not complied with the requirements specified in paragraphs 7.1, 7.5 and 8.3.

8.7. If an insured person is insured under several insurance contracts with different insurers, then the insurance benefit payable in case of an insured event shall be reduced proportionately.

8.8. If the insurance benefit has already been paid in relation to the same insured event for the same service or purchased medicine/medical instrument, a repeated insurance premium shall not be paid.

9. Procedure for Payment of Insurance Benefits

9.1. The insurer shall pay insurance benefits not later than within 15 calendar days from the date of receipt of all information significant for establishing of the fact, circumstances and consequences of the insured event, and the amount of insurance benefit. The insurer shall pay insurance benefits in the national currency at the exchange rate set by the Bank of Lithuania effective on the day of payment of the benefit.

9.2. The insurer has the right to reduce the insurance benefit by the amount of insurance premiums unpaid before the insured event and deduct the amounts related to concluding and execution of the contract unpaid by the policyholder according to the procedure established by the insurer.

10. Right of Subrogation

10.1. The insurer, who has paid an insurance benefit, receives the right to claim the amounts paid out from the person responsible for the damage.

11. Termination of an Insurance Contract

11.1. The policyholder has the right to terminate the insurance contract by giving the insurer at least one month written notice before the intended date of the insurance contract termination.

11.2. The insurer may terminate the insurance contract unilaterally out of court in the cases specified in paragraphs 5.3 and 7.4 of these rules.

11.3. When the insurance contract is terminated on the policyholder's initiative or on the insurer's initiative due to the breach of the insurance contract conditions by the policyholder, the insurance premiums shall not be reimbursed.

11.4. When the insurance contract is terminated on the policyholder's initiative due to the breach of the insurance contract conditions by the insurer, the portion of the insurance premium for the remaining duration of the insurance cover after the termination date shall be reimbursed to the policyholder, after deduction of the insurance contract concluding and execution costs, which shall not exceed 25% of the estimated annual amount of the insurance premium.

11.5. When the insurance contract is terminated on the policyholder's initiative without the breach of the insurance contract conditions by the insurer, the portion of the insurance premium for the remaining duration of the insurance cover after the termination date shall be reimbursed to the policyholder, after deduction of the insurance benefits paid out and the insurance contract concluding and execution costs, which shall not exceed 25% of the estimated annual amount of the insurance premium.

12. Amendment of an Insurance Contract

12.1. In order to amend the insurance contract, the policyholder shall submit to the insurer in writing (by e-mail/fax/registered mail) the application of the form established by the insurer about the desired changes to the insurance contract not later than one month before the intended date of the amendment of the insurance contract. If the policyholder misses this deadline or does not specify it, the insurance shall amend the insurance contract no later than one month from the date of receipt of the policyholder's application. The insurer, after assessing the changing circumstances, may refuse to amend the insurance contract conditions. The amendments to the insurance contract shall take effect from the date specified in the amendment to the insurance contract or amended insurance policy issued by the insurer.

12.2. When contract conditions are to be amended, the insurer may request information on the state of health of the insured persons, their leisure interests and other risk factors.

13. Liability for Violation of the Insurance Contract

13.1. If the policyholder does not pay insurance premiums or other payments under an insurance contract within the prescribed time limit, the policyholder at the insurer's request must pay 0.02% interest on the unpaid amount for each day of delay.

13.2. If the insurer does not pay insurance benefits within the prescribed time limit, at the policyholder's request, he must pay 0.02% interest on the outstanding amount of insurance benefits for each day of delay.

14. Procedure for Assignment of Rights and Obligations under the Insurance Contract

14.1. The insurer on the basis of a written contract and a permit received from the Supervisory Authority has the right to assign its rights and obligations under the insurance contract to another insurance company, to an insurance company of another EU Member State or the branch of a foreign insurance company established in the Republic of Lithuania or another EU Member State according to the procedures established by the laws of the Republic of Lithuania.

14.2. The insurer's notice of its intention to transfer its rights and obligations under the insurance contract must specify a term of not less than two (2) months, during which the policyholder has the right to express in writing to the insurer its objections regarding the intention to transfer the insurer's rights and obligations under the insurance contract.

14.3. If the policyholder does not agree with assignment of the rights and obligations under the insurance contract, he is entitled to terminate the insurance contract within one month after the assignment of the rights and obligations with the insurance contract termination notice made in writing to the insurer. The insurance contract is terminated on the date of receipt of the insurance contract termination notice.

Upon termination of the insurance contract on the grounds specified in this paragraph, the portion of the insurance premium for the remaining duration of the insurance cover shall be reimbursed to the policyholder, after deduction of the insurance contract concluding and execution costs.

15. Special Insurance Conditions

15.1. **Conditions for insurance of outpatient service costs**

15.1.1. **Explanation of terms**

"Outpatient service" means treatment in an outpatient health care institution.

"Price list" means the price list is made by the insurer for the determination of payment for outpatient services.

15.1.2. **Insured events**

"Insured event" means the insured person's health disorder related costs for medically-substantiated outpatient services in Lithuania.

15.1.3. **Insurance benefit and its payment**

If the price of an outpatient service is higher than the maximum price set in the pricelist for the relevant service, the insurer shall pay the costs incurred by the insured person according to the price specified in the price applying the percentage of payment for the service specified in the insurance contract.

15.1.4. **Non-insured events**

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

a) consultations on family planning, contraception; insertion, control or removal of contraception means, diagnostic tests prior to the appointment of contraception and tests intended to prevent complications due to use of these means;
b) immunotherapy, psychotherapeutic treatment;
c) immunologic - immunoenzymatic tests for the detection of antibodies-antigens (except for the thyroid gland hormone antibodies);
d) diagnosis and treatment of osteoporosis;
e) genetic and cytogenetic, allergen-specific IgE (food, inhaled), sex hormone tests;
f) tests of medicines, narcotic substances, heavy metals;
g) somnography examination, trichogram;
h) treatment of diseases included in the list of severe diseases;
i) services of specialized doctors not specified in the insurance contract;
j) rehabilitative therapy services (physiotherapy, physical therapy, occupational therapy, massages);
k) day care and day surgery services, unless the insurance contract provides otherwise

15.2. **Special conditions for insurance of inpatient service costs**

15.2.1. **Explanation of terms**

"Inpatient service" means health care service provided in the state inpatient health care institution when the insured person need medical aid continuing more than twenty four (24) hours.

15.2.2. **Insured events**

"Insured event" means the insured person's health disorder related costs for medically-substantiated inpatient services in Lithuania, Latvia or Estonia.

15.2.3. **Insurance benefit and its payment**

Costs of pharmaceutical services are compensated, when an insured person submits a discharge summary issued by a physician who treated him in an inpatient health care institution.

15.2.4. **Non-insured events:**

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

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

15.3. **Special conditions for insurance of severe diseases treatment costs**

15.3.1. **Explanation of terms**

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

"Diagnosis code" means the diagnosis, established according to the International Classification of Diseases ICD-10.

15.3.2. **"Insured event"** means the insured person's severe disease treatment related costs for medically-substantiated health care services in Lithuania, Latvia or Estonia.

15.3.3. **Insurance cover effectiveness period**

Insurance cover is effective for 12 months after the insured event date.

15.3.4. **List of severe diseases:**

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

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

Diagnosis is confirmed by:

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

Exceptions:

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

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

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

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

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

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

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

Diagnosis is confirmed by:

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

Exceptions:

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

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

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

Diagnosis is confirmed by:

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

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

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

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

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

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

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

Diagnosis is confirmed by:

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

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

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

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

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

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

VI. eating: the ability to eat independently, if the food is prepared and placed in an accessible place.

Exceptions:

- If the disease is caused by chronic alcoholism, overdose of medication.

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

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

Diagnosis is confirmed by:

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

Exceptions:

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

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

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

Diagnosis is confirmed by:

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

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

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

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

Diagnosis is confirmed by:

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

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

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

Diagnosis is confirmed by:

- Laboratory and X-ray tests;
- Phthisiologist's opinion.

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

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

Diagnosis is confirmed by:

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

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

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

Diagnosis is confirmed by:

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

Exceptions:

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

15.3.4.13. **Coronary artery bypass surgery**

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

The need for operation is confirmed by:

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

Exceptions:

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

15.3.4.14. **Heart valve surgery**

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

The need for operation is confirmed by:

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

Exceptions:

- Heart valve plastic and/or correction operation.

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

Diagnosis is confirmed by:

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

Exceptions:

- stem cell transplantation.

15.3.5. **Non-insured events:**

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

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

15.3.5.2. if the severe disease does not meet the criteria for acknowledgement as a severe disease and an insured event set out in paragraph 15.3.4.

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

15.4.1. **Explanation of terms:**

"Accident" means an event where the insured person's body is suddenly, outside his will, affected from outside and damage to health is caused.

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

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

15.4.2. **Insured events**

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

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

15.4.3. Policyholder's, insured person's obligations

15.4.3.1. Apply to a physician (a health care institution) immediately, but not later than within 48 hours.

15.4.4. Insurance benefit and its payment

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

15.4.5. Non-insured events:

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

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

b) carries out military service in the army or other similar formation, participates in the peacekeeping mission;

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

d) participates in any sports competitions, trainings, unless the insurance contract provides otherwise;

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

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

f) being intoxicated with alcohol and/or narcotic substances, strong medications, toxic, psychotropic or other intoxicating substances causes by his actions the actions of third parties damaging the insured person's health;

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

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

b) health disorders resulting from treatment, surgery or other medical procedures. If surgery or treatment was necessary because of the accident, then it is considered an insured event;

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

d) fracture of osteosynthesis structures and dislocation, joint prostheses fracture and dislocation;

e) removable denture breakage or damage; loss of teeth damaged by parodontosis and other tooth and gum diseases;

dental injury due to internal injuries (in the process of chewing, biting, eating);

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

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

15.5.1. **Explanation of terms:**

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

15.5.2. **Insured events**

Insured event means insured person's costs for dental treatment services.

15.5.3. **Non-insured events**

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

a) oral hygiene, fluoride application, dental coverage with sealants;

b) teeth whitening, laminating (veneering);

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

16. Final Provisions

16.1. The insurance contract is governed by the laws of the Republic of Lithuania.

16.2. The disputes arising between the policyholder and the insurer shall be settled out of court, according to the dispute settlement rules established by the Supervisory Authority, or at court, according to the laws of the Republic of Lithuania.

16.3. The insurer has the right to amend the insurance rules, which make the basis for the insurance contract, if it does not violate the interests of the policyholder, the insured person and the beneficiary.

16.4. The insurer also has the right to supplement and amend certain paragraphs of the insurance rules, which make the basis for already concluded insurance contracts, in the following cases: amendment or adoption of new laws, which the insurance rules were based on, or amendment of laws directly applicable to the insurance contract, or when an objective necessity occurs due to economic situation (e.g. in the event of hyperinflation).

New provisions of the insurance rules shall not worsen the situation of the policyholder and/or insured persons in comparison with the previous version.

16.5. The insurer must inform the policyholder in writing about amendment of the insurance rules. The amendments of the insurance rules shall take effect one month after the date on which the policyholder received notification about amendment of the insurance rules, unless the insurer indicates a different date.

If the policyholder does not agree with the amendment of the insurance rules, he may terminate the insurance contract. When an insurance contract is terminated on this basis, provisions of paragraph 11.5 of the rules shall apply to the benefits.

Dr. Kęstutis Bagdonavičius
Chief Executive Officer

Ingrida Kirse
Member of the Board