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Special Conditions of Cancer and Other Critical Illness Insurance of Adults No 028-04

(these conditions shall apply along with the Universal Life Insurance Rules No 028)

1. Object of insurance

1.1. The object of insurance shall be property interests if the Insured develops cancer or another critical illness insured under the Insurance Agreement conditions and corresponding to the list of insured critical illnesses and the criteria for recognizing it as an Insured Event (Annex 1 to these conditions).

2. Insured persons

2.1. The person specified in the Insurance Certificate who is 18 to 64 years old at the time of conclusion of the Insurance Agreement and who shall be subject to insurance coverage for the period of time specified in the Insurance Agreement, but no longer than until he turns 70.

2.2. Minor children and/or adopted children of the person referred to in clause 2.1 that have not been indicated in the Insurance Agreement shall be co-insured under cancer insurance. They shall be covered for as long as one of their parents has cancer insurance coverage for the period specified in the Agreement, but no longer than until they turn 18.

3. Insured events

3.1. When the Insured is diagnosed with an illness referred to in the list of insured critical illnesses for the first time during the validity period of insurance coverage or undergoes a surgery, where the diagnosis has been confirmed by medical documents and meets the description of the illness and the criteria for recognition as an insured event as set out in the Insurance Agreement and Annex 1 to these conditions, except as provided for in Article 4 hereof.

3.2. An event shall only be recognised an insured event if all the statements made by the Insured (or by the Policyholder on his behalf) in the health questionnaire provided by the Insurer were true before the moment of entry into force of the Insurance Agreement, or if the circumstances referred to in the statements were already manifested after the entry into force of insurance coverage.

4. Non-insured events

4.1. Non-insured events when no Insurance Benefit shall be paid include cases when an illness has been diagnosed:

4.1.1. within the first 3 months from the date of entry into force of insurance coverage in respect of the Insured, also before the commencement of insurance coverage or when the insurance coverage is suspended, as well as 3 months following the resumption of insurance coverage, when coverage has been suspended. **Exception:** the 3-month timeframe shall not apply if:

- agreed in writing in the Insurance Agreement;
- the Insured has previously been insured against the illness (to the same extent) with the same insurance company, and the insurance coverage has continued uninterruptedly;

- blindness, paralysis and/or loss of limbs, deafness, coma, severe head injury has been diagnosed as a consequence of an accident and occurred during the insurance coverage period;

4.1.2. cases that do not meet the definition of critical illness and the criteria for recognition as an insured event provided in Annex 1 hereto;

4.1.3. cases related to hostilities (whether or not a war has been declared) and participation in a peacekeeping mission, exposure to nuclear energy and radioactive radiation (excluding the effects of radiotherapy);

4.1.4. events caused by the Insured as a result of being under the influence of alcohol, drugs or toxic, psychotropic or other psychoactive substances used for the purpose of intoxication, or of potent medicinal products that were not prescribed by a doctor;

4.1.5. events suffered while the Insured was committing or preparing to commit a criminal offence, or from any other act contrary to the law;

4.1.6. events caused by deliberate self-harm or attempted suicide;

4.1.7. events related to engagement of the Insured in professional and/or extreme sports/leisure-time. If the Insured has notified of engagement in such a sport at the time of conclusion or during the validity period of the Insurance Agreement, and the Insurer has assessed and assumed this risk, the specific agreement between the Insurer and the policyholder regarding the risk assumed shall be indicated in the Insurance Agreement;

4.1.8. in respect of a person who is infected with HIV or AIDS;

4.1.9. a critical illness was the cause of the death of the Insured occurring within 30 days of the diagnosis of a critical illness (not applicable in case of cancer).

5. Insurance options

5.1. The Policyholder may choose one of the following insurance options:

- Option A – 1 critical illness;
- Option B – a list of 4 critical illnesses;
- Option C – a list of 39 critical illnesses.

6. Sum insured and insurance benefits

6.1. The Insured's Sum Insured for cancer and critical illness insurance shall be indicated in the Insurance Certificate and can be variable.

6.2. Having recognized the Insured person's critical illness to be an insured event, the Sum Insured of the critical illness insurance of that person shall be paid, and, in case of cancer, the Sum Insured or a part of the Sum Insured may be paid as provided for in clause 5.2 of the Special Conditions of Cancer Insurance.

6.3. If a person has already been paid a part of the Sum Insured as provided for in clause 5.2 of the Special Conditions of Cancer Insurance, it shall not be deducted from the 100 % of the Sum Insured payable for critical illnesses.

6.4. Having paid a benefit of 100% of the Sum Insured for a critical illness, the cancer and other critical illness insurance in respect of that Insured shall terminate.

6.5. If the Sum Insured has been increased, and the Insured contracts a critical illness within the first 3 months from the date of increase of the Sum Insured, the Sum Insured equal to the Sum Insured of the Insured applicable 3 months ago shall be paid. This clause shall not apply if the Insured is diagnosed with blindness, paralysis and/or loss of limbs, deafness, coma, or a severe head injury as a result of an accident suffered during the validity period of the Insurance Agreement.

6.6. Upon death of the Insured, insurance coverage under the Insurance Agreement for that person shall cease in full.

7. Procedure of reporting insured events

7.1. In case of a critical illness of the Insured, the following shall be submitted to the Insurer:

7.1.1. a report on contracting a critical illness in the form prescribed by the Insurer;

7.1.2. documents from health care institutions confirming the diagnosis of the illness, the medical history, a description of the examinations performed and the treatment prescribed, as well as the surgeries performed;

7.1.3. any other documents requested by the Insurer which are relevant for determining circumstances of the Insured Event.

7.2. Costs related to obtaining the documents listed in clause 7.1 above in support of the Insured Event shall be borne by the person claiming an Insurance Benefit.

7.3. The beneficiary/the Insured or the policyholder shall notify the Insurer in writing of the critical illness within 30 days from the date when the critical illness was diagnosed.

8. Procedure of payment of insurance benefits

8.1. The Insurer shall pay an Insurance Benefit in the event of a critical illness to the Insured, unless the Insurance Agreement establishes otherwise.

8.2. If the Insured is deceased on the date the event is recognized as an insured event, an Insurance Benefit shall be paid to the beneficiaries designated by the Insured and indicated in the Insurance Agreement as beneficiaries in the event of his death or, in the absence of such designation, – to the heirs of the estate of the Insured.

9. Procedure of amending the insurance conditions

9.1. In light of developments in medical science or changes in incidence rates, as well as changes in legal regulation, the Insurer shall have the right to change definitions of critical illnesses and/or the criteria for diagnosing them. The Insurer may make unilateral amendments provided that they do not violate rights or interests of the customer, and by warning the Policyholder thereof in writing at least 30 days before the scheduled date of amendment of the insurance conditions.

9.2. The Policyholder shall have the right to terminate the Insurance Agreement or to cancel the selected insurance coverage before the date of entry into force of amendments to the rules, if he finds amendments unacceptable.

9.3. The Insurer shall have the right to amend the Special Conditions of Cancer and Other Critical Illness Insurance of Adults for insurance agreements concluded for a period of 1 year, by notifying the Policyholder thereof at least 30 days before the date of automatic extension of the Insurance Agreement.

General Manager
Bogdan Benczak

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Annex No 1 to Special Conditions of Cancer and Other Critical Illness Insurance of Adults No 028-04

List of Critical Illnesses Insured and Criteria for Recognizing Insured Events

Option A – 1 critical illness (covering the illness referred to in clause 1)

1. Cancer – invasive cancer, invasive skin cancer, non-invasive/early-stage cancer.
The Special Cancer Insurance Conditions No 028-01 and the illness criteria set out herein shall be followed.

Option B – 4 critical illnesses (covering the illnesses listed in clauses 1 to 4)

2. Myocardial infarction – an irreversible damage to cardiac muscle tissue (necrosis) due to prolonged circulatory problems. The diagnosis shall be confirmed by a change in the levels of laboratory myocardial infarction indicators (troponin or CK-MB) to levels typical of myocardial infarction and have the illness-specific symptoms:
- ischemic symptoms (e.g. chest pain);
- new changes in electrocardiogram (ECG) showing myocardial infarction ischemia (new ST-T changes or a new block of the left bundle of His);
- appearance of pathological Q waves on the electrocardiogram (ECG).

3. Cerebral infarction/stroke – an acute cerebral blood flow disorder where a sudden blockage of a blood vessel supplying the brain results in impaired blood flow to brain tissue and symptoms of brain damage.
It shall be confirmed by a neurologist, with diagnosed acute onset of neurological symptoms, and a new objective neurological deficit confirmed during a clinical examination and imaging tests. The neurological deficit shall be permanent and persist for more than 3 months after the onset of the illness.

4. Multiple sclerosis – a diagnosis shall be confirmed by a neurologist, diagnosing it based on permanent illness symptoms and on all the below criteria:
- the existing clinically diagnosed sensory or motor dysfunctions lasting longer than 6 months;
- at least two cases of demyelination typical of multiple sclerosis found in the brain or spinal cord during a Magnetic Resonance Imaging (MRI) test.

Option C – 39 critical illnesses (covering the illnesses listed in clauses 1 to 39)

5. Coronary artery bypass surgery – an open-heart surgery for correcting stenosis or occlusion of two or more coronary arteries by using arterial grafts.
The need for surgery shall be confirmed by a cardiologist or a cardio surgeon and proven by data of coronary angiography.
An Insurance Benefit shall not be paid in the following cases:
- a bypass surgery was performed for treating one coronary artery;
- coronary artery angioplasty or stent implantation was performed.

6. Chronic renal failure – an irreversible terminal insufficiency of the function of both kidneys requiring a regular dialysis.
The need for dialyses shall be confirmed by a nephrologist and renal function tests.
An Insurance Benefit shall not be paid in case of an acute reversible insufficiency of renal function treated by temporary kidney dialyses.

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

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

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

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8. Heart valve surgery – performed in order to replace or repair one or more affected heart valves. The need for surgery shall be confirmed by a cardiologist or cardiac surgeon and an echocardiogram or heart catheterisation data.
A Benefit shall be paid in the following cases:
- open heart valve replacement or repair surgery;
- Ross procedure;
- transcatheteral valve plastics;
- transcatheteral aortic valve implantation (TAVI).

The need for the surgery shall be confirmed by a cardiologist or cardio surgeon, and this must be confirmed by echocardioscopy or cardiac catheterization.

An Insurance Benefit shall not be paid in the following cases:
- transcatheter mitral valve stenosis.

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9. Aortic surgery – surgery performed in order to treat aortic stenosis, occlusion, aneurysm or flattening.
The need for surgery shall be confirmed by a cardiologist and imaging tests.
It shall cover minimally invasive procedures such as endovascular repair.

An Insurance Benefit shall not be paid in the following cases:
- chest and abdominal aortic surgery (including shunting of the aorta and femoral/hip artery);
- aortic surgery related to congenital connective tissue diseases (e.g. Marfan syndrome, Ehlers-Danlos syndrome;
- surgeries after traumatic injury of the aorta.

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

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

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

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

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13. Loss of speech – complete and irreversible loss of the ability to speak as a result of physical injury or illness.
A permanent condition confirmed by an otorhinolaryngologist persisting for more than 6 months from the onset of the illness.

An Insurance Benefit shall not be paid in the following cases:
- loss of speech due to a mental disorder or mental illness.

14. Alzheimer's disease – shall be diagnosed before the age of 65, confirmed by a neurologist, meet diagnostic criteria and be confirmed by imaging tests of the nervous system, when the Insured requires permanent care due to the disease.

An Insurance Benefit shall not be paid:
- having diagnosed other forms of dementia due to cerebral, systemic or psychiatric diseases.

15. Idiopathic Parkinson's disease – shall be diagnosed for individuals up to 65 years of age; confirmed by a neurologist based on at least at least two of the following clinical symptoms:
- muscular rigidity;
- tremor;
- bradykinesia (abnormally slow movement, sluggish physical and mental response).

The impairment shall have persisted for at least 3 months from the date of diagnosis, with the person being unable to perform independently at least 3 out of 6 (washing, dressing/undressing, eating, personal hygiene, moving around indoors, getting in and out of bed) activities of daily living and there is no sign of improvement despite ongoing treatment.
The implantation of a neurostimulator for symptom control by deep brain stimulation shall also be considered a critical illness, when the necessity of the procedure has been confirmed by a neurologist or neurosurgeon. In this case, the degree of impairment in the functions of daily living shall not be assessed.

An Insurance Benefit shall not be paid in the following cases:
- secondary parkinsonism (including the one caused by drugs or toxins);
- essential (spontaneous) tremor;
- Parkinsonism associated with other neurodegenerative disorders.

16. Transient vegetative state – absence of responsiveness and awareness due to hemispheric dysfunction in the brain, when the brainstem, which controls respiratory and cardiac functions, is intact.
The clinical condition of the Insured shall be confirmed by the treating neurologist as not having improved for at least one month and shall meet the diagnostic criteria for the illness.

17. Primary cardiomyopathy – one of the below-listed:
- dilated cardiomyopathy;
- hypertrophic cardiomyopathy (obstructive or non-obstructive);
- restrictive cardiomyopathy;
- arrhythmogenic right ventricular cardiomyopathy.

The diagnosis shall be confirmed on the basis of one of the following criteria:
- a left ventricular ejection fraction (LVEF) of less than 40%, measured twice at least 3 months apart;
- at least 6 months of noticeably restricted physical activity, with less than normal activity leading to fatigue, cardiac palpitations, shortness of breath or chest pain (NYHA class III or IV);
- implantation of an implantable cardioverter/defibrillator (ICD) to prevent sudden death due to cardiac problems.
- Medical necessity of implantable cardioverter/defibrillator (ICD) implantation, diagnosis to be confirmed by a cardiologist and supported by an echocardiogram or cardiac MRI results.

An Insurance Benefit shall not be paid in the following cases:
- secondary (ischaemic, valvular, metabolic, toxic or hypertensive) cardiomyopathy;
- transient ventricular dysfunction due to myocarditis;
- cardiomyopathy due to systemic diseases;
- implantable cardioverter/defibrillator (ICD) implantation due to primary arrhythmias (e.g. Brugada or prolonged QT syndrome).

18. Sporadic Creutzfeldt-Jakob Disease (sCJD) – is a diagnosis confirmed by a neurologist based on all of the following criteria:
- progressive dementia;
- at least two of the following four clinical features: muscle convulsions, visual or balance impairment, pyramidal/extrapyramidal signs, akinetic mutism;
- an electroencephalogram (EEG) showing sharp wave complexes and/or detection of protein 14-3-3 in cerebrospinal fluid;
- the results of routine investigations do not suggest another diagnosis.

An Insurance Benefit shall not be paid in the following cases:
- iatrogenic or familial Creutzfeldt-Jakob disease;
- other variants of Creutzfeldt-Jakob disease (vCJD).

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19. Aplastic anaemia – resulting in severe bone marrow failure with anaemia, neutropenia and thrombocytopenia. The condition requires treatment with blood transfusions and at least one additional one of the following treatment methods:
- bone marrow stimulants;
- immunosuppressants;
- a bone marrow transplant.

The diagnosis shall be confirmed by a haematologist and substantiated by the results of a bone marrow histological examination.

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

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

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

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

The diagnosis shall be confirmed by a neurologist.

An Insurance Benefit shall not be paid in the following cases:
- coma has been artificially induced by medical means or medication (for medically justified reasons);
- coma has been caused by deliberate self-harm, alcohol or drug use.

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22. Severe lever disease – a chronic condition based on at least 7 Child-Pugh points (Child-Pugh class B or C).
Diagnosis shall be confirmed by a gastroenterologist, based on imaging findings, calculating the score on the basis of all these criteria:
- total serum bilirubin;
- serum albumin level;
- severity of ascites;
- International Normalised Ratio (INR);
- hepatic encephalopathy.

An Insurance Benefit shall not be paid having diagnosed:
- severe liver disease due to alcohol or drug use (including hepatitis B or C infections contracted by the patient using intravenous drugs).

23. Chronic lung disease – manifests in chronic respiratory failure.
Diagnosis shall be confirmed by a pulmonologist, substantiated with results of instrumental investigations and confirmed according to all the following criteria:
- FEV1 (forced expiratory volume in 1 second) less than 40 % of default, determined by two measurements with at least one month apart;
- treatment with oxygen therapy for at least 16 hours per day for 3 months at the least;
- a persistent decrease in partial pressure of oxygen (PaO2) below 55 mmHg (7,3 kPa) in arterial blood (without supplementary oxygen therapy), confirmed by an arterial blood gas test.

24. Acute viral encephalitis – a diagnosis causing a permanent neurological deficit[1] that persists for at least 3 months from the diagnosis.
The diagnosis shall be confirmed by a neurologist and substantiated with typical clinical symptoms and cerebrospinal fluid tests or the results of a brain biopsy.

An Insurance Benefit shall not be paid in the following cases:
- encephalitis where the Insured has been diagnosed with HIV infection;
- encephalitis caused by bacterial or protozoal infections;
- myalgic or paraneoplastic encephalomyelitis.

25. Fulminant viral hepatitis – a diagnosis shall be confirmed by a gastroenterologist or infectologist based on laboratory test results and all of the following criteria:
- serological tests characteristic of acute viral hepatitis;
- development of hepatic encephalopathy;
- reduction in liver size;
- an increase in bilirubin levels;
- a blood clotting disorder (coagulopathy) with a TNS value greater than 1.5;
- development of hepatic failure within 7 days of onset of symptoms;
- no history of liver disease.

An Insurance Benefit shall not be paid in the following cases:
- acute liver failure caused by all other non-viral causes (including drug poisoning, paracetamol or aflatoxin);
- fulminant viral hepatitis associated with intravenous drug use.

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

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

28. HIV infection due to transfusion of blood products – infection following transfusion of blood products confirmed by all of the following criteria:
- the infection developed as a result of a medically necessary transfusion of blood products carried out after the entry into force of the Insurance Agreement;
- the establishment which carried out the transfusion is an officially registered and licensed healthcare establishment;
- the establishment that supplied the blood products and the establishment that carried out the transfusion has assumed liability for the fact of infection;
- HIV seroconversion occurred within 12 months from the transfusion date;
- transfusion of infected blood product has been carried out in a European Union or European Economic Area state, the United Kingdom or Switzerland.

An Insurance Benefit shall not be paid in the following cases:
- HIV infection resulting from any other means of transmission, including sexual intercourse or drug use;
- HIV infection resulting from transfusion of blood products intended for the treatment of haemophilia or thalassaemia.

29. HIV infection contracted at work in the course of legal employment – when the Insured contracted infection due to an accident in the course of his normal job duties, i.e. while working:
as a medical doctor or dentist, nurse or midwife, physician's assistant or dental assistant, laboratory worker or laboratory technician, member of an ambulance team, hospital housekeeper or hospital maintenance worker, member of a fire service, police or prison officer.
HIV infection shall be confirmed according to all of the following criteria:
- the incident must have occurred after the Insurance Agreement came into force;
- the incident must have been reported, investigated and documented in accordance with the current recommendations of the relevant authorities (e.g. the authority investigating the workplace incident);
- the HIV test taken within 5 days of the incident was negative;
- HIV seroconversion must have occurred within 12 months of the incident;
- the incident must have occurred in the course of official duties in the European Union or Switzerland.

An Insurance Benefit shall not be paid in the following cases:
- HIV infection contracted by other means of transmission, including sexual intercourse or drug use.

30. Muscular dystrophy – one of the following diagnoses confirmed by a neurologist and supported by electromyography (EMG) and muscle biopsy test results:
- Duchenne muscular dystrophy (DMD);
- Becker muscular dystrophy (BMD);
- Emery-Dreifuss muscular dystrophy (EDMD);
- Limb-Girdle muscular dystrophy (LGMD);
- Facioscapulohumeral muscular dystrophy (FSHD);
- Myotonic dystrophy type 1 (MMD or Steinert's disease);
- Oculo-ocular muscular dystrophy (OPMD).

The Insured is unable to perform at least 3 out of 6 daily tasks independently (washing, dressing/undressing, eating, personal hygiene, moving around indoors, getting in and out of bed) and there are no signs of improvement.

An Insurance Benefit shall not be paid in the following cases:
- Myotonic dystrophy type 2 (PROMM) and all forms of myotonia.

31. Motor neurone disease – one of the following diagnoses, confirmed by a neurologist and supported by nerve conduction studies and electromyography:
- Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease);
- primary lateral sclerosis (PLS);
- progressive muscular atrophy (PMA);
- progressive bulbar palsy (PBP).

The impairment must have lasted for at least 3 months from the date of diagnosis, with the person being unable to perform independently at least 3 out of 6 daily tasks (washing, dressing/undressing, eating, personal hygiene, moving around indoors, getting in and out of bed) and there are no signs of improvement.

An Insurance Benefit shall not be paid in the following cases:
- multifocal motor neuropathy (MMN) and inclusion body myositis;
- post-polio syndrome;
- spinal muscular atrophy;
- polymyositis and dermatomyositis.

32. Systemic scleroderma – a diagnosis confirmed by a rheumatologist based on all of the following criteria:
- typical laboratory test results (e.g. scleroderma anti-Scl-70 antibodies);
- typical clinical features (e.g. Raynaud's syndrome, skin sclerosis, erosions);
- continuous treatment with corticosteroids or other immunosuppressants.
- The presence of damage to one of the following organs shall also be established:
- pulmonary fibrosis with less than 70% than normal gas diffusion capacity (DCO);
- pulmonary hypertension with a mean pulmonary artery pressure greater than 25 mmHg at rest, as measured by right heart catheterisation procedure;
- chronic kidney disease with a glomerular filtration rate of less than 60 ml/min (MDRD-formula);
- echocardiographic features characteristic of severe left ventricular diastolic dysfunction.

An Insurance Benefit shall not be paid in the following cases:
- localised scleroderma not affecting organs;
- eosinophilic fasciitis;
- CREST syndrome.

33. Systemic lupus erythematosus – a diagnosis confirmed by a rheumatologist on the basis of all of the following criteria:
- laboratory test results, e.g. detection of antibodies against nuclear antigens (ANA) or double-stranded DNA (dsDNA);
- symptoms characteristic of systemic lupus erythematosus (bow-tie-shaped rash, photosensitivity, serositis);
- continuous treatment with corticosteroids or other immunosuppressants.
- In addition, damage to one of the following organs shall be diagnosed:
- lupus-related nephritis, with proteinuria of at least 0.5 g/day and a glomerular filtration rate of less than 60 ml/min (MDRD formula);
- Libman-Sacks endocarditis or myocarditis;
- neurological deficits[1] or seizures lasting more than 3 months, confirmed by appropriate cerebrospinal fluid studies or EEG results. Headache, cognitive and psychiatric symptoms shall not be considered a typical neurological deficit in this context.

An Insurance Benefit shall not be paid in the following cases:
- discoid lupus erythematosus or subacute cutaneous lupus erythematosus;
- drug-induced lupus erythematosus.

34. Severe rheumatoid arthritis – a diagnosis confirmed by a rheumatologist based on all of the following criteria:
- typical symptoms of inflammation (arthralgia, swelling, tenderness) lasting more than 6 weeks from the date of the diagnosis, a significant increase in CRB levels;
- a positive rheumatoid factor test result (at least twice the upper limit) and/or the presence of antibodies to cyclic citrullinated peptide;
- continuous treatment with corticosteroids;
- treatment with disease-modifying anti-rheumatic drugs (e.g. methotrexate and sulfasalazine/leflunomide) or a TNF inhibitor for at least 6 months.

An Insurance Benefit shall not be paid in the following cases:
- reactive arthritis;
- psoriatic arthritis;
- osteoarthritis.

35. Necrotizing fasciitis – a diagnosis confirmed by a surgeon, substantiated with microbiological or histological tests and based on all of the following criteria:
- progressive, rapidly spreading bacterial infection of the deep muscle fascia accompanied by secondary subcutaneous lesions of the extremities or trunk secondary necrosis of the tissues of the trunk and lower limbs;
- fever and rapidly increasing C-reactive protein (CRB) levels;
- surgical removal of all dead (necrotic) tissue as part of the treatment.
- Fournier's gangrene shall also be considered a critical illness.

An Insurance Benefit shall not be paid in the following cases:
- gaseous gangrene;
- gangrene caused by diabetes, neuropathy or vascular disease.

36. Chronic pancreatitis – a diagnosis confirmed by a gastroenterologist, substantiated with imaging studies and laboratory tests (e.g. faecal elastase), lasting at least 3 months from the date of diagnosis and confirmed on the basis of all the following criteria:
- exocrine pancreatic insufficiency in presence of weight loss and steatorrhea;
- endocrine pancreatic insufficiency in presence of pancreatic diabetes;
- pancreatic enzyme replacement therapy is required.

An Insurance Benefit shall not be paid in the following cases:
- chronic pancreatitis due to alcohol or drug use;
- acute pancreatitis.

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37. Third-degree burns – affect the skin throughout its entire depth to the subcutaneous tissue and cover at least 20 % of the surface area of the body of the Insured as determined by the Rule of Nines, the Lund-Browder diagram or the rule of the palm (1 % of the surface area of the body is equal to the surface area of the palm of the hand (palm and fingers together) of the insured hand). The diagnosis shall be confirmed by a surgeon.

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38. Primary pulmonary hypertension – a diagnosis shall be confirmed by a cardiologist or pulmonologist based on all of the following criteria:
- marked limitation of physical activity for at least 6 months, where less than ordinary activity leads to fatigue, cardiac palpitations, shortness of breath or chest pain (NYHA (New York Heart Association) class III or IV);
- a mean pulmonary artery pressure greater than 25 mmHg at rest as measured by right heart catheterisation.

An Insurance Benefit shall not be paid in the following cases:
- secondary hypertension due to pulmonary/cardiac or systemic diseases;
- chronic thromboembolic pulmonary hypertension (CTEPH).

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39. Bacterial meningitis – the diagnosis that causes:
- a permanent neurological deficit[1] that persists for at least 3 months after diagnosing it; or
- in children under the age of 6 years, complete loss or cessation of motor, cognitive and speech skills for 12 months development.
- The diagnosis shall be confirmed by a neurologist or an infectologist and be based on the results of a bacteriological examination when growth of pathogenic bacteria is detected in a cerebrospinal fluid sample.

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

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

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

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