Health Insurance Terms and Conditions

No THE-20241

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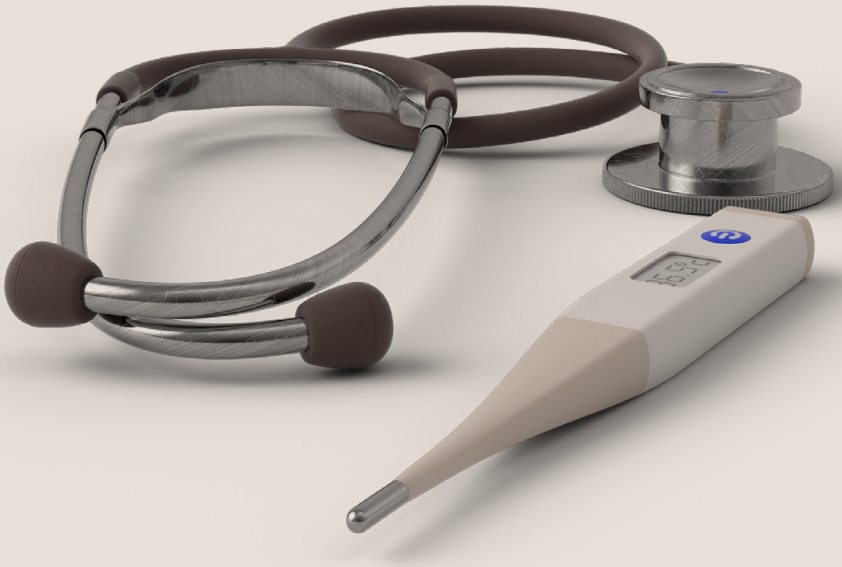

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1. Application of Terms and Conditions

The present insurance Terms and conditions shall be applied in conjunction with the General personal insurance Terms and conditions. This means that the rights and obligations laid down below shall be applied in conjunction with the rights and obligations stipulated in the General personal insurance Terms and conditions and do not contradict each other.

2. Definitions

Renewed insurance agreement – a new health insurance agreement concluded by the same policyholder not later than within 2 months from the insurance agreement expiry.

Health insurance policy - a document issued by the insurer and corroborating the conclusion of the insurance agreement.

Insurance coverage provision – a group of services referred to in the insurance policy whereby the insurer is obligated to pay the insurance indemnity upon occurrence of insured event.

Insured person – a natural person named in the insurance policy or annex thereto upon occurrence of an insured event in whose life the insurer must pay the insurance indemnity.

Insured event – an event that has occurred within the insurance period as a result of which the insured person might require medical services or other services that are reimbursed under a specific insurance coverage, if such is specified in the insurance policy for the specific insured person.

Insurance indemnity – an amount of money or a part thereof payable under the conditions of the insurance agreement for the services provided to the insured person upon occurrence of the insured event.

Compensation rate – a value in per cent stipulated in the insurance policy for a specific health insurance coverage provision that specifies the portion of health expenses incurred by the insured person in case of an insured event that the insurer must compensate within the limits of sum insured.

Medical services – procurement of services of illness prevention, consulting by doctors, diagnostics and treatment, medical rehabilitation and patient care, medicines, and opticians' products during the insurance period in medical institutions registered in the insurance validity territory.

Services – medical services as well as procurement of additional sports-related services, health care or wellness services, and procedures for cosmetic, plastic or aesthetic purposes during the insurance period in service provider's institutions registered in the insurance validity territory.

Health insurance card – a card issued to each insured person that may be a plastic or digital card downloaded to If Mobile Baltics app.

Medical institution – an institution, a company or a person pursuing individual business activities under certificate entitled to provide medical services in accordance with the procedure established by the legal acts of the state of insurance validity territory. Sales outlets of vision correction (optician's) aids are also classified as medical institutions.

Service provider's institution – medical institutions including sports institutions where wellness and prevention services are provided by sports specialists certified in accordance with the procedure established by the legal acts of the state of insurance validity territory, SPA and wellness centres operating in insurance validity territory.

Partner institution – a medical institution providing services in the insurance validity territory that has concluded a cooperation agreement with the insurer concerning the reimbursement of specific services for the insured person. A current list of partner institutions is published on the insurer's website at www.if.lt.

Health expenses – expenses sustained by the insured person for medical services provided in a medical institution or service provider's institution.

Inpatient day care service – planned curative and/or diagnostic activities of personal health care ensuring patient's care up to 8 hours.

Day surgery service – planned interventional curative and/or diagnostic activities of personal health care in the course of which local, regional or general anaesthesia may be applied ensuring patient's care up to 24 hours and possibility to provide services using modern technologies and without removing the patient from their customary social environment. If required, patient's care may be extended up to 48 hours.

Outpatient surgery service – planned curative health care service in the course of which local or regional anaesthesia may be applied by the physician performing the surgery or procedure and after which postoperative (post-procedural) care is ensured for the patient as well as the possibility to provide health care services without removing the patient from their customary social environment.

3. Sum Insured

3.1. Sum insured is a maximum amount of money specified in the insurance policy that the insurer has to pay for the services received by the insured person under the selected insurance coverage provision.

3.2. Upon the payment of insurance indemnity, sum insured shall be reduced by the amount of insurance indemnity paid. Each insurance coverage provision may have a separate sum insured. Moreover, separate sums insured may be specified for certain medical services.

4. Conditions of Validity

4.1. Object of insurance – material interests of the insured person pertaining to health expenses due to an insured event.

4.2. Insurance validity territory includes the Republic of Lithuania, Republic of Latvia, and Republic of Estonia, unless otherwise specified in the insurance policy.

4.3. Insurance coverage shall be valid around the clock, unless otherwise specified in the insurance policy.

4.4. Insurance agreement shall be concluded for a specified period and expire on the last day of insurance period.

4.5. Insurance period shall be twelve month, unless otherwise specified in the insurance policy.

5. Insurance Coverage Provisions

5.1. These insurance coverage provisions shall apply only when they are indicated in the insurance agreement (in insurance policy, the title of the insurance coverage provision is to be specified).

5.2. The following insurance coverage provisions may be included in the insurance agreement:

5.2.1. Ambulatorinės diagnostikos ir chirurgijos išlaidos

5.2.1.1. . Within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of outpatient services provided in a medical institution shall be compensated:

- consulting by a family practitioner or physician specialist, including remote consulting and home visits of family practitioner/therapist;
- treatment and nursing services prescribed by a physician, e.g. injections, infusions and replacement of wound dressings, provided in a medical institution or in the home of the insured person, as prescribed by the physician;
- laser procedures aimed at removing skin lesions, when medical indications are present;
- emergency medical assistance (including provided by a private institution) so that when necessary, medical assistance would be provided both at the site of accident/at home and during transportation, including the cases where the patient is unconscious or such conditions as convulsions appear, the patient stops breathing, has sustained a grave trauma, there is strong bleeding, and other life threatening conditions are present;
- outpatient surgical procedures performed by a surgeon/traumatologist (e.g. draining of abscesses, suturing of wounds, stopping of bleeding, repositioning of bones in case of dislocation, subluxation or fractures, immobilization etc.);
- diagnostic tests prescribed by a physician:
  - laboratory tests;
  - instrument-aided tests.

5.2.1.2. According to the Outpatient diagnostics and surgery expenses' coverage provision, medical services shall not be treated as insured events and the insurer shall not compensate the following expenses:

5.2.1.2.1. Medical checkups and laboratory tests:

- health check programmes / full body medical checkup,
- preventive medical checkup, including obligatory examination associated with work
- functional diagnostics for physical fitness level testing,
- full body magnetic resonance imaging,
- food intolerance testing,
- complex allergen (panel) test without an allergologist's or immunologist's referral.

5.2.1.2.2. Services associated with the following:

- services of a psychologist, psychiatrist, psychotherapist, nutrition specialist, and dietician,
- services of curative manicure and pedicure, treatment of feet skin and toenail diseases and of cosmetic changes (podology and podiatry),
- inpatient or outpatient rehabilitation services, such as kinesitherapy, therapeutic massages or exercising, and sports services,
- inpatient treatment and surgery, including in day surgery and inpatient day care (unless otherwise specified in the insurance policy),
- treatment and operations of teeth and jawbones,
- vaccines and vaccination,
- acquisition of medicines and medical aids,
- optician's products and services,
- cosmetic treatment, beauty procedures, plastic operations,
- platelet-rich plasma injections for beauty and against hair loss,
- feet fungus treatment,
- immunotherapy, however only in the case where it is not associated with the treatment of chronic allergies,
- removal of skin lesions and subcutaneous tissues without histological testing.

5.2.1.3. Medical certificates, such as:

- of medical checkups (medical commissions) in order to receive a driving licence or weapons' permit,
- examinations and consulting concerning issue of foreign visas and drawing up of medical documents.

Furthermore, please read other general exclusions and non-insured events.

5.2.2. Preventive checkups

5.2.2.1. Within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of preventive medical checkup services provided in a medical institution shall be compensated:

- work-related compulsory medical checkups performed in accordance with the procedure established in the legal acts,
- where the services listed below are included in the insurance policy, under Preventive checkups coverage provision, the following health expenses shall be also compensated:
  - medical checkups intended for obtaining medical certificates of drivers of road vehicles and weapons' permit,
  - health check programmes / full body medical checkups,
  - tests carried out at the request of the insured person without any complaints concerning health condition,
  - medical consulting and tests aimed at evaluating health and timely diagnosing of a potential illness.

Furthermore, please read other general exclusions and non-insured events.

5.2.3. Vaccines

5.2.3.1. . Within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of vaccination services provided in a medical institution (health care institution or pharmacy) shall be compensated:

- consulting by a physician specialist concerning vaccines or vaccination;
- vaccine;
- vaccination service.

Furthermore, please read other general exclusions and non-insured events.

5.2.4. Medical rehabilitation

5.2.4.1. Within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of rehabilitation services provided in a medical institution and prescribed by a physician shall be compensated:

- physiotherapy (kinesitherapy, halotherapy, shock wave therapy, electric reflexology therapy, magnetotherapy, ultrasound therapy, inhalations, phototherapy, hydrotherapy, pelotherapy (paraffin, mud applications, charkot shower) etc.),
- ergotherapy,
- curative massages (manual therapy) and curative exercises.

Provider of medical services who provides the rehabilitation services (except for swimming pool) should have an operations license or professional certificate enabling the provision of the appropriate outpatient rehabilitation service.

5.2.4.2. Medical expenses shall not be treated as insured events and the insurer shall not compensate the following expenses:

- general body massage, vacuum massage, cryomassage, prostate and gynaecological massage
- lymph drainage for beauty and cellulite treatment,
- healthy environment (health promotion) capsule.

Furthermore, please read other general exclusions and non-insured events.

5.2.5. Inpatient treatment

5.2.5.1. Within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of inpatient treatment services provided in an inpatient treatment institution (hospital, whether state/municipality-controlled or private) shall be compensated:

- tests and consulting;
- conservative and surgical treatment;
- expenses and patient's own contribution for medicines and medical aids prescribed at the hospital (dressings, plasters, test-tubes, threads, disposable medical kits, disposable instruments, IV systems, X-ray images). Expenses of medical aids and medicines under this insurance coverage provision shall be compensated only when included in the total invoice of the inpatient treatment institution or when the prescription is presented of the physician who attended to the patient at the inpatient unit for medicines/aids whose use is associated with urgent continuation of treatment prescribed at the inpatient unit; comfort services (single or double room
- inpatient day care and day surgery services.

5.2.5.2. Under this insurance coverage provision, medical services shall not be treated as insured events and the insurer shall not compensate the following expenses:

- stomach reduction operation,
- cosmetic treatment, beauty procedures, plastic surgery,
- upper and/or lower eyelid operations,
- vision correction operation,
- stay of the insured person in an inpatient health care institution, where this is not associated with the treatment of the insured person but rather with the treatment of the insured person's immediate family member as well as stay of insured person's immediate family member in a paid inpatient health care institution due to the treatment of the insured person,
- inpatient rehabilitation expenses,
- teeth and jawbone surgery,
- birth delivery services,
- treatment of veins and sclerotherapy.

Furthermore, please read other general exclusions and non-insured events.

5.2.6. Vein operations and sclerotherapy

5.2.6.1. Within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of vein treatment services provided in a medical institution (whether state/municipality-controlled or private) and prescribed by a physician shall be compensated:

- leg vein surgery and the associated inpatient care,
- sclerotherapy.

Furthermore, please read other general exclusions and non-insured events.

5.2.7. Birth delivery services

5.2.7.1. Within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of birth delivery services provided in a medical institution (whether state/municipality-controlled or private) shall be compensated:

- medical services pertaining to delivery including the Caesarean section and alleviation of birth pains as well as comfort services (single or double room) for the insured woman in child-birth or insured father to be.

5.2.7.2. According to this insurance coverage provision, medical services shall not be treated as insured events and the insurer shall not compensate the following expenses:

- expenses of birth delivery at home (not in a birth delivery institution);
- postnatal care expenses following the discharge from the medical institution;
- transportation expenses of the insured person, including transportation to the hospital and from it.

Furthermore, please read other general exclusions and non-insured events.

5.2.8. Inpatient rehabilitation

5.2.8.1. Within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of inpatient rehabilitation services provided in an inpatient medical institution (hospital or sanatorium) shall be compensated, provided that all the conditions below have been met:

- rehabilitation is necessary due to an illness or trauma because of which the insured person has been treated in an inpatient unit;
- rehabilitation was prescribed by an attending physician;
- the need for the rehabilitation treatment appears during the insurance period and the rehabilitation has been planned at a hospital or sanatorium holding the appropriate operations license;
- provision of rehabilitation services started within 90 days after the discharge from the inpatient unit.

Health expenses to be compensated include rehabilitation services, accommodation and meals in the course of the rehabilitation, provided that these expenses are included in the general invoice for the rehabilitation services received.

Furthermore, please read other general exclusions and non-insured events.

5.2.9. Treatment of critical illnesses

5.2.9.1. Insured event – a critical illness specified in Annex No 1 to the Terms and conditions first diagnosed to the insured person during the insurance agreement validity period and due to which the insured person sustains medically reasonable health expenses, which are not compensated under the compulsory health insurance of the Republic of Lithuania.

Within the limits of sum insured, the following medically reasonable health expenses that are not compensated to individuals covered by the compulsory health insurance of the Republic of Lithuania due to inpatient or outpatient services provided in a medical institution during the insurance period shall be compensated:
- health expenses due to paid outpatient services,
- health expenses due to inpatient services,
- cost of medicines.

5.2.9.2. Critical illnesses that meet the criteria below shall not be considered as insured events:
- illnesses diagnosed during the first 2 months of insurance agreement validity, except in the case of renewed insurance agreement, on condition that the provision of insurance of critical illness treatment expenses had been chosen in the previous insurance agreement;
- illnesses not included in the list presented in Annex No 1 or not meeting the criteria for a critical illness stipulated therein.

Furthermore, please read other general exclusions and non-insured events.

5.2.10. Medicines and medical aids

5.2.10.1. Within the limits of sum insured and in consideration of the applicable compensation rate, medically reasonable health expenses sustained by the insured person during the insurance period as a result of medicines and medical aids acquired in a medical institution shall be compensated.

5.2.10.2. Two insurance coverage options shall be available:

5.2.10.2.1. Medicines and medical aids prescribed by the physician, where, within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of medicines and medical aids acquired in a medical institution shall be compensated:
- medicines prescribed by a physician and registered in the Union Register for Medicinal Products;
- auxiliary medical aids: dressings, medical plaster, syringes, IV systems, splint systems, prosthetic systems for the movement apparatus, crutches.

5.2.10.2.2. Medicines and medical aids without the physician's prescription, where, within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of medicines and medical aids acquired in a medical institution shall be compensated:
- medicines prescribed by a physician and registered in the Union Register for Medicinal Products, Nutritional Supplements, and Vitamins;
- auxiliary medical aids: dressings, medical plaster, syringes, IV systems, splint systems, prosthetic systems for the movement apparatus, crutches.

5.2.10.3. Health expenses shall not be treated as insured events and the insurer shall not compensate the following expenses:
- for medicines that are not registered in the Union Register for Medicinal Products;
- for nutritional supplements and vitamins, when the insurance coverage option 'Medicines and medical aids prescribed by a physician' has been selected;
- for medicines intended for treatment of health disorders caused by the consumption of alcohol or narcotics (or other psychoactive substances);
- for medicines affecting reproductive system and potency, including contraceptives;
- for medicines pertaining to mental illnesses (such as antidepressants); for medicinal preparations for weight regulation;
- for vaccines;
- for diagnostic products such as thermometers, testers, diagnostic tests except for COVID and flue antigen tests, diagnostic biochemical kits, disposable containers for urine, faeces, and other samples, containers, test-tubes, medical devices such as blood pressure monitors, glucose meters, inhalators, hearing aids, infusion pumps;
- for orthopaedic devices such as special orthopaedic footwear for treating feet deformations, orthopaedic soles, elastic or compression stockings, post-surgical girdles, belts and shoes, walking sticks, walkers, zimmer frames, mechanical wheelchairs for the disabled, massage equipment, heel protections, orthopaedic and/or ergonomic cushions for position adjustment;
- nursing equipment, e.g. shower or bathroom chairs, hoists/lifts, rails, bath board, ramp for the wheelchairs, furniture for patients such as special desks, functional beds etc., oxygen devices, wheelchairs for the disabled;
- first aid kits, weighing scales, heaters;
- products for pregnant and nursing women, babies, and children;
- protection and disinfection aids, hygiene products, cosmetic products, food products, and nutritional supplements for athletes.

Furthermore, please read other general exclusions and non-insured events.

5.2.11. Emotional health and nutrition

5.2.11.1. Within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period due to psychologist's, psychotherapist's or psychiatrist's and nutrition specialist's services provided in a medical institution shall be compensated:
- services of medical psychologist, psychiatrist or psychotherapist,
- consulting by nutrition specialist and dietologist.

5.2.11.2. Please note that the provider of medical services should have an operations licence or certificate corroborating their competence for the provision of the appropriate medical service (services of self-employed specialists shall not be compensated).

5.2.11.3. Under this insurance coverage provision, medical services shall not be considered as insured events and the insurer shall not compensate the expenses of any medicines pertaining to mental illness (such as antidepressants) or addictions or those intended for weight regulation.

Furthermore, please read other general exclusions and non-insured events.

5.2.12. Dental treatment and care

5.2.12.1. Within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of odontological services provided in a medical institution shall be compensated:
- oral hygiene services,
- consulting, teeth treatment including periodontology, orthodonthics, and prosthesis, X ray, tooth extraction, and anaesthesia,
- dental surgery (surgical treatment of teeth and jawbones/ jawbone diseases and all the services associated therewith).

5.2.12.2. Under this insurance coverage provision, medical services shall not be considered as insured events and the insurer shall not compensate the following expenses:
- teeth whitening and other services of aesthetic odontology such as attachment of tooth gems etc.;
- purchasing of medicines prescribed after providing the service (e.g. medicines following a tooth extraction);
- hygiene and beauty products' acquisition costs.

Furthermore, please read other general exclusions and non-insured events.

5.2.13. Dental treatment after traumas

5.2.13.1. Under this insurance coverage provision, an insured event shall be gums injury and/or damage or loss of teeth due to a sudden and unexpected event (traffic accident, impact to face, falling etc.) that occurs during the insurance period. To prove the fact of the insured event, an excerpt from the medical records of the insured person should be presented. Gums injury and/ or damage or loss of teeth when eating, chewing or biting shall not be treated as insured events.

5.2.13.2. Within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of odontological services provided in a medical institution shall be compensated:
- consulting, teeth treatment including periodontology, orthodonthics, and prosthesis, X ray, tooth extraction, and anaesthesia;
- dental surgery (surgical treatment of teeth and jawbones/ jawbone diseases and all the services associated therewith).

5.2.13.3. The insurer shall not compensate the expenses of dental care services that appeared due to reasons other than trauma.

Furthermore, please read other general exclusions and non-insured events.

5.2.14. Optician's aids and services

5.2.14.1. Within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of services provided in a medical institution (including optician's stores or pharmacies) shall be compensated:
- procurement of the eyeglasses or lenses for eyeglasses prescribed by the physician or optometrician;
- procurement of contact lenses prescribed by the physician or optometrician;
- vision correction operation prescribed by the physician;
- making or repairs of spectacles.

5.2.14.2. Health expenses associated with the procurement of eyeglasses, lenses for eyeglasses or contact lenses shall be compensated only when these items have been procured at an opticians' store, specialised online opticians' stores or pharmacies.

5.2.14.3. Under this insurance coverage provision, medical services shall not be considered as insured events and the insurer shall not compensate the following expenses:
- acquisition of non-corrective eyeglasses and sunglasses;
- acquisition of eyeglasses or lenses maintenance products and accessories (e.g. cases for spectacles, napkins, cleansers, liquids etc.);
- medicines and nutritional supplements.

Furthermore, please read general exclusions and other non-insured events.

5.2.15. Wellnesses services

5.2.15.1. Insured event – health expenses incurred by the insured person during the insurance period and associated with wellnesses services. Wellnesses services are generally intended for immunity enhancement, protection against illnesses or traumas, overcoming stress, and enhancing working capacity.

5.2.15.2. Within the limits of sum insured and in consideration of the applicable compensation rate, the following medically reasonable health expenses sustained by the insured person during the insurance period as a result of services provided in a medical institution or service provider's institution shall be compensated:
- rehabilitation services such as physiotherapy (halotherapy, shock wave therapy, electric impulse therapy, magnetotherapy, ultrasound therapy,

inhalations, phototherapy, hydrotherapy, pelotherapy (paraffin, mud applications, charkot shower), ergotherapy, curative massages (manual therapy), and curative exercises provided in medical institutions;
- consultations of a psychologist, psychiatrist or psychotherapist, nutrition specialist, dietician, specialist of alternative (complementary) medicine received in medical institutions;
- the following sports sessions organised by sports organisations or licensed sports coaches: workouts in a gym, pool visits including water aerobics, squash, tennis, badminton and Ping-Pong; group or individual lessons indoors, outdoors or remotely: workout in a gym, pregnancy exercises, running, biking, orienteering, Nordic walking, skating, skiing training. Moreover, participant's fee for participation in running, biking, orienteering, roller-skating, cross-country skiing competitions and expenses and fees for the instructor's services associated with the leisure time spent while engaging in mountain or cross-country skiing or snowboarding sports, ice skating, orienteering, or indoor climbing;
- procedures for cosmetic, plastic or aesthetic purposes including specialist consulting and procedures: face cleansing, mezotherapy, body scrubbing, anti-cellulite procedures, various body wrapping and other procedures, plastic operations, laser treatment, procurement of aesthetic products including those intended for treatment of acne, stretch marks etc.

5.2.15.3. Please note that the mentioned wellnesses services may be compensated in full extent specified in para. 5.2.15.2. or in part, as stipulated in the insurance policy.

5.2.15.4. Services shall not be considered as insured events and the insurer shall not compensate the following expenses:
- sports / activities not specified as paid,
- rent of hall and field,
- rent of equipment, where it is specified in a separate invoice issued for the rent of equipment only.

Furthermore, please read other general exclusions and non-insured events.

5.2.16. Medical products and services:

5.2.16.1. Within the limits of sum insured, the following health expenses sustained by the insured person during the insurance period as a result of services provided in a medical or service provider's institution shall be compensated:
- health expenses associated with the services described in other insurance coverage provisions specified in the insurance policy provided that the sum insured for the respective insurance coverage provision has been already exhausted. Expenses reimbursed additionally shall be compensated under the same conditions, i.e. the same compensation rate and insured and non-insured events shall apply;
- health expenses associated with the services described in insurance coverage provisions not specified in the insurance policy as a separate insurance coverage provision but included as an additional provision 'Medical products and services'.

5.2.16.2. All the other Insurance coverage provisions stipulated in Chapter 5 shall be deemed as primary with regard to the present insurance coverage provision. Under the present insurance coverage provision, expenses of services under any of the insurance coverage provisions listed in Chapter 5 may be reimbursed; however in all cases, where the specific insurance coverage provision has been specified in the insurance policy as separate insurance coverage, expenses of the appropriate services shall be first compensated under the primary insurance coverage provision and only when the sum insured has been almost entirely exhausted, the expenses shall be paid under the present insurance coverage provision.

5.2.16.3. When reimbursing for the expenses under the present insurance coverage provision where the sum insured of the primary insurance coverage provision has been exhausted, the same compensation rate shall be applied as stipulated for the primary provision. For example, if the compensation rate for consulting provided by a physician under the insurance coverage provision 'Outpatient diagnostics and surgery expenses' is 80 per cent, however the entire sum insured under this primary insurance provision has been already paid, expenses of the insured person for physician's consultation shall be paid under the present insurance provision 'Medical products and services', applying the same 80 per cent compensation rate.

5.2.16.4. Health expenses that have not been included in the insurance policy as separate insurance coverage provisions and that are compensated under the present insurance coverage condition only shall be applied the compensation rate specified in the insurance policy under the insurance coverage provision 'Medical products and services'.

5.2.16.5. The present insurance coverage provision shall be in all cases applied the insured and non-insured events specified under the primary insurance coverage provisions.

Furthermore, please read other general exclusions and non-insured events.

6. Non-Insured Events

6.1. Exclusions specified below shall be applied to all insurance coverage provisions and such events shall be treated as non-insured. Headings of exclusions are presented for clarity only and should not be taken into account when construing the present Terms and conditions. Please note that the general exclusions are also presented in the General personal insurance Terms and conditions.

6.2. General:

6.2.1. Non-insured events shall be health disorders that appear as a result of the following:

6.2.1.1. an attempted suicide or deliberate self-injury as well as due to consumption of alcohol, narcotic or toxic substances and medicines not prescribed by a licenced physician (or prescribed by a non-licenced physician);

6.2.1.2. actions of the insured person, which were acknowledged by the law enforcement authorities of the insured person's whereabouts as crimes as well as those which occurred when detaining the insured person due to the mentioned actions and while in imprisonment institutions;

6.2.1.3. outbreak of communicable diseases due to which a pandemic or state of emergency has been announced in the country.

6.2.2. The insurer shall not compensate the health expenses associated with the following:

6.2.2.1. treatment administered or prescribed to the insured person by the family members (spouse, parents, children, siblings);

6.2.2.2. services or expenses not corroborated by official documents;

6.2.2.3. diagnostic tests, treatment or rehabilitation and other health services provided anonymously;

6.2.2.4. money, gratuities, additional fees and additional payments for the option to choose the physician and personal agreement with the physician;

6.2.2.5. premiums for patient consulting outside working hours, additional fees for complexity or integration of medical services, unless such services are included in the official pricelist of the medical institution;

6.2.2.6. advance payments for services not provided;

6.2.2.7. trainings, workshops, and lectures;

6.2.2.8. transportation of the insured person and/or the associated accessories (e.g. wheelchairs for the disabled);

6.2.2.9. accommodation and/or catering services, irrespective of whether this service is provided as part of the service considered as health expenses, except for the cases where otherwise specified in the insurance certificate.

6.3. Non-registered medical institutions and medical technologies

6.3.1. Medical services shall not be considered as insured events and the insurer shall not pay for them where:

6.3.1.1. they have been provided in treatment institutions not registered with the appropriate accreditation authorities of health care institutions in the Republic of Lithuania, Republic of Latvia and/or Republic of Estonia (check out the registered institutions in the register of health care institutions in the respective websites at: https://licencijavimas.vaspvt.gov.lt/License/PublicSpecialistIndex, www.vi.gov.lv, www.medre.tehik. ee) Medical treatment services shall not be considered as insured events and the insurer shall not pay for them where they have been provided in contravention of the requirements established for the health care institutions of the Republic of Lithuania, Republic of Latvia and/or Republic of Estonia or using medical technologies not approved in the Republic of Lithuania, Republic of Latvia and/or Republic of Estonia.

6.3.1.2. the service provided by the service provider's institution does not have a valid professional certificate or they did not have the right to provide it in accordance with the laws, for example, had no operations license necessary for the provision of the appropriate service.

6.3.1.3. the seller of pharmaceutical products and services does not have a valid operations license.

6.4. Illnesses, health condition, and types of treatment:

6.4.1. Medical services shall not be considered as insured events and the insurer shall not pay for them where they are associated with the following illnesses or health conditions:

6.4.1.1. treatment of fatigue or burnout syndrome, mental illnesses and addictions /drug addiction, sleep or eating disorders, unless otherwise specified in the insurance certificate,

6.4.1.2. sexually transmitted diseases, AIDS and HIV viruses,

6.4.1.3. consulting, tests, and treatment associated with hair loss / trichology,

6.4.1.4. obesity, overweight,

6.4.1.5. sex reassignment;

6.4.1.6. consulting by a genetic specialist and genetic tests,

6.4.1.7. family planning and infertility treatment, including treatment of infertility-related illnesses, artificial insemination, diagnostic hysteroscopy, laparoscopic operations associated with the separation of accretions and recanalization of Fallopian tubes, preservation (freezing) of ovules, services of surgical and pharmaceutical contraception, sperm analysis;

6.4.1.8. pregnancy termination, where not necessary from a medical point of view;

6.4.2. consulting by a logopedist;

6.4.3. constant, palliative and/or long-term treatment of elderly and disabled people, including services provided at home or at an inpatient care institution, nursing institution, medical centre, or social care institution;

6.4.4. services of alternative (complementary) medicine provided in non-medical institution or service provider's institution shall not be considered as insured events and the insurer shall not pay for such services as, for example, acupuncture, consulting and therapy by an acupuncture specialist, aromatherapy, osteoreflexotherapy, endobiogenic medicine, bioresonance diagnostics, diagnostics by R. Voll's method, consultations of homeopaths and treatment prescribed by them, hydrotherapy of the colon, iridodiagnosis, juice and diet sessions, ayurvedic procedures, floating sessions etc.

7. Rights and Obligations of the Parties

7.1. The policyholder shall be obligated:

7.1.1. when concluding the insurance agreement, to inform the insured persons about the fact of insurance agreement conclusion, familiarise them with the insurance Terms and conditions and applicable insurance coverage provisions, and explain the rights and obligations of the insured person ensuing from the insurance agreement;

7.1.2. to refund immediately to the insurer the amount of money paid by the insurer to the insured person for health services after the termination of the insurance agreement or deletion of the insured person from the list of insured persons, in the event where the insurance

agreement is terminated before the term or the insured person is deleted from the list of insured persons, however this has not been duly notified to the insurer due to the error or through the fault of the policyholder and health insurance cards were not deactivated.

7.2. The insured person shall be obligated:

7.2.1. to prevent all other persons from using their health insurance card and, in case of unauthorised access or loss of their health insurance card, notify the insurer thereof without any delay, so that the insurer could block the health insurance card. The insurer shall not be liable for any losses sustained by the insured person due to the fact that the latter failed to duly inform about the lost health insurance card or unauthorised access to it;

7.2.2. to produce a document corroborating personal identity and a health insurance card, where health services are provided in a partner institution;

7.2.3. to refund to the insurer the amount that the insurer has paid to the insured person or partner institution provided that this amount has been paid when at least one of the circumstances below was present:

7.2.3.1. exceeds sums insured specified in the insurance policy were exceeded;

7.2.3.2. payment was made for services that are not eligible for payment under the insurance coverage provisions;

7.2.3.3. payment was made for health services provided after excluding the insured person from the list of insured persons or terminating the insurance agreement.

7.3. The insurer shall be obligated:

7.3.1. Upon conclusion of insurance agreement, to enable the insured person to use the health insurance cards via the If Mobile Baltics app as well as on the Self-Service Portal Mano If. If the insured person has opted for a plastic health insurance card, it shall be activated for the insured person in accordance with the procedure established by the insurer, i.e. subject to receipt of the consent for personal data processing of the insured person in writing.

7.3.2. Should the insured person notify the insurer in writing during the insurance contract validity period about the loss of a valid plastic health insurance card, the insurer shall issue a new health insurance card to the insured person. The insured person may fill the appropriate request on the insurer's website at: www.if.lt or send it by email to sveikata@if.lt.

8. Insurance Indemnity Payment Procedure

8.1. Insurance indemnity for heath expenses shall be paid to the banking account of the insured person (or their lawful custodian, where the insured person is a minor) or directly to the medical institution.

8.2. Insurance indemnity shall be paid in accordance with the insurance coverage provisions included in the insurance policy, without exceeding the sums insured specified.

8.3. Upon occurrence of insured event, the insurer shall be entitled to send the physicians designated by them to check the medical condition of the insured person.

8.4. Payment for services in partner institutions:

8.4.1. If the insured person has paid using their health insurance card, the insurer shall receive all information about the health expenses incurred directly from the partner institution whose services the insured person has used.

8.4.2. The insurer shall pay the insurance indemnity directly to the partner institution in accordance with the insurance coverage provisions included in the insurance policy and in consideration of compensation rate, by covering the health expenses entirely or in part, provided that all the conditions below have been met:

8.4.2.1. the insured person presented their health insurance card and a document corroborating their personal identity to the partner institution;

8.4.2.2. in cases provided for in insurance coverage provisions, the insured person presented a physician's referral or prescription to the partner institution;

8.4.2.3. the service was included in the list of services eligible for compensation according to the contract concluded by the insurer and partner institution.

8.5. Reimbursement for services to the insured person:

8.5.1. Where the insured person pays for the services from their own funds in medical institutions that do not have a contract with the insurer concerning the payment for their services using health insurance cards, the insurer shall compensate the health expenses incurred by the insured person and calculate the insurance indemnity in accordance with the insurance coverage provisions stipulated in the insurance policy and in consideration of the sum insured and compensation rate.

8.5.2. The insurer shall pay the insurance indemnity to the insured person in accordance with the insurance coverage provisions included in the insurance policy, by covering the health expenses entirely or in part, provided that all the conditions below have been met:

8.5.2.1. the insured person sustained health expenses during the insurance period and paid for them from their own funds;

8.5.2.2. . the insured person submitted a request for insurance indemnity and the required documents listed under para. 8.4.3 hereof to the insurer not later than within 30 (thirty) days from the end of the insurance period;

8.5.2.3. the request for the insurance indemnity together with the required documents, scanned, photographed or photocopied, was submitted as follows:

8.5.2.3.1. by filling an electronic request on the insurer's website at www.if.lt or via the If Mobile Baltics app;

8.5.2.3.2. by sending a free-format request by email to sveikata.zalos@if.lt.

8.5.3. The following documents, scanned, photographed or photocopied, should be enclosed to the request to pay the insurance indemnity:

8.5.3.1. . financial documents corroborating the payment of health expenses:

- a cheque, cash receipt or bank payment order containing the following information:

a) banking particulars of the service provider's institution (name, registration No, address);
b) personal data of the insured person (given name, surname);
c) payment date;

- VAT invoice containing the following information:

a) particulars of the service provider's institution;
b) data of the service recipient (given name, surname);
c) service description, quantity, price, and provision date.

Where the documents corroborating the payment lack the abovementioned information, another document issued by the service provider's institution and specifying the lacking information shall be required.

8.5.3.2. a medical document corroborating the need for the services provided:

- in case of examinations and tests, a physician's referral or printout from the medical records may be additionally requested;
- in case of outpatient rehabilitation services, - a physician's referral issued by the physician not more than 6 months ago;
- in case of health expenses that are applied the insurance coverage provision 'Medical products and services', - a prescription issued by the physician, unless otherwise specified in the insurance policy;
- in case of health expenses under the insurance coverage provision 'Optician's aids and services', - a prescription issued by the physician.

8.5.4. In the event where the referral of the physician, excerpt, prescription or other medical documents were issued and processed using a centralised electronic information system of the health care sector, the insured person should present a printout from this system.

8.5.5. The insurer shall have the right not to accept medical and financial documents containing corrections that do not correspond to the requirements of the legal acts in force in the insurance validity territory.

8.6. Adoption of the decision to pay the insurance indemnity or refuse to pay it:

8.6.1. Before adopting the decision whether to acknowledge the event as insured and pay the health expenses incurred by the insured person, the insurer shall have the right to:

8.6.1.1. verify if the information provided is correct and whether the payment of the insurance indemnity is justified and ask the insured person to provide all the other documents and information in their possession;

8.6.1.2. familiarise themselves with the medical documents of the insured person that are kept in medical institutions and request an independent expert examination.

8.6.2. After receiving all the necessary documents and information, the insurer shall adopt the decision to pay the insurance indemnity or refuse to pay it as soon as possible, however not later than within 30 days.

8.6.2.3. After adopting the decision to pay the insurance indemnity, the insurance indemnity shall be remitted to the banking account given in the request for insurance indemnity.

8.6.2.4. Where the event is recognised as a non-insured event, insurance indemnity shall not be paid.

8.6.2.5. The insurer shall be entitled to refuse to pay the insurance indemnity or reduce it where:

8.6.2.5.1. fact, date, gravity, and circumstances of the insured event cannot be established based on the documents provided by the policyholder and/or insured person;

8.6.2.5.2. policyholder and/or insured person do not permit or hinder the insurer from familiarising themselves with the medical documents of the insured person or other documents pertaining to the event, or from examining their state of health;

8.6.2.5.3. in other cases prescribed by the laws and/or insurance contract.

9. Changes of Conditions of Payment for Services

9.1. After giving an appropriate one-month notice to the policyholder during the insurance period, the insurer shall have the right to change the conditions of payment for health services or request an additional insurance premium in the event where new taxes or new additional charges have been imposed during the insurance agreement validity period in accordance with the national legislation associated with the insurance services provided.

9.2. If the policyholder does not accept the changes proposed by the insurer or additional insurance premium calculated in the event referred to in para. 9.1 above, the insurer shall be entitled to terminate the insurance agreement before the term by notifying the policyholder thereof.

9.3. During the insurance agreement validity period the insurer shall have the right, subject to a prior notice to the policyholder, to change the insurance indemnity payment procedure while retaining the sums insured specified in the insurance policy.

10. Change of the List of Insured Persons

10.1. The list of insured persons may be changed by the policyholder submitting a request in writing (on the insurer's website at www.if.lt or by email).

10.2. Insurance coverage provisions previously set for the insured persons shall not be changed throughout the insurance period.

10.3. Inclusion of an insured person in the list of insured persons:

10.3.1. When adding a new insured person to the list of insured persons, the policyholder shall indicate which of the insurance coverage provisions specified in the insurance policy are to be applied to the specific insure person. Insurance coverage for the insured person

included in the list shall commence as of the date specified in the request and expire on the last day of the insurance period specified in the insurance policy, unless the insured person is removed from the list before the end of the insurance period.

10.3.2. The insurer shall produce a plastic health insurance card, if a plastic card has been selected and this has been noted in the request received from the policyholder, within the period agreed with the policyholder.

10.3.3. The insurer shall calculate the additional insurance premium according to the additional conditions concerning the change of the list of insured persons specified in the insurance policy.

10.3.4. Insurance premium for insured persons included in addition shall be distributed proportionately to the remaining instalments due for the insurance policy. Where the entire insurance premium for the insurance period has already been paid, a one-off insurance premium for the additional insured persons shall be paid by the policyholder by the date specified in the invoice.

10.4. Exclusion of an insured person from the list of insured persons:

10.4.1. The insured person shall be removed from the list of insured person as of the date given in the request of the policyholder.

10.4.2. The insurer shall calculate the part of insurance premium to be refunded for the unused insurance period according to the additional conditions concerning the change of the list of insured persons stipulated in the insurance policy. The difference shall be deducted from the remaining partial instalments due according to the schedule for payment of premiums set forth in the insurance policy. Where the entire insurance premium has already been paid, at the discretion of the policyholder, the excess shall be used to pay for the next insurance period or returned to the banking account of the policyholder.

Annex No 1. List of Critical Illnesses

1. Myocardial infarction
2. Coronary bypass surgery
3. Stroke (brain infarction)
4. Malignant tumour (cancer)
5. Renal failure
6. Transplantation of internal organs
7. Loss of limbs / loss of limb function
8. Blindness
9. Third degree burns
10. Aorta operations
11. Cardiac valve replacement or restoration of function
12. Deafness
13. Loss of speech
14. Multiple sclerosis
15. Parkinson's disease before the age of 60
16. Benign cerebral tumour
17. Alzheimer's disease before the age of 60

1. Myocardial infarction

Myocardial infarction is an acute permanent damage to the heart muscle (necrosis) that develops due to the interruption of the essential blood circulation in the corresponding area of the heart muscle.

The diagnosis must be based on all three criteria below:
1) Characteristic prolonged chest pain.
2) New electrocardiographic changes specific to myocardial infarction.
3) Increase of myocardial infarction-specific enzyme concentration in blood serum.

2. Coronary bypass surgery

Open surgery of coronary blood vessels of the heart carried out for the purpose of correcting two or more stenotic or blocked blood vessels using a superficial vein of a lower limb, internal thoracic artery or other suitable artery as a graft. Insurance indemnity shall be paid only when the necessity of the operation is based on angiography. No insurance indemnity shall be paid due to a balloon angioplasty.

3. Stroke (brain infarction)

An acute disorder of blood circulation in the brain (due to non-traumatic haemorrhage of the brain tissue from cerebral blood vessels or blockage by clots or embolisation of cerebral blood vessels from extracranial (outside the cranium) sources) diagnosed based on clinical indications for specialised neurological or neurosurgical inpatient treatment and instrument-aided tests (computer tomography, magnetic resonance imaging) and causing clinical symptoms inherent to stroke and lasting more than 24 hours.

4. Malignant tumour (cancer)

Non-controlled growth and spreading (penetration) of malignant cells in tissues. Insurance indemnity shall be paid only when there are indisputable proofs of tissue invasion and histological evidence of cell malignancy. Diagnosis must also be confirmed by a doctor having the right to diagnose and treat malignant diseases.

The term 'cancer' shall also include leukaemias and lymphomas. In these cases, the diagnosis must be confirmed by a doctor oncologist or haematologist and corroborated by the appropriate blood test.

The insurance indemnity shall not be paid due to:
- localised non-invasive tumours having only the early indications of malignancy (carcinoma in situ) or premalignant conditions;
- skin cancer (except for malignant melanoma);
- first stage lymphogranulomatosis;
- chronic lymphotic leukaemia;
- any kind of tumours, when the insured person is HIV (human immunodeficiency virus) infected.

5. Renal failure

Complete renal failure due to chronic and permanent damage to the function of both kidneys. Insurance indemnity shall be paid if the insured person underwent a kidney transplantation surgery or is subject to regular dialyses. Insurance indemnity shall not be paid due to one-side nephrectomy and acute renal failure (when dialyses are required temporarily).

6. Transplantation of internal organs

Transplantation operation of the heart, lungs, liver or bone marrow, when the insured person is the recipient.

7. Loss of limbs or limb function

Complete and permanent of loss of a limb due to a trauma or illness. Loss of a limb shall mean the loss of a limb or its function above the knee or elbow joint for at least 6 months.

8. Blindness

Complete loss of sight in both eyes due to a trauma or illness. The diagnosis must be clinically substantiated by a doctor ophthalmologist. In certain cases, blindness can be temporary; in this case the insurance indemnity shall be paid if complete blindness in both eyes remains following 6 months from the establishment of diagnosis.

9. Third degree burns

Burns that cover at least 20% of the body surface and destroy all skin layers.

10. Aorta operations

Open surgery in the course of which the damaged part of the aorta is removed and replaced by prosthesis. The insurance indemnity shall be paid only in the case of thoracic or abdominal aorta part operation. The insurance indemnity shall not be paid due to operations on aorta branches or operations performed due to a traumatic injury to an aorta.

11. Cardiac valve replacement or restoration of function

Replacement of one or more cardiac valves (aortic, bicuspid (mitral), pulmonary (pulmonary trunk), tricuspid) by prosthesis or restoration of function in an open heart surgery due to stenosis, deficiency or combination of the two. The insurance indemnity shall not be paid if the cardiac valve function was restored in a closed surgical intervention.

12. Deafness

Complete loss of hearing. The diagnosis must be confirmed by a doctor otorhinolaryngologist. In certain cases, the loss of hearing can be temporary; in this case, the insurance indemnity shall be paid if the complete loss of hearing in both ears persists following 6 months after the establishment of diagnosis.

13. Loss of speech

Complete loss of the ability to speak due to a traumatic damage or illness. The insurance indemnity shall be also paid in the cases when the loss of speech occurs due to surgical and medicamental treatment of an illness. The diagnosis must be confirmed by a doctor otorhinolaryngologist. In certain cases, the loss of speech can be temporary; in this case the insurance indemnity shall be paid if the complete loss of speech persists following 6 months after the establishment of diagnosis.

14. Multiple sclerosis

A definite diagnosis of multiple sclerosis must be confirmed by a doctor neurologist following inpatient neurological tests in accordance with the diagnostic criteria for multiple sclerosis valid as on the diagnosis date. Furthermore, an obvious disorder of motoric or sensory functions should be obvious, persisting for at least 6 months.

15. Parkinson's disease before the age of 60

A definite diagnosis of idiopathic (primary) Parkinson's disease for an insured person before the age of 60 must be confirmed by a doctor neurologist following inpatient neurological tests in accordance with the diagnostic criteria for Parkinson's disease valid as on the diagnosis date. Obvious symptoms of involuntary hand tremor, muscle rigidity and slowed body movements must be present. This condition must be confirmed by medical documents and persist for at least 3 months. The insurance indemnity shall not be paid, if the Parkinson's disease was caused by alcohol abuse, overdosing of medicaments or use of restricted-access drugs, except in the cases provided for by the laws.

16. Benign cerebral tumour

Insured event shall be the removal of a non-malignant cerebral tumour under general anaesthesia with residual permanent neurological effects or an inoperable condition, when the non-malignant cerebral tumour causes permanent neurological symptoms. The indemnity shall not be paid in the cases of cerebral cysts, granulomas, formations of cerebral arteries and veins, hematomas, benign tumours of pineal body and medulla. The diagnosis must be confirmed during inpatient treatment by a doctor neurologist or neurosurgeon and corroborated by computerised tomography or nuclear magnetic resonance tests.

17. Alzheimer's disease before the age of 60

A definite diagnosis of Alzheimer's disease for an insured person before the age of 60must be confirmed by a doctor neurologist in accordance with the diagnostic criteria for Alzheimer's disease valid as on the diagnosis date. This condition must be confirmed by medical documents and persist for at least 3 months.