These Terms and Conditions are translated into English from the original version in Lithuanian. In the event of any discrepancy between the Terms and Conditions, the Terms and Conditions in Lithuanian shall prevail.

GENERAL PART

Structure of the Unit-linked life insurance contract

1. The Unit-linked life insurance contract (hereinafter – the insurance contract) is a set of conditions set out in:
   1.1 The present Unit-linked life insurance terms and conditions (hereinafter – the insurance terms and conditions);
   1.2 The policyholder's application to conclude an insurance contract and other documents completed and submitted by the policyholder;
   1.3 The insured person's questionnaire(s);
   1.4 The insurance offer after the insurance risk assessment;
   1.5 The price list;
   1.6 The insurance policy and annexes to the insurance policy;
   1.7 The amendments and supplementations to the conditions of the insurance contract drawn up in a manner established by the insurer.
2. The insurance terms and conditions comprise the following parts:
   2.1 General part;
   2.2 Life insurance condition No 100;
   2.3 *Additional Insurance Conditions* (No 200: Severe injury due to an accident, No 300: Injury due to an accident, No 400: Death due to an accident, No 500: Critical illnesses).

The *Additional Insurance Conditions* shall apply to the insurance contract only if this is specified in the insurance policy or in amendments and supplementations to the insurance contract drawn up in a manner established by the insurer. The *Life insurance* and *Additional Insurance Conditions* shall apply together with the provisions of the *General part,* i. e. in the absence of certain provisions in the *Life insurance* and *Additional Insurance Conditions*, the provisions of the *General part* shall apply accordingly.

Insurer, policyholder, insured person and beneficiary

3. Insurer – UAB Artea Life Insurance.
4. Policyholder shall mean a natural or legal person who has concluded an insurance contract with the insurer.
5. The parties to the insurance contract are the policyholder and the insurer (hereinafter – the parties).
6. Insured person (hereinafter – the insured person) shall mean a natural person specified in the insurance contract to whom the insurance risk is related.
7. Beneficiary shall mean a person specified in the insurance contract who acquires the right to the insurance benefit under the conditions set out in the insurance contract. The policyholder shall assign the beneficiary in accordance with the procedure provided in the legal acts of the Republic of Lithuania.

Insured object and sum insured

8. The insured object is the insurable interest related to the life expectancy of the insured person and capital accumulation.
9. If the *Additional Insurance Conditions* apply to the insurance contract, the insured object is also the insurable interest related to the health of the insured person.
10. The amounts of the sums insured for *Life Insurance* and the *Additional Insurance Conditions* are specified in the insurance contract. A separate sum insured shall be set for each *Life Insurance Condition* and *Additional Insurance Condition* applicable to a specific insurance contract.

Procedure of conclusion of the insurance contract. Pre-contractual rights and duties of the parties

11. A person wishing to conclude an insurance contract shall be acquainted with the insurance terms and conditions, price list, information on the selected investment directions and other information.
12. Having selected the desired insurance conditions, the policyholder shall fill out an application in the form established by the insurer and other documents required by the insurer, and the insured person shall fill out the insured person's questionnaire(s), if the insurer requires to do so. The policyholder and the insured person are responsible for the accuracy of the data provided in the application and questionnaire(s). Submission of the application and other documents shall not oblige the parties to conclude an insurance contract.
13. The policyholder and the insured person must provide the insurer with all known information about the circumstances that may have a significant impact on the probability of occurrence of the insured event. The circumstances about which the insurer requests information in writing shall be considered to be material circumstances.
14. The insurer shall have the right to request that the insured person's health be examined at a healthcare institution proposed by the insurer and that data on the examination results be provided to the insurer, as well as to request any other information necessary to assess the insurance risk. The insurer shall have the right to request information about the health of the insured person directly from healthcare institutions or other third parties.
15. The insurer, based on the information provided by the policyholder and the insured person and the data provided by the healthcare institution about the results of the insured person's health examination, shall assess the insurance risk and determine the conditions of the insurance contract. The insurer may offer to conclude an insurance contract by establishing increased rates of insurance risk coverage fee and/or other terms than those initially requested by the policyholder (different sums insured, different insurance period, adjusted list of insured events and exclusions, etc.).
16. The insurer shall have the right to refuse to conclude an insurance contract without stating reasons or postpone conclusion of the contract.
17. The insurance contract between the insurer and the policyholder shall be considered concluded from the day when both parties agree to all conditions of the insurance contract, and when the first insurance premium specified in the insurance offer after the insurance risk assessment has been received in the insurer's bank account. The insurer, upon confirming the conclusion of the insurance contract, shall issue an insurance policy to the policyholder.
18. The policyholder must inform the insured person and the beneficiary about the conclusion of the insurance contract and their rights and duties established in the insurance contract.

19. The insurance contract shall enter into force on the first day of the insurance period specified in the insurance policy, however, no earlier than the day following the date of receipt of the first insurance premium.
20. Insurance period might differ from the validity period of the insurance contract. The insurance period is the time interval from the beginning until the end of insurance coverage. The insurance period shall be indicated in the insurance policy.
21. Unless otherwise specified in the insurance offer after the insurance risk assessment, the insurance contract shall enter into force only if the first insurance premium has been received within 65 days from the date of submission of the application to conclude the insurance contract.

Insurance premiums

22. The insurance premiums payment plan (hereinafter – the payment plan) shall be agreed upon between the parties and specified in the insurance contract.
23. The policyholder shall be responsible for paying the insurance premiums. The insurance premiums must be paid into a bank account specified by the insurer, using one of the methods offered by the insurer.
24. During the term of validity of the insurance contract, the policyholder shall have the right to pay higher insurance premiums than those set out in the payment plan or additional insurance premiums, as well as to pay insurance premiums in advance for future periods. Once the premiums paid have been allocated to the investment directions chosen by the policyholder, the policyholder shall not be entitled to a refund of the premiums paid. Premiums paid after the expiry of the insurance contract shall be refunded to the payer.
25. During the term of validity of the insurance contract, additional insurance premiums may be paid solely for the purpose of investment (hereinafter – the additional premium). Payment of the additional premium shall not relieve the policyholder of the obligation to pay the insurance premiums according to the payment plan.
26. The insurance premiums shall be considered paid when the relevant amount has been credited to the insurer's bank account and the payment documents contain details sufficient to identify the insurance premium (at least the following information is indicated: insurance contract number or registration number of the application to conclude a contract, the policyholder's name and surname (or name of a legal entity) and personal code (or legal entity code). If the information in the payment documents is insufficient for identification, the date of payment of the insurance premium shall be deemed to be the date on which the insurance premium is identified and attributed to the insurance contract.
27. The insurance premiums shall be paid in the national currency of the Republic of Lithuania. The insurance premiums in other currencies can only be paid under the insurance contract with the insurer's consent. In this case, the costs of money transfer, currency exchange and other related costs shall be borne by the policyholder. These costs shall be deducted from the insurance premium paid.
28. Insurance premiums (including additional premiums) may be paid under the insurance contract by other persons without any rights to the insurance contract and the premiums paid.
29. The insurance premiums paid after the insurer has received notification of the insured person's death shall be refunded to the payer.

Investment direction and capital accumulation principles

30. Investment direction shall mean an investment fund, investment basket or other investment object or combination of investment objects, to which premiums paid, and accumulated capital may be linked.
31. The insurer shall be entitled to use third parties (hereinafter – the 'asset managers') for the management of investment directions and investment transactions.
32. The investment directions are linked to the insurance contract solely for the purpose of calculating the amount of accumulated capital under the insurance contract. The policyholder shall not acquire any property rights in the investment direction as a result of such a link. The ownership of the investment direction linked to the insurance contract shall belong to the insurer.
33. The policyholder can choose one or more of the investment directions offered by the insurer. The insurer shall have the right to limit in the contract the number or combination of investment directions to be chosen with other investment directions offered by the insurer. The insurer shall have the right to unilaterally change the list of investment directions offered to the policyholder (by adding new investment directions or removing existing investment directions).
34. The value of the accumulated capital in the investment directions shall be recorded in investment units (hereinafter – the investment units). The investment direction unit price shall be set by the manager (insurer or asset manager) of the relevant investment direction, in accordance with the rules of the investment direction. The unit price of the investment direction is published on the insurer's website.
35. The insurer shall apply an investment direction fee, which is intended to cover costs related to the management of the investment direction and the administration of the insurance contract. The amount of the investment direction fee may vary from one investment direction to another, depending on the objects of investment and other criteria. The amount of the fee shall be set out in the rules of the investment direction or in other documents providing information about the investment direction.
36. The investment direction fee and other potential costs associated with the direct investment of the investment direction, including custody costs, acquisition and redemption fees, trading costs and any taxes and other fees, shall be deducted from the value of the investment direction at the time the unit price is calculated. The investment direction value may also be reduced by fees on third-party investment funds, investment baskets or other financial instruments (or collections of financial instruments) that may be targeted for investment.
37. The policyholder shall bear the investment risk of the investment direction linked to the insurance contract – all investment gains and losses associated with the investment direction result in a corresponding change in the unit price of the direction, which can go up or down. The insurer or asset manager shall not be liable for changes in the unit prices of the investment directions linked to the insurance contract and, consequently, for changes in the value of the total accumulated capital. All actions taken by the policyholder in relation to the investment directions linked to the insurance contract shall be subject to investment risk, i.e. the probability of incurring losses or failing to meet expectations. The historical return of the units of a particular investment direction is not a reliable indicator of future returns and does not guarantee future performance.
38. The investment risk borne by the policyholder shall include situations in which the trading (sale or purchase) of investment units is temporarily or indefinitely suspended by decision of the manager (insurer or asset manager) or a state institution of the investment object in which the funds of the investment direction are invested, as well as cases when the calculation of the investment unit price is suspended (when the unit price is calculated later than the planned date). In such cases, unit prices for investment directions shall be calculated, investment orders by policyholder and other transactions relating to insurance contracts shall be executed as soon as the sale or purchase of units resumes and unit prices for investment objects are known.

Investment plan and accumulated capital

39. The Investment plan (hereinafter – the investment plan) shall determine the investment directions and the proportions to which the premiums paid, net of applicable taxes, will be allocated. The investment plan shall be determined by agreement between the parties.
40. When paying the additional premium, the policyholder may, upon agreement of the insurer, specify investment directions or proportions other than those set out in the investment plan.
41. The value of the investment direction linked to the insurance contract shall be equal to the number of units multiplied by the unit price at the date

of calculation of the investment direction's value.
42. The accumulated capital from insurance premiums (excluding additional premiums) shall be known as main capital (hereinafter – the main capital) and the accumulated capital from additional premiums shall be known as additional capital (hereinafter – the additional capital).
43. The accumulated capital of an insurance contract shall be equal to the sum of the amounts of the main capital and the additional capital.
44. The amount of the main capital is equal to the sum of the main capital of the individual investment directions plus the sum of the funds currently held in main capital.
45. The amount of the additional capital is equal to the sum of the additional capital of the individual investment directions plus the sum of the funds currently held in additional capital.
46. The insurance premium received shall be deducted from the applicable taxes and the remainder of the insurance premium shall be allocated to the main or additional capital as cash. These funds are linked to the investment directions in the proportions set out in the investment plan.
47. If, before paying the additional premium, the policyholder has submitted a separate investment order specifying different investment directions or proportions from those set out in the investment plan, the premium funds (after deduction of fees) shall be linked to the investment directions in accordance with the investment order submitted.
48. Cash shall be converted into units of the investment directions after the insurance premium has been received, however, not before the insurance contract takes effect. If conversion is not possible because the unit price of an investment direction is not known or conversion is not possible for other reasons beyond the control of the insurer, the cash attributable to the investment directions shall be converted into units at a later date, however, as soon as it becomes possible.
49. The number of units in the relevant investment direction attributable to the accumulated capital of the insurance contract shall be equal to the ratio of the amount of cash converted into that investment direction to the unit price of that investment direction on the date of conversion.

Fees calculation and deduction

50. The amounts and principles of deduction of fees levied by the insurer that do not affect the unit price are described in the insurance terms and conditions and specified in the insurance contract. Fees that affect the unit price are set out in the rules of the investment direction or in other documents that provide information about the investment direction.
51. In each calendar month, in accordance with the procedure referred to in paragraph 57, the insurer shall deduct the following from the main capital:
    51.1 life and additional risk coverage fees;
    51.2 insurance contract administration fee.
52. The life coverage fee shall be calculated by multiplying the rate of the life coverage fee by the difference between the amount the insurer would be liable to pay in the event of the insured person's death and the accumulated capital.
53. The fees for the additional coverage shall be calculated by multiplying the rates of such fees by the respective amounts of additional coverage set out in the insurance contract.
54. The fee rates for life and additional coverage depend on the age of the insured person at the date of deduction and the results of the insurer's assessment of the insurance risk (at the time of conclusion of the insurance contract, amendment of the conditions of the insurance contract or renewing the insurance coverage validity). If the policyholder requests, the insurer shall provide the rates at which the fees for life and additional risk cover is calculated.
55. If the amount that the insurer would be liable to pay in the event of the insured person's death does not exceed the amount of the accumulated capital, no life coverage fee shall be deducted. The life coverage fee shall also not be deducted from the date the insurer receives notification of the insured person's death.
56. If the insurance contract is subject to the *Additional Insurance Condition* No 500: Critical Illnesses or No 400: Death due to an accident, the insurer shall no longer deduct the relevant excess coverage fee from the date on which the insurer is contacted in respect of the insured event in accordance with these *Additional Insurance Conditions*. The relevant additional insurance risk coverage fee deducted during the investigation period shall be subsequently refunded if the event is deemed to be insured.
57. The insurer shall deduct all fees provided in the insurance contract from the main (additional) capital in the following procedure:
    57.1 It is determined what share of the accumulated capital falls on each investment direction or cash, if any, on the calculation date. The fees to be deducted shall be allocated to each investment direction or cash in proportion to the amount of the main (additional) capital attributable to each investment direction or cash funds;
    57.2 The share of the fees of the investment directions shall be divided by the unit price of the relevant investment direction at the date of the deduction and the resulting number of units is subtracted from the number of units held in the main (additional) capital of that investment direction;
    57.3 The cash share of the fees shall be deducted from the funds of the main (additional) capital;
    57.4 If the main capital is insufficient to deduct the fees provided in the insurance contract, the amount of fees not deducted shall be added to the amount of the next month's fees or may be deducted from the additional capital if the amount of the additional capital is sufficient.
58. The insurer shall have the right to change the price list, having notified the policyholder in writing or in another manner agreed upon by the parties about the intended change no later than one month before the intended change of the price list. If the policyholder does not agree with the change, the policyholder shall have the right to terminate the insurance contract. If the policyholder fails to contact the insurer in writing regarding the termination of the insurance contract by the date specified in the notification, it shall be deemed that the policyholder has agreed to the change. The procedure for changing the price list specified in this paragraph shall apply when changing the amounts of fees applied by the insurer, however, if the price list contains additional information (for example, information on the minimum or maximum sum insured that may be determined when concluding or amending the insurance contract, restrictions on the minimum cash payment, the minimum amount of accumulated capital after partial redemption of accumulated capital), the insurer shall have the right to change it unilaterally, without separately notifying the policyholder in writing, and the changed price list shall be published on the insurer's website.
59. In the event of a change in the insurance risk, in accordance with the changed statistical data on insured events and insurance benefits, the insurer shall have the right, upon notification to the policyholder in the procedure set forth in paragraph 58, to increase or decrease fees rates for life and/or additional insurance risk coverage no more than once per calendar year. If the policyholder does not agree with the change, the policyholder shall have the right to change the sums insured free of charge or terminate the insurance contract.

Changing the investment plan. Reallocation of accumulated capital to investment directions

60. The policyholder shall have the right to request a change to the investment plan. The investment plan shall be changed upon receipt of a relevant request. The revised investment plan shall apply only to premiums paid from the date the insurer applies the revised investment plan.
61. The policyholder shall have the right to submit a request to the insurer to change the proportions and/or the list of investment directions in the accumulated capital (hereinafter – the redistribution). A prerequisite for satisfying the policyholder's requests is that any investment and/or redistribution transactions of the accumulated capital under the insurance contract must be financed with the funds of the insurance contract. The insurer shall not finance such transactions.
62. The insurer shall have the right to impose restrictions on the policyholder's requests for investment directions in the investment plan or redistribution.

63. The insurer shall deduct a fee from the main capital for the redistribution. The redistribution fee shall not be deducted if the redistribution is due to the termination or merger of one or more investment directions.
64. The insurer carries out the redistribution in the following procedure:
64.1 the part of the redistributable main (additional) capital to be converted into cash is calculated by multiplying the number of units by the unit price of the relevant investment direction on the date of conversion into cash (conversion into cash may be carried out on different dates for different investment directions); the conversion into cash shall be carried out at the policyholder's request;
64.2 the share of the cash to be allocated to each investment direction after reallocation is determined;
64.3 the cash part of the investment direction is divided by the unit price of the relevant investment direction on the date of the cash conversion (cash conversions may be executed on different dates for different investment directions) and the resulting number of units shall be attributed to the main (additional) capital of that investment direction; the allocation of units shall be carried out as soon as possible after the execution of the relevant cash conversion. If, for reasons beyond the control of the insurer, it is not possible to calculate the unit price of an investment direction or it is not possible to redistribute a part of the accumulated capital, the part of the accumulated capital that can be redistributed shall be redistributed, and redistribution of the remaining share shall be effected as soon as possible and without undue delay.
65. If, by a unilateral decision of the insurer or the asset manager, one of the investment directions provided in the investment plan of the insurance contract or to which part of the accumulated capital belongs is terminated or merged with another investment direction, the insurer must inform the policyholder in writing after becoming aware of the above or after having taken a decision to that effect. The policyholder shall have the right to notify the insurer of its decision on how to change the investment plan and/or carry out the redistribution before the date of the termination or merger of the investment direction. If the policyholder has not notified its decision by the date of termination/merger, the insurer shall allocate the accumulated capital in the investment direction to be terminated to another of the investment directions offered at that time. In the case of a merger of investment directions, the premiums paid after the merger shall continue to be invested in the investment direction to which the investment direction was merged.

Returning part of the accumulated capital to the policyholder

66. The policyholder shall have the right to withdraw part of the accumulated capital without termination of the insurance contract, upon a written request and by providing the relevant information, either in writing or in any other manner agreed between the parties. After redemption of part of the accumulated capital, the remaining amount of the accumulated capital must not be less than the minimum amount set out in the price list.
67. Upon return of a part of the main capital to the policyholder, the life insurance sum insured shall be reduced in the cases specified in the *Life Insurance Condition*.
68. Upon return of a part of the main (additional) capital, unless the policyholder and the insurer agree otherwise, the main (additional) capital of each investment direction shall be reduced proportionally. If, upon returning a part of the main (additional) capital, there are cash funds in it, the funds shall not be reduced (unless the policyholder and the insurer agree otherwise).
69. In the event of a return of a part of the accumulated capital, the insurer shall deduct the fee specified in the price list.
70. The returned part of the accumulated capital shall be converted to cash. The amount payable to the policyholder shall be calculated as soon as possible after receipt of the policyholder's request. If, for reasons beyond the control of the insurer, it is not possible to calculate the unit price of an investment direction or to convert the returned part of the accumulated capital to cash, the conversion of that part shall be carried out as soon as it becomes possible. The part of the capital to be returned that has already been converted may at that time be held in accumulated capital as cash. The redemption of the accumulated capital shall be made as soon as it has been calculated, subject to the time limits and restrictions imposed by the insurer and/or the asset managers in respect of the transactions. The amount paid shall be subject to taxation in accordance with the law.

Suspension and renewal of the insurance coverage

71. The insurer's obligation to pay an insurance benefit in case of occurrence of an insured event may be suspended (hereinafter – suspension of insurance coverage) in the following cases:
71.1 if the policyholder delays payment of the insurance premiums for a period during which the policyholder cannot pay less than the insurance premiums set out in the payment plan (hereinafter – the compulsory period). The compulsory period is specified in the price list.
71.2 when the amount of accumulated capital becomes insufficient to meet the insurer's deductions.
72. In the case referred to in paragraph 71.1 of the insurance terms and conditions, if the policyholder delays payment of the regular insurance premium (other than the first premium) for more than 30 days, the insurer shall send a notice in writing or by any other manner agreed between the parties, stating that if the policyholder fails to pay the insurance premiums within 30 days of receipt of the notice, the insurance coverage shall be suspended. The insurer shall charge a fee for sending the notice, which shall be deducted from the main capital.
73. In the case referred to in paragraph 71.2 of the insurance terms and conditions, if the amount of the main capital becomes less than the sum of three months' fees (as provided in paragraph 51), the insurer shall send the policyholder a notice in writing or in any other manner agreed between the parties, specifying a period of no less than 30 days within which the policyholder shall pay the insurance premium specified in the notice and/or increase the premium to the amount of the premium specified. If the policyholder fails to pay the specified insurance premium and/or increase the premium to the specified amount within the specified time limit, the insurance coverage shall be suspended. The insurer shall charge a fee for sending the notice, which shall be deducted from the main capital.
74. After the insurance coverage is suspended, the insurer shall continue to deduct all the fees set out in the insurance contract, except for the fees for life and additional risk coverage.
75. If no more than six months have elapsed since the suspension of coverage, the insurance coverage shall be renewed on the day after the policyholder provide payment of the following:
75.1 in the case referred to in paragraph 71.1 of the insurance terms and conditions, all outstanding premiums (for the period prior to the suspension of insurance coverage and for the period during which insurance coverage was suspended).
75.2 in the case referred to in paragraph 71.2 of the insurance terms and conditions, the insurance premium of the amount agreed between the insurer and the policyholder.
76. If more than six months have passed since the suspension of insurance coverage, upon the policyholder's request to renew the insurance coverage, the insurer may:
76.1 offer to complete the insured person's questionnaire(s) and/or request a health examination of the insured person at the policyholder's expense at a healthcare institution proposed by the insurer. The policyholder and the insured person shall be responsible for accuracy of the data provided;
76.2 propose to renew the insurance coverage by setting increased insurance risk coverage fee rates and/or otherwise changing the conditions of the insurance contract (reducing the sums insured, adjusting the list of insured events and exclusions, etc.);
76.3 refuse to satisfy the policyholder's request to renew the insurance coverage.
77. In the case referred to in paragraph 76 of the insurance terms and conditions, the insurance coverage shall be renewed, with the consent of the insurer, on the day following the day on which the policyholder provides payment of the following:
77.1 in the case referred to in paragraph 71.1 of the insurance terms and conditions, all outstanding insurance premiums (for the period prior to the suspension of insurance coverage and for the period during which insurance coverage was suspended);

77.2 in the case referred to in paragraph 71.2 of the insurance terms and conditions, the insurance premium of the amount set forth by the insurer.
78. Upon renewal of the insurance coverage, the insurer shall deduct from the main capital any arrears incurred as a result of the insufficiency of the main capital to meet the prescribed fees before and/or at the time of the suspension of the coverage.
79. If the suspension of the insurance coverage lasts longer than six months, it shall be considered that the policyholder has violated the terms of the insurance contract, and the insurer shall have the right to unilaterally terminate the insurance contract.

Termination of the insurance contract

80. The insurance contract may be terminated by agreement of the parties or in accordance with the legal acts.
81. The policyholder shall have the right to cancel the insurance contract by giving a written notice to the insurer and by providing documents and other information requested by the insurer (e.g. information needed to calculate the taxes imposed by the state).
82. If the policyholder, a natural person, unilaterally terminates the unit-linked life insurance contract by notifying the insurer in writing within 30 days from the moment when former was notified of the concluded insurance contract, the policyholder shall be refunded the amount of the insurance premiums paid adjusted by the investment result experienced during the period of validity of the insurance contract.
83. The insurer shall have the right to unilaterally terminate the insurance contract, by notifying the policyholder about it in writing, only when there is a material breach of the terms of the contract or in other cases provided by the legal acts.
84. If the policyholder or the insured person has withheld information or has provided knowingly false information which has led to the insurer's decision to conclude or modify the insurance contract or which has affected the conditions of the insurance contract, the insurer shall have the right to terminate or modify the insurance contract or to have the contract or the modified conditions of the insurance contract declared null and void.
85. Upon termination of the insurance contract, the insurer shall pay the policyholder the surrender value thereof.
86. The surrender value shall include:
86.1 the amount of the main capital, accumulated up to the date of termination of the insurance contract, less the fee specified in the price list for calculating the surrender value;
86.2 the amount of additional capital, accumulated up to the date of termination of the insurance contract.
87. Upon termination of the contract, the accumulated capital to be returned shall be converted into cash. The amount payable to the policyholder shall be calculated as soon as possible after receipt of the policyholder's request. The conversion of units of different investment directions of accumulated capital into cash may be carried out on different days.
If, for reasons beyond the control of the insurer, the unit price of an investment direction is not published, and it is not possible to calculate the amount payable, such amount shall be calculated as soon as it becomes possible to do so.
All insurer's benefits shall be paid as soon as possible, subject to the time limits and restrictions imposed by the insurer and/or the asset managers on the transactions. The amount paid shall be subject to taxation in accordance with the law.

End of validity of the insurance contract

88. The insurance contract shall expire, if:
88.1 the insurer pays the full amount of insurance benefits specified in the insurance contract;
88.2 expiration of the insurance period established in the insurance contract;
88.3 the contract is terminated in accordance with the procedure set out in the present insurance terms and conditions;
88.4 the policyholder (natural person) dies or is declared missing by a court and there is no successor to his/her rights and obligations. In this case, the insurer shall pay the surrender value to the policyholder's legal heirs;
88.5 the policyholder (legal person) is wound up and there is no successor to its rights and obligations. In this case, the insurer shall pay the surrender value to the policyholder;
88.6 there are other cases of termination of obligations under the law.
89. Other cases of termination of the insurance contract may be provided in the *Life Insurance Condition* or the *Additional Insurance Conditions.*

Amendment of the conditions of the insurance contract

90. By agreement of the parties, the conditions of the insurance contract may be amended or supplemented in the manner established by the insurer.
91. If the policyholder submits a request for amendment of the conditions of the insurance contract, the insurer shall examine the policyholder's request for amendment of the insurance contract no later than within 30 days from the date of receipt of the policyholder's request and the documents referred to in paragraph 92, if required, and shall notify the policyholder of the decision.
92. Before deciding on a change in the insurance terms and conditions, the insurer may require the insured person to complete insured person's questionnaire(s) and/or health examinations carried out at the insured's expense at a healthcare institution proposed by the insurer.
93. For amendment or supplementation of the conditions of the insurance contract, the insurer shall deduct from the main capital of the insurance contract a fee as specified in the price list.
94. The insurer shall have the right to unilaterally supplement or amend the insurance terms and conditions, provided that the interests of the policyholder, the insured person and the beneficiary are not adversely affected, as well as in the following cases: in the event of a change in the legal provisions under which the insurance contract was concluded, in the event of an objective necessity due to the economic or market situation, or at the request of the insurer's supervisory body. The insurer shall notify the policyholder in writing, or any other manner agreed by the parties of any amendments to the terms and conditions at least one month before the date of entry into force of the amendments. If the policyholder does not agree with the changes, the policyholder shall have the right to terminate the insurance contract and receive the surrender value. If the policyholder fails to contact the insurer in writing regarding the termination of the insurance contract by the date specified in the notification, it shall be deemed that the policyholder has agreed to the said changes.
95. Any changes to the investment direction rules shall not be deemed to be changes to the insurance terms and conditions.

Rights and duties of the parties during the validity period of the insurance contract

96. The policyholder shall have the following duties:
96.1 to provide the insurer with the correct information and documents required by the insurer in connection with the insurance contract;
96.2 to pay insurance premiums in a timely manner;
96.3 to inform the insured person of amendments and supplementations to the insurance contract;
96.4 to inform the beneficiary of amendments and supplementations to the insurance contract, if the amendments and supplementations affect the beneficiary's rights or duties;
96.5 to designate in writing or in any other manner agreed between the parties a person residing in the Republic of Lithuania and authorised to receive the insurer's notifications on behalf of the policyholder if the policyholder departs abroad for a period of longer than 3 months;

96.6 to notify the insurer as soon as possible, however, no later than within 30 days, in writing or in another manner agreed upon by the parties, of any change in their or the insured person's place of residence or contact information;

96.7 to notify the insurer in writing of any pledge or assignment of any rights arising under the insurance contract.

97. The insurer shall have the following duties:

97.1 to provide a copy of the insurance policy or other documents confirming the conclusion of the insurance contract at the request of the policyholder;

97.2 to pay the established insurance benefits within the conditions set out in the insurance contract; If the insurer fails to pay the insurance benefit or any other amount under the insurance contract within the prescribed period, the insurer, upon the beneficiaries request, shall pay a default interest in the amount of 0.05% of the unpaid amount for each day of delay, however, the total amount of the default interest shall not exceed 10% of the unpaid amount.

97.3 at least once a year, in a manner agreed between the parties, to provide the policyholder with a report on the policyholder's insurance contract, or publish this information in an electronic service delivery system;

97.4 to meet all requests related to the insurance contract within a reasonable period of time, unless a specific number of days is specified.

98. In case of occurrence of an insured event, the policyholder and/or a person claiming the insurance benefit, or a person authorised by them, must:

98.1 notify the insurer of the insured event within the time limits and in accordance with the procedure set out in the present terms and conditions;

98.2 keep and provide the insurer with all documents related to the insured event;

98.3 grant the insurer or its authorised representative all the necessary authorizations and facilitate conditions to investigate the causes, consequences and circumstances of the insured event.

99. In addition to other rights set out in these terms and conditions, the insurer shall have the right:

99.1 in the case of several requests made by the policyholder without specifying the exact order in which they are to be carried out, or in the case of previous activities or requests, the order in which they are to be carried out shall be determined by the insurer. In this case, the time limit for the execution of the request may be extended;

99.2 to assign its rights and duties under the insurance contract to one or more insurance companies in accordance with the procedure laid down by law. If the policyholder does not agree to the assignment of the insurer's rights and duties to other insurance companies, the policyholder shall have the right to terminate the insurance contract in accordance with the procedure laid down in the insurance terms and conditions;

99.3 not to pay the insurance or any other benefit if the payment of such benefit would mean that the insurer violates the requirements for compliance with international sanctions implemented in the Republic of Lithuania and their implementation.

Payment procedure of the insurance benefit

100. With the exception of the case provided in paragraph 101 of the insurance terms and conditions, the insurance benefit shall be calculated and paid no later than within 30 days from the date of receipt of all necessary information relevant to determining the fact, circumstances and consequences of the insured event and the amount of the insurance benefit, and all documents required for payment of insurance benefits have been provided.

101. The payable insurance benefit upon expiry of the insurance period shall be paid within seven business days at the latest, calculated from the later of the expiry of the insurance period and the date of submission of the application for payment of the insurance benefit with the information requested by the insurer.

102. If, for reasons beyond the control of the insurer, it is not possible to determine the amount of the payable insurance benefit or to calculate the unit price of any of the investment directions, the insurer shall be deemed to have incomplete information relevant for the determination/calculation of the amount of the insurance benefit, and the time limit for payment thereof shall be extended, with the benefit being paid as soon as possible.

103. If the insured event is the subject of criminal or administrative proceedings or there is an ongoing civil lawsuit concerning the insurance contract, the insurer shall have the right to postpone the payment of the insurance benefit until the conclusion of these proceedings.

104. The insurance benefit shall be subject to tax in accordance with the procedure established by the legal acts.

Restrictions on the payment of the insurance benefit

105. The insurance benefit shall not be paid if:

105.1 the notified event does not fall within the definition of an insured event;

105.2 the event is an exclusion;

105.3 the event occurs when the insurance coverage is suspended. In these cases, the amounts that would be payable if the insurance contract is terminated after the event shall be calculated in accordance with the procedure set out in *the Life Insurance Condition.*

106. The insurer shall have the right to reduce or waive the payment of the insurance benefit if:

106.1 the policyholder and/or the insured person has concealed or provided knowingly false information which could have influenced the determination of the conditions of the insurance or influenced the insurer's decision to conclude or modify the contract, to renew the coverage or to renew a suspended insurance contract;

106.2 the policyholder and/or the insured person negligently failed to provide all the information known to him/her about the circumstances which could have had a material impact on the assessment of the insurance risk. In this case, in case of occurrence of an insured event specified in *the Life Insurance Condition* or the *Additional Insurance Conditions,* the insurer must pay a proportion of the benefit that would have been payable if all known information had been provided in proportion to the ratio of the rate of the fee for the coverage of the life insurance or the additional insurance risk as set out in the contract and the rate of the fee for the coverage of the life insurance or the additional insurance risk as set out in the contract that would have been payable if the policyholder had been provided with all known information. This provision shall apply for the first ten years after the conclusion of the insurance contract or for the first ten years after the entry into force of the insurance period provided in the *Life Insurance* or the relevant *Additional Insurance Condition*;

106.3 the person claiming the insurance benefit has provided the insurer with knowingly false information;

106.4 the insurer was not notified about the insured event in due time;

106.5 the date, severity and circumstances of the insured event cannot be established from the documents submitted by the person claiming the insurance benefit;

106.6 the policyholder, the insured person or the person claiming the insurance benefit prevents or obstructs the insurer from accessing the insured person's medical records, examining the insured person's state of health, conducting an investigation of the insured event or obtaining the necessary information;

106.7 other circumstances provided by law.

Responsibility to protect information

107. The insurer is not entitled to disclose information about the policyholder, the insured person or the beneficiary, their state of health and financial situation (including special categories of personal data such as health data) obtained in the course of concluding and/or performing the insurance

contract. Information obtained by the insurer must be kept confidential and used only for the purposes of the insurance contract or for the purposes laid down by law.

108. Information related to the insurance contract (including special categories of personal data) may be disclosed without the explicit consent of the policyholder or the insured person to:

108.1 the insured person, as far as the insured person's rights and duties under the insurance contract are concerned;

108.2 the beneficiary, as far as this person's rights and duties under the insurance contract are concerned;

108.3 the courts, law enforcement and other authorities in cases specified by the legal acts;

108.4 the national tax authorities, in accordance with local legislation, provision of the international treaties or agreements and European Union law;

108.5 the reinsurance undertaking with which the insurance contract is reinsured;

108.6 the third parties involved in the conclusion and performance of the insurance contract. In other cases, disclosure of such information requires a written consent or request of the policyholder and/or the insured person and/or the beneficiary.

109. The insurer shall process personal data (including special categories of personal data) in accordance with the procedure established by the legislation of the Republic of Lithuania and the European Union. Detailed information on the processing of personal data is provided in the privacy policy of the companies of Artea Bank Group in Lithuania, which is published on the insurer's website.

Notifications

110. All notifications from one party to the insurance contract to the other must be done in writing, unless the insurer and the policyholder agree on a different form of notification and must be given in the manner agreed between the parties. The written notification shall be given/sent directly to the policyholder or insurer at their last known address. The date of receipt of the notification shall be deemed to be the date on which the notification is actually delivered to the addressee, or the fifth business day after the dispatch of the letter.

111. In cases where the provision of information must be done in writing, this requirement shall be deemed to be fulfilled if, with the prior agreement of the parties to the contract and with individual discussion between them, the information is provided by the insurer on a secure online platform, by e-mail or by other telecommunications terminal devices that enable proof of the provision of the information.

112. If the policyholder fails to notify the insurer of a change of its own or the insured person's address in accordance with the procedure laid down in the insurance terms and conditions, the insurer's notifications sent to the last known address of the policyholder or the insured person shall be deemed to have been duly delivered to the addressee.

113. Losses due to the delay in delivery of the notification shall be compensated by the party that fails to fulfil its obligation, except in cases where the late notification is not due to the fault of that party to the contract.

Final provisions

114. The present insurance contract shall be governed by the law of the Republic of Lithuania. Any issues not provided herein shall be governed by the legislation of the Republic of Lithuania.

115. When concluding or amending the insurance contract, the parties to the insurance contract may amend and/or supplement these insurance terms and conditions by a written agreement.

116. Disputes between parties of the insurance contract shall be settled under the procedure set forth in the legal acts of the Republic of Lithuania. The policyholder, the insured person, the beneficiary or any other person who considers that the insurer has violated their rights or interests in connection with the insurance contract may apply to the insurer in writing by lodging a complaint or claim. The insurer's procedure governing the handling of complaints and the provision of responses to applicants can be found on the insurer's website.

117. Disputes between consumers and life insurance companies shall be settled out of court by the Bank of Lithuania. Information on dispute resolution is available online at http://www.lb.lt.

LIFE INSURANCE CONDITION NO 100

Insured events

100.1. Insured events are the following:
100.1.1. death of the insured person during the period of insurance coverage;
100.1.2. expiration of the insurance period, if the insured person survives until its end.
100.2. An event shall be considered insured if it occurred while the insurance coverage is valid, and if it is confirmed by official documents and appropriate evidence.
100.3. If the insured person is declared dead by a court, this shall be considered an insured event if the date of the insured person's disappearance and presumed death falls within the period of validity of the insurance coverage. If a court declares the insured person to be missing, this shall not constitute an insured event.
100.4. In case of occurrence of an insured event, validity of the insurance contract shall cease to apply.

Exclusions

100.5. An exclusion shall mean the death or presumed death of the insured person (paragraph 100.3) related to:
100.5.1. the insured person's deliberate bodily injury, suicide or attempted suicide. This exclusion does not apply if the insurance coverage has been in force continuously (without interruption) for more than three years before the date of the insured person's suicide or self-inflicted injury;
100.5.2. war (whether declared or undeclared), hostilities, participation in riots or revolutions, exposure to radioactive radiation.

Insurance benefit due to an insured event in the event of the death of the insured person

100.6. The insurance benefit in the event of the insured person's death depends on the following terms of the insurance contract:
100.6.1. insurance option (A or B);
100.6.2. life insurance sum insured.
100.7. The day on which notification of the insured person's death is received, and the death is certified by an official document is referred to as the notification date.
100.8. Where the insurance contract provides insurance option A, in the event of the insured person's death, the additional capital, accumulated up to the notification date shall be paid and the higher of the following amounts:
100.8.1. life insurance sum insured, or;
100.8.2. main capital, accumulated up to the notification date.
100.9. Where the insurance contract provides insurance option A, in the event of the insured person's death, the life insurance sum insured and capital, accumulated up to the notification date shall be paid.
100.10. If the insurance contract provides insurance option A and part of the main capital has been redeemed to the policyholder, the insurer shall be entitled to reduce the life insurance sum insured by the amount by which the main capital has been reduced as a result of the redemption of the main capital.
100.11. If the sum insured has been increased, in the event of the insured person's suicide during the first three years following the increase in the sum insured (except where death is an exclusion under the provisions of paragraph 100.5.1), the sum insured payable shall be determined taking into account the lowest life insurance sum over the last three years in accordance with the conditions of the insurance contract in force.
100.12. When calculating the amount of the payable insurance benefit in respect of the death of the insured person, the insurer shall be entitled to use the amount of accumulated capital after the notification date instead of the amount of capital, accumulated before the notification date. If, for reasons beyond the control of the insurer, it is not possible to calculate the unit price or the benefit payable for any investment direction, the amount of accumulated capital calculated later, however, immediately after it became possible, shall be used.
100.13. In the cases set out in the *Additional Insurance Conditions* applicable to the insurance contract, additional insurance benefits paid shall be deducted from the insurance benefits paid out in the event of the death of the insured person.

Insurance benefit due to an insured event after the end of the insurance period

100.14. The insurance benefit in the event of the survival of the insured person until the end of the insurance period shall be equal to the capital, accumulated until the end of the insurance period. When calculating the amount of the payable insurance benefit, the insurer shall be entitled to use the amount of the accumulated capital before the end of the insurance period instead of the amount of the accumulated capital after the end of the insurance period, however as early as possible and without undue delay. If, for reasons beyond the control of the insurer, it is not possible to calculate the unit price or the payable benefit for any investment direction, the amount of accumulated capital calculated later, however, immediately after it became possible, shall be used.

Outpayment in case of an exclusion

100.15. In the event of occurrence of an exclusion or an event occurring after insurance coverage has been suspended, the insurer pays the surrender value. The surrender value calculated after the notification date and the insurer shall be entitled to use the amount of accumulated capital after the notification date of the insured person's death. If, for reasons beyond the control of the insurer, it is not possible to calculate the unit price or the surrender value payable for any investment direction, the amount of accumulated capital calculated later, however, immediately after it became possible, shall be used. The surrender value shall be paid to the beneficiary designated in case of death or, if no beneficiary has been designated, to the insured person's legal heirs.

Expiry of the insurance contract in the event of an exclusion

100.16. In the event of occurrence of an exclusion or an event occurring after insurance coverage has been suspended, the insurance contract validity shall expire.

Deadlines for reporting an insured event

100.17. The insurer must be notified about the death of the insured person in writing (or by any other manner acceptable to the insurer) without delay and it must be done at the latest within one year after the death of the insured person or within one year after the entry into force of the court's decision declaring the insured person dead.

Documents to be submitted when applying for an insurance benefit

100.18. When contacting the insurer for payment of the insurance benefit upon expiration of the insurance period, the application for the insurance benefit to be transferred to a specified bank account must be submitted.
100.19. When applying to the insurer for the payment of an insurance benefit in the event of the death of the insured person, the following documents must be submitted together with the application:
100.19.1. the document confirming the identity of the person claiming the insurance benefit;
100.19.2. the document confirming the designation of the beneficiary, if separately signed;
100.19.3. notification of the insured person's death, specifying the date, place and nature of the event, as well as the bank account to which the sum insured should be paid;
100.19.4. detailed documentation from the medical institution describing the exact diagnosis of the illness or injury that led to the insured person's death, medical history, tests and treatment administered;
100.19.5. the insured person's medical death certificate or an extract of the death record issued by the state civil registry. If the insurer uses the data from the state civil registry, the insurer may not require provision of a death certificate or extract;
100.19.6. the certificate of inheritance, if there are legal heirs claiming the insurance benefit;
100.19.7. the occupational accident report, if one has been drawn up;
100.19.8. the accident report drawn up by the police, if any, the investigation report, the court decision, if criminal proceedings were initiated due to the death of the insured person, or if the death of the insured person is related to the event for which proceedings were initiated.
100.20. The insurer may at its own discretion require other documents not listed in paragraph 100.19 of these insurance terms and conditions, which are necessary to determine the validity of an insurance benefit or the right to a benefit, as well as documents required for tax purposes.
100.21. If the document is issued by a foreign authority, the insurer may require a duly certified translation of the document into Lithuanian. The insurer shall not reimburse translation costs.

Beneficiaries of the insurance benefit

100.22. The insurance benefit shall be paid to the last designated beneficiary known to the insurer. If no beneficiary has been designated, the insurance benefit shall be paid:
100.22.1. upon expiration of the insurance period – to the insured person;
100.22.2. in the event of the insured person's death – to the insured person's legal heirs.
100.23. If the information about the designation/replacement/cancellation of the beneficiary is submitted to the insurer after the payment of the insurance benefit, the insurer will not settle the claims of the persons who submitted the information and will not pay any additional benefits.
100.24. If the only designated beneficiary died at the same time, during occurrence of the insured event, or died before the insured event and no other beneficiary was designated, the insurance benefit due to the death of the insured person shall be paid to the insured person's legal heirs, and upon expiration of the insurance period – to the insured person. If one of the designated beneficiaries died at the same time, during occurrence of the insured event, or died before the insured event and no other beneficiary was designated in his/her place, the insurance benefit shall be proportionally paid to the other designated beneficiaries, proportionally increasing the share of the benefit due to them.
100.25. No insurance benefit can be paid to a person whose deliberate act (as determined by a court of law) led to the insured person's death. In this case, the part of the insurance benefit due to the guilty person shall be paid to:
100.25.1. other designated beneficiaries, with a proportional increase in their share of the benefit;
100.25.2. the insured person's legal heirs, if no other beneficiaries have been designated.
100.26. If, after the insured event, the beneficiary dies before receiving the insurance benefit, the insurance benefit shall be paid to the deceased beneficiary's legal heirs.

UAB Artea Life Insurance, data is collected and stored in the Register of Legal Entities of the Republic of Lithuania | Company code 110081788 | SME scheme user VAT No LT100817811 | Konstitucijos pr. 14A, 09308 Vilnius | Tel. +37061044447 | info@artea.lt | E-delivery box address 110081788 | www.artea.lt

ADDITIONAL INSURANCE CONDITION No 200: SEVERE INJURY DUE TO AN ACCIDENT

Insured events

200.1. The insured event shall mean an accident occurring to the insured person while the coverage is valid if, as a result of bodily injuries sustained in the course of that accident, the insured person acquires, within one year, a severe injury which meets the conditions listed in Annex No 1. The severe injury includes loss of organs or incurable loss of function of organs as listed in Annex No 1 to this *Additional Insurance Condition*. An accident is considered to be a sudden, unexpected occurrence, the time and place of which can be determined, during which a physical force (including chemical, thermal, poisonous gas or other physical effects) exerted from outside the body against the insured person's will, damages the health of the insured person. Accidents are also considered to be accidental acute poisoning of the insured person of moderate or severe degree with food, medicines, chemicals, gases, vapours, poisonous plants or mushrooms that occur against the will of the insured person. An infectious disease shall not be considered to be an accident.
200.2. An event shall be considered insured if it occurred while the insurance coverage is valid, and if it is confirmed by official documents and appropriate evidence.

Exclusions

200.3. The exclusion shall mean an accident or health impairment of the insured person related to:
200.3.1. the insured person's deliberate self-inflicted bodily injury, poisoning or attempted suicide.
200.3.2. the insured person's intoxication with alcohol, toxic, narcotic, psychotropic or other substances affecting the central nervous system, or the use of medicines without the appropriate prescription by a doctor;
200.3.3. a deliberate act by the insured person that renders him/her liable to administrative or criminal prosecution;
200.3.4. war (whether declared or undeclared), hostilities, participation in riots or revolutions, and exposure to radioactive radiation;
200.3.5. the insured person's participation in and/or initiation of a fight (except where the limit of self-defence is not exceeded, or the use of physical force is directly related to the performance of official duties);
200.3.6. surgery, treatment or other medical procedures, unless these procedures were carried out for the treatment of a medical condition arising from the insured event.

Insurance benefit due to an insured event

200.4. Upon occurrence of an insured event, a lump sum insurance benefit shall be paid, the amount of which is calculated as a percentage of the sum insured specified in the insurance contract in the event of a severe accidental injury. The percentage rates according to the consequences of the insured event are set out in Annex No 1 to this *Additional Insurance Condition*.
200.5. During the term of validity of the insurance contract, the insurer shall have the right to amend Annex No 1 to this *Additional Insurance Condition*. The insurer shall notify the policyholder in writing of the intended change no later than one month prior to the intended change of Annex No 1. If the policyholder does not agree with the change, the policyholder must notify the insurer about it in writing. In this case, the policyholder shall have the right to modify the conditions of the insurance contract in relation to this *Additional Insurance Condition* or to terminate the insurance contract free of charge. If the policyholder fails to contact the insurer in writing regarding the termination of the insurance contract or amendment of the conditions by the date specified in the notification, it shall be deemed that the policyholder has agreed to the change.
200.6. If the insured person dies as a result of the insured event within 30 days of the event, no insurance benefit shall be paid for severe injury resulting from the accident. If this benefit has already been paid, it shall be deducted from the payable insurance benefit in the event of the insured person's death.

Insurance benefit in case of an exclusion

200.7. In the event of occurrence of an exclusion or an event occurring after insurance coverage has been suspended, the insurer shall not pay any insurance benefits.

Deadlines for reporting an insured event

200.8. The insurer must be notified about the insured event in writing as soon as possible and in any case within one month of the occurrence of the insured event (or its consequences if the consequences occurred/were discovered later).

Documents to be submitted when applying for an insurance benefit

200.9. When contacting the insurer for payment of insurance benefit, the following documents must be provided:
200.9.1. the document confirming the identity of the person claiming the insurance benefit;
200.9.2. the document confirming the designation of the beneficiary, if separately signed;
200.9.3. an application, stating the date, place and circumstances of the insured event and the beneficiary's bank account to which the benefit is to be paid;
200.9.4. detailed medical certificates from the healthcare institution(s) stating a precise confirmed diagnosis, medical history, tests and treatment administered;
200.9.5. document constituting proof of disability or incapacity for work, if the insured person has been issued one;
200.9.6. the occupational accident report, if one has been drawn up;
200.9.7. the accident report drawn up by the police, if any, the investigation report, the court decision, if criminal proceedings were initiated due to the accident, or if the accident is related to the event for which proceedings were initiated.
200.10. The insurer may at its own discretion require other documents not listed in paragraph 200.9 of these insurance terms and conditions, which are necessary to establish the validity of the insurance benefit and the amount of the benefit.
200.11. If the document is issued by a foreign authority, the insurer may require a duly certified translation of the document into Lithuanian. The insurer shall not reimburse translation costs.

Beneficiary of the insurance benefit

200.12. The insurance benefit shall be paid to the insured person, unless the insurance contract specifies a separate beneficiary entitled to the benefits of this *Additional Insurance Condition*.

200.13. No insurance benefit can be paid to a person whose deliberate act (as determined by a court of law) led to the occurrence of an insured event. In this case, the part of the insurance benefit due to the guilty person shall be paid to:
200.13.1. other designated beneficiaries, with a proportional increase in their share of the benefit;
200.13.2. the insured person if no other beneficiaries have been designated.
200.14. If, after the insured event, the beneficiary dies before receiving the insurance benefit, the insurance benefit shall be paid to the deceased beneficiary's legal heirs.

ADDITIONAL INSURANCE CONDITION No 200: SEVERE INJURY DUE TO AN ACCIDENT, ANNEX NO 1

1. General provisions

1.1 The insurance benefit shall be a part of the sum insured for the severe injury due to an accident, which is provided for the bodily injuries indicated in the present table and incurred during the insured event.
1.2 The total insurance benefit sum in respect of the consequences of one or more insured events during a 12-calendar month period may not exceed 100% of the sum insured in the case of a severe injury due to an accident.
1.3 The insurance benefit for injury to one part of the body incurred due to the same accident shall be paid only under one point of the respective item, comprising the severest injury indicated in that item.
1.4 The percentage rating for all injuries to one part of the body resulting from the same accident cannot exceed the rating for the loss of that part of the body. When paying an insurance benefit for the loss of an organ (organ functions), benefits paid under the severe injury due to an accident coverage for injuries to that organ suffered as a result of the same accident shall be deducted from it.
1.5 If due to the insured event, the insured person sustained loss of the organ (function of organ), a part of which (part of function of which) was lost prior to the insured event, the payable insurance benefit shall be reduced in proportion to the loss of part of the organ (part of function of the organ) prior to the trauma.
1.6 The irreversible loss of function of an organ shall be determined no earlier than 9 months and no later than 18 months after the date of occurrence of the insured event. However, if the irreversible loss of function of the organ is definite, the insurance benefit shall be provided before the period of 9 months elapses.
1.7 The insurer shall have the right not to pay the insurance benefit in respect of an accident if the documents of the healthcare institution do not clearly indicate the date of the accident and/or the relevant documents do not confirm that the insured event occurred during the period of validity of the insurance coverage, or if there are material contradictions in the said documents.
1.8 In case of the bodily injury, which resulted in a full or partial loss of the functions, and which is not listed in this table, the payment of the insurance benefit and percentage payable for the consequences of the injury shall be decided by the insurer at its own discretion.

2. Loss of limbs or their functions

Remarks.
1. The irreversible loss of function of a limb or part of a limb shall be assessed at least 9 months and no more than 18 months after the date of occurrence of the insured event (if the irreversible loss of function of the limb or part of a limb is certain, the benefit shall be paid without waiting the 9-month time limit).
2. Irreversible loss of function of a limb or part of a limb shall be defined as the loss of movement of a limb or part of a limb.
3. The insurance benefit for partial loss of function of a limb or part of a limb shall be equal to 50% of the payable insurance benefit in respect of the loss of that limb or part of that limb.
4. No benefit shall be paid if the loss of function of the limb or part of the limb is less than 50%.
5. Total loss of function of a limb shall be equivalent to the loss of a limb.
6. The insured event shall be deemed to be only a long-term and permanent disability or a reduction in the insured person's ability to work, as evidenced by a certificate from the Disability and Working Capacity Assessment Office under the Ministry of Social Security and Labour, or, where this is not available due to the insured person's age, by other medical documents that confirm the impairment of the insured person health condition for at least two years.
7. Limb and joint mobility impairments (contractures and ankylosis) shall be treated as partial loss of limb and joint function.
8. Where replantation (reattachment of the lost limb or its part) is performed due to loss of a limb or its part, the insurance benefit shall be paid only for loss of function in the limb or its part.

Row No	Consequences of an insured event	Share of insured sum paid for severe injury (%)
2.1.	Loss of the only arm above the elbow joint	100%
2.2.	Loss of the arm with other bones of the shoulder girdle (scapula, clavicle or part thereof)	80%
2.3.	Loss of the arm above elbow joint	75%
2.4.	Loss of the arm through the elbow joint (exarticulation)	70%
2.5.	Loss of the arm above wrist joint	65%
2.6.	Loss of hand	60%
2.7.	Loss of 1st finger (thumb) together with the metacarpal bone	25%
2.8.	Loss of 1st finger (thumb)	20%
2.9.	Loss of distal phalanx of 1st finger (thumb)	10%
2.10.	Loss of distal phalanx of part of 1st finger (thumb)	5%
2.11.	Loss of all three phalanges of 2nd finger (index)	15%
2.12.	Loss of two phalanges of 2nd finger (index)	10%
2.13.	Loss of distal phalanx of 2nd finger (index)	5%

2.14.	Loss of 3rd, 4th or 5th (middle, ring or little) finger	10%
2.15.	Loss of two phalanges of 3rd, 4th or 5th (middle, ring or little) finger	8%
2.16.	Loss of distal phalanx of 3rd, 4th or 5th (middle, ring or little) finger	4%
2.17.	Loss of 1st finger (thumb) and one other – 3rd, 4th or 5th (middle, ring or little) – finger and the corresponding metacarpal bones	30%
2.18.	Loss of 1st, 2nd (thumb, index) fingers and the corresponding metacarpal bones	35%
2.19.	Loss of 1st finger (thumb) and two other – 3rd, 4th or 5th (middle, ring or little) – fingers and the corresponding metacarpal bones	35%
2.20.	Loss of three fingers, except 1st (thumb), and the corresponding metacarpal bones	25%
2.21.	Loss of the only leg above the knee joint	100%
2.22.	Loss of leg above knee joint	80%
2.23.	Loss of leg at the knee joint (exarticulation)	70%
2.24.	Loss of leg above ankle joint	60%
2.25.	Loss of leg at the ankle joint (exarticulation)	50%
2.26.	Loss of foot below the ankle joint	45%
2.27.	Loss of foot in the metatarsal region	35%
2.28.	Loss of foot in the region of the phalangeal-metatarsal joints	25%
2.29.	Loss of one toe (except 1st (big) toe)	3%
2.30.	Loss of 1st (big) toe	8%
2.31.	Loss of distal phalanx of 1st (big) toe	5%
2.32.	Loss of four toes, except 1st (big) toe	10%

3. Loss of organs or their functions

3.1.	**Respiratory system organs** Injury to the respiratory system organs resulting in the following consequences 9 months after the date of occurrence of the insured event:	
	a) functional tracheostoma	40%
	b) complete loss of voice	45%
	c) pulmonary insufficiency (II-degree)	40%
	d) pulmonary insufficiency (III-degree)	60%
3.2.	**Cardiovascular system** Heart, cardiac tissue or blood vessel injury resulting in cardiac or blood vessel function insufficiency 9 months after the date of occurrence of the insured event:	
	a) cardiovascular insufficiency of II-degree III functional class	40%
	b) cardiovascular insufficiency of III-degree IV functional class	60%
	Remark. The insurance benefit shall depend on the functional tests and indicators confirming the blood flow insufficiency degree.	
3.3.	**Digestive organs** Injuries to the digestive system organs:	
	a) loss of part of a jaw, resulting in chewing disorder	30%
	b) loss of the whole jaw.	60%
	c) loss of the tongue in the middle third	40%
	d) loss of the tongue in the proximal third (root) or loss of the entire tongue	70%
	e) esophageal obstruction resulting in formation of gastrostoma (external opening into the stomach through the abdominal wall)	80%
	f) removal of the entire stomach	50%
	g) removal of the entire stomach and part of the intestine (mesentery)	70%
	h) removal of the entire stomach (part of stomach) with part of intestines and pancreas (part of pancreas)	80%
	i) a permanent stoma is formed (external opening of the bowel through the abdominal wall)	40%
	j) complete (III-degree) bowel incontinence	50%
	k) pancreatic injury (traumas) resulting in development of insulin-dependent diabetes mellitus	40%
	l) liver injury resulting in II- or III-degree hepatic function insufficiency persisting longer than 9 months of the date of the insured event (in case of increase blood and urine enzymes and pigments values: bilirubin, urobilin, GGT, ALT, AST, LDH, etc.)	60%
	m) removal of the spleen	20%
	n) sum insured in the amount of 25% may be paid due to any gastrointestinal injury not mentioned above which results in a marked impairment of function persisting for 9 months after the date of occurrence of the insured event.	

3.4.	**Urogenital system** Urinary organs injuries, which resulted in the following consequences persisting for more than 9 months from the date of the insured event:	
	a) Renal insufficiency (II-degree)	30%
	b) Renal insufficiency (III-degree), systematic haemodialysis, or performance of transplantation	80%
	c) removal of both ovaries (or the only functioning one) or removal of both fallopian tubes and/or uterus	50%
	d) removal of part (at least one quarter) of the penis	30%
	e) removal of both testicles and/or whole penis	50%
	f) severe urinary incontinence	35%
3.5.	**Nervous system** Consequences of damages to the central nervous system at least 9 months after the date of injury:	
	a) traumatic epilepsy with or without seizures, if the epilepsy was not present before the injury	15%
	b) post-traumatic parkinsonism in persons under 40 years of age (if the disease was not present before the injury)	20%
	c) laminectomy or spondylodesis due to trauma	20%
	d) paralysis of one limb (monoplegia)	50%
	e) dementia	75%
	f) paralysis of one side of the body (hemiplegia); paralysis of the lower or upper limbs (paraplegia)	80%
	g) hemiplegia or paraplegia with total function impairment in pelvic organs	90%
	h) paralysis of the upper and lower limbs (tetraplegia), decortication (cortex removal)	100%
3.6.	**Visual organs**	
	a) complete ptosis, severe lacrimal duct dysfunction, diplopia, marked reduction in vision (both eyes) or traumatic strabismus	15%
	b) total incurable loss of sight in one eye	50%
	Remarks. Injury to the only seeing eye shall be treated as an injury to both eyes. The consequences of the injury shall be assessed no earlier than 3 months after the date of injury.	
3.7.	**Hearing organs** Total loss of hearing:	
	a) in one ear	15%
	b) in both ears	60%
3.8.	Disfigurement of the face that has altered its natural appearance - deformity or disfigurement of the face at the end of the healing period, with contrasting spots or scars of an unusual colour that interfere with facial expressions; loss of nose Remark. Scars and pigmented spots shall be assessed at least 6 months after the accident	40%
3.9.	Total disablement, which makes it impossible to carry out any occupational or other work activity	100%

ADDITIONAL INSURANCE CONDITION NO 300: INJURY DUE TO AN ACCIDENT

Insured events

300.1. The insured event shall mean an accident that occurs to the insured person while the insurance coverage is in force. An accident is considered to be a sudden, unexpected occurrence, the time and place of which can be determined, during which a physical force (including chemical, thermal, poisonous gas or other physical effects) exerted from outside the body against the insured person's will, damages the health of the insured person. Accidents are also considered to be accidental acute poisoning of the insured person of moderate or severe degree with food, medicines, chemicals, gases, vapours, poisonous plants or mushrooms that occur against the will of the insured person. An infectious disease shall not be considered to be an accident.
300.2. An event shall be considered insured if it occurred while the insurance coverage is valid, and if it is confirmed by official documents and appropriate evidence.

Exclusions

300.3. The exclusion shall mean an accident or health impairment of the insured person related to:
300.3.1. the insured person's deliberate self-inflicted bodily injury, poisoning or attempted suicide.
300.3.2. the insured person's intoxication with alcohol, toxic, narcotic, psychotropic or other substances affecting the central nervous system, or the use of medicines without the appropriate prescription by a doctor;
300.3.3. the insured person driving any vehicle without the right to drive such a vehicle;
300.3.4. the insured person's pursuit of high-performance sport (high-performance sport is defined as sport where the income from the sport is earned), unless otherwise provided in the insurance contract;
300.3.5. congenital and/or acquired physical defects or medical conditions (diseases, residual effects of illnesses or injuries, congenital or acquired anomalies), excluding physical defects or medical conditions resulting from another insured event occurring during the period of validity of the contract;
300.3.6. a deliberate act by the insured person that renders him/her liable to administrative or criminal prosecution;
300.3.7. war (whether declared or undeclared), hostilities, participation in riots or revolutions, and exposure to radioactive radiation;
300.3.8. the insured person's participation in and/or initiation of a fight (except where the limit of self-defence is not exceeded, or the use of physical force is directly related to the performance of official duties);
300.3.9. surgery, treatment or other medical procedures, unless these procedures were carried out for the treatment of a medical condition arising from the insured event.

Insurance benefit due to an insured event

300.4. Upon occurrence of an insured event, a lump sum insurance benefit shall be paid, the amount of which is calculated as a percentage of the sum insured specified in the insurance contract in the event of an injury due to an accident. The percentage rates according to the consequences of the insured event are set out in Annex No 1 to this *Additional Insurance Condition.*
300.5. During the term of validity of the insurance contract, the insurer shall have the right to amend Annex No 1 to this *Additional Insurance Condition*. The insurer shall notify the policyholder in writing of the intended change no later than one month prior to the intended change of Annex No 1. If the policyholder does not agree with the change, the policyholder must notify the insurer about it in writing. In this case, the policyholder shall have the right to modify the terms and conditions of the insurance contract in relation to this *Additional Insurance Condition* or to terminate the insurance contract free of charge. If the policyholder fails to contact the insurer in writing regarding the termination of the insurance contract or amendment of the terms and conditions by the date specified in the notification, it shall be deemed that the policyholder has agreed to the change.
300.6. If the insured person dies as a result of the insured event within 30 days of the event, no insurance benefit shall be paid for injury resulting from the accident. If this benefit has already been paid, it shall be deducted from the payable insurance benefit in the event of the insured person's death.

Insurance benefit in case of an exclusion

300.7. In the event of occurrence of an exclusion or an event occurring after insurance coverage has been suspended, the insurer shall not pay any insurance benefits.

Deadlines for reporting an insured event

300.8. The insurer must be notified about the insured event in writing as soon as possible and in any case within one month of the occurrence of the insured event (or its consequences if the consequences occurred/were discovered later).

Documents to be submitted when applying for an insurance benefit

300.9. When contacting the insurer for payment of insurance benefit, the following documents must be provided:
300.9.1. the document confirming the identity of the person claiming the insurance benefit;
300.9.2. the document confirming the designation of the beneficiary, if separately signed;
300.9.3. an application, stating the date, place and circumstances of the insured event and the beneficiary's bank account to which the benefit is to be paid;
300.9.4. detailed medical certificates from the healthcare institution(s) stating a precise confirmed diagnosis, medical history, tests and treatment administered;
300.9.5. document constituting proof of disability or incapacity for work, if the insured person has been issued one;
300.9.6. the occupational accident report, if one has been drawn up;
300.9.7. the accident report drawn up by the police, if any, the investigation report, the court decision, if criminal proceedings were initiated due to the accident, or if the accident is related to the event for which proceedings were initiated.
300.10. The insurer may at its own discretion require other documents not listed in paragraph 300.9 of these insurance terms and conditions, which are necessary to establish the validity of the insurance benefit and the amount of the benefit.
300.11. If the document is issued by a foreign authority, the insurer may require a duly certified translation of the document into Lithuanian. The insurer shall not reimburse translation costs.

Beneficiary of the insurance benefit

300.12. The insurance benefit shall be paid to the insured person, unless the insurance contract specifies a separate beneficiary entitled to the benefits of this *Additional Insurance Condition*.
300.13. No insurance benefit can be paid to a person whose deliberate act (as determined by a court of law) led to the occurrence of an insured event. In this case, the part of the insurance benefit due to the guilty person shall be paid to:
300.13.1. other designated beneficiaries, with a proportional increase in their share of the benefit;
300.13.2. the insured person if no other beneficiaries have been designated.
300.14. If, after the insured event, the beneficiary dies before receiving the insurance benefit, the insurance benefit shall be paid to the deceased beneficiary's legal heirs.

ADDITIONAL INSURANCE CONDITION NO 300: INJURY DUE TO AN ACCIDENT ANNEX NO 1

1. General provisions

1.1. The insurance benefit shall be a part of the sum insured for the injury due to an accident, which is provided for the bodily injuries indicated in the present table and incurred during the insured event.
1.2. The total insurance benefit sum in respect of the consequences of one or more insured events during a 12-calendar month period may not exceed 100% of the sum insured in the case of an injury due to an accident.
1.3. The insurance benefit for one injury shall be paid only under one point of the respective item, comprising the severest injury indicated in that item.
1.4. The percentage rating for all injuries to one part of the body resulting from one injury cannot exceed the rating for the loss of that part of the body. When an insurance claim is paid for the loss of an organ (organ function), it shall be reduced by the benefits paid for the injury to that organ at the time of the injury.
1.5. If due to the insured event, the insured person sustained loss of the organ (function of organ), a part of which (part of function of which) was lost prior to the insured event, the payable insurance benefit shall be reduced in proportion to the loss of part of the organ (part of function of the organ) prior to the trauma.
1.6. Hernias (diaphragmatic, intervertebral discs, abdominal wall - umbilical, linea alba, inguinal, inguinal scrotum) and their consequences (radiculopathies, neuropathies, compression of the spinal cord, etc.) due to physical strain (including lifting heavy loads) shall not be eligible for insurance benefits.
1.7. The first (admission) and last (discharge) days of an inpatient treatment shall be counted as one day (bed day).
1.8. The insurance benefit for surgeries performed due to fracture of one bone (primary fracture, repeated fracture, dislocation or pseudoarthrosis) or damages to an organ, shall be paid additionally to the insurance benefit for fracture or organ damage, however, no more than 2 times. The insurance benefits shall not be provided in case of removal of osteosynthesis.
1.9. If a single insured event results in fractures, dislocation of bones, soft tissue, muscles, tendons, ligaments, menisci in a single limb, the insurance benefit shall be based on the single most severe consequence and the highest insurance benefit.
1.10. No benefit shall be paid in the event of an adverse reaction to a vaccination (post-vaccination complication), abscesses of any origin, congenital or acquired fistulas, arthritis, arthroses, arthropathies, radiculopathies, spondyloses and osteochondropathies, dermatomyositis, myositis, synovitis, synovitis, tendosynovitis, bursitis, cramp-fasciculation syndrome, enthesitis, fasciitis, capsulitis, epicondylitis, tendinitis, osteochondritis (spondylitis, periostitis), chondritis, thrombophlebitis, varicose veins, and similar disorders.
1.11. The insurer shall have the right not to pay the insurance benefit in respect of an accident if the documents of the healthcare institution do not clearly indicate the date of the accident and/or the relevant documents do not confirm that the insured event occurred during the period of validity of the insurance coverage, or if there are material contradictions in the said documents.

2. Bone fractures and dislocations

Remarks.
1. A fracture of a single bone in several places (in the course of a single insured event) shall be treated as a single fracture, except where the item provides multiple fractures.
2. The insurance benefit due to bone fractures, dislocations, subluxations and syndesmolyses (symphysis ruptures) shall be paid if these bodily injuries are based on the radiological tests (CT or MRI).
3. Surgery of bones fractures or dislocations shall be considered a surgical procedure during which fractured bone ends are stabilized (with a surgical spike or wire, plate, external fixation apparatus) or the joint is fixed. Skeletal stretching shall be treated as osteosynthesis of the fractured bone.
4. The insurance benefit shall not be paid for fractures and dislocations of foreign bodies (prosthetic joints, osteosynthesis implants).
5. When a primary subluxation has been diagnosed, 50% of the insurance benefit that would have been payable for a dislocation shall be paid.
6. If an artificial joint was implanted due to a fracture during the acute period of injury, an additional 15% benefit shall be paid.
7. 50% of the calculated sum insured shall be paid for a bone fracture or avulsion fracture.
8. No benefit shall be paid if the fracture or the nature of the fracture is not recognised by the insurer.

Row No	Injury or condition	Share of sum insured paid for injury (%)
2.1.	Cranial vault fracture Remark. Fractures of several bones of the vault shall be treated as a single fracture.	10%
2.2.	Cranial base fracture Remark. Fractures of several bones of the base shall be treated as a single fracture.	15%
2.3.	Surgery for skull fracture	10%

2.4.	Fracture of the nasal bones Remark. No insurance benefit shall be paid for injury to the cartilaginous structures of the nose and distortion of the nasal septum.	4%
2.5.	Ethmoid bone, orbital bone, maxillary and mandibular bone, walls of the facial sinuses, cheekbone, hyoid-bone:	
	a) open fractures	8%
	b) all other fractures	5%
	Remarks. 1. Up to three broken bones caused by the same insured event shall be indemnified. 2. Fracture of maxillary alveolar process shall not be considered as a maxilla facture. 3. If the jaw is accidentally fractured during dental manipulation, the benefit shall be paid.	
2.6.	Surgery for fracture of facial bones (except nasal bones) Remarks. No benefit shall be paid for the placement of mandibular advancement splints.	5%
2.7.	Dislocation of the mandible (radiological confirmation required) Remark. In the event of a dislocation of the mandible, the benefit shall be paid if it is a primary dislocation.	5%
2.8.	Rib fractures:	
	a) 1-2 ribs	3%
	b) 3-5 ribs	5%
	c) 6 and more ribs	10%
	Remarks. 1. The insurance benefit shall also be paid if a rib is fractured during resuscitation, regardless of the reason for resuscitation. 2. A fracture of the cartilage part of a rib or a dislocation of a rib shall be considered a rib fracture.	
2.9.	Cervical, thoracic or lumbar vertebral body or arch factures:	
	a) 1 vertebra	15%
	b) 2 vertebrae	20%
	c) 3 vertebrae	25%
	d) 4 or more vertebrae	30%
2.10.	Cervical, thoracic or lumbar vertebral dislocation	5%
2.11.	Cervical, thoracic or lumbar vertebral process fractures:	
	a) 1 vertebra	3%
	b) 2 vertebrae	5%
	c) 3 or more vertebrae	8%
	Remark. If an insurance benefit is paid under item 2.9 in respect of a fracture of a vertebral column, no insurance benefit shall be paid in respect of a fracture of the processes of the same vertebra.	
2.12.	Surgery for fracture or subluxation of the cervical, thoracic or lumbar vertebrae	10%
2.13.	Sternal fracture Remark. The insurance benefit shall also be paid in the event of sternal fractured occurred during resuscitation (regardless of the reason for resuscitation).	5%
2.14.	Coccygeal bone fracture	5%
2.15.	Surgery for a coccygeal bone fracture	5%
2.16.	Sacral bone fracture	10%
2.17.	Surgery for a sacral bone fracture	5%
2.18.	Scapular fracture:	
	a) open fracture	8%
	b) all other fractures	5%
2.19.	Surgery for a scapular fracture	5%
2.20.	Clavicle fracture:	
	a) open fracture	8%
	b) all other fractures	5%
2.21.	Surgery for a clavicle fracture	5%
2.22.	Humeral fracture:	
	a) open fracture	15%
	b) all other fractures	10%
2.23.	Surgery for a humeral fracture	10%
2.24.	Forearm bone fractures:	
	a) open fracture	10%
	b) all other fractures	5%
	Remark. The insurance benefit shall be paid for each broken bone.	

2.25.	Surgery for forearm bone fractures Remark. The amount of the benefit does not depend on the number of bones operated on.	5%
2.26.	Carpal bone fractures (except scaphoid bone) Remark. Up to three broken bones caused by the same insured event shall be indemnified.	3%
2.27.	Scaphoid bone fracture	5%
2.28.	Surgery for carpal bone fractures Remark. If payment is made for surgery for fractures of the forearm in accordance with item 2.25, no benefit shall be provided for surgery for carpal bones fractures.	5%
2.29.	Fractures and dislocations of metacarpal bones and 1st finger (thumb) phalanges Remarks. 1. Fractures of 1st finger (thumb) several phalanges are treated as a single fracture. 2. Up to three broken or dislocated bones caused by the same insured event shall be indemnified.	3%
2.30.	Finger II-V phalanges fractures and dislocations:	
	a) Finger II-V phalanges dislocations	1%
	b) Finger II-V phalanges fractures	2%
	Remark. Fractures of several phalanges in one finger shall be treated as a single fracture. Up to three broken or dislocated bones caused by the same insured event shall be indemnified.	
2.31.	Surgery for carpal bone fractures or dislocations:	
	a) one bone	3%
	b) two or more bones	5%
	Remark. If payment is made for surgery for carpal bone fractures in accordance with item 2.28, no benefit shall be provided for surgery under this item.	
2.32.	Fractures of the pelvic bones (iliac bone, ischium, pubic bone):	
	a) fracture of one pelvic bone, avulsion fracture of the acetabulum, rupture of the pubic symphysis	5%
	b) fractures of two pelvic bones, acetabulum fracture	12%
	c) fractures of three or more pelvic bones, compromising the integrity of the pelvic ring	20%
2.33.	Surgery for pelvic bone fractures	10%
2.34.	Femoral bone fracture:	
	a) open fracture	20%
	b) all other fractures	15%
2.35.	Surgery for a femoral bone fracture	10%
2.36.	Patellar fracture	5%
2.37.	Surgery for a patellar fracture	5%
2.38.	Tibial fracture (except posterior edge of tibia, medial malleolus):	
	a) open fracture	15%
	b) all other fractures	10%
	Remark. Intercondylar eminence (eminentia intercondilaris) fracture is considered to be a tear of the cruciate ligament of the knee joint. The insurance benefit shall be paid according to item 8.7	
2.39.	Tibial posterior edge and medial malleolus fracture	5%
2.40.	Lateral malleolus fracture	5%
2.41.	Calf bone (fibula) fracture:	
	a) open fracture	8%
	b) all other fractures	5%
2.42.	Surgery for tibia bone fractures Remark. The amount of the benefit does not depend on the number of bones operated on.	5%
2.43.	Tarsal bone fractures (excluding the calcaneus and talus) Remark. Up to three broken bones caused by the same insured event shall be indemnified.	3%
2.44.	Calcaneal fracture	8%
2.45.	Talus fracture	5%
2.46.	Surgery for tarsal bone fractures Remark. The amount of the benefit does not depend on the number of bones operated on. If payment is made for surgery for tibia bone fractures in accordance with item 2.42, no benefit shall be provided for surgery for tarsal bones fractures.	5%
2.47.	Fractures and dislocations of the metatarsal bones and bones of the 1st (big) toe Remark. Up to three broken or dislocated bones caused by the same insured event shall be indemnified. Fractures of several phalanges in 1st toe shall be treated as a single fracture.	3%

2.48.	Toe II-V phalanges fractures and dislocations:	
	a) Toe II-V phalanges dislocations	1%
	b) Toe II-V phalanges fractures	2%
	Remark. Fracture and dislocation of several phalanges of one toe shall be treated as a single fracture or dislocation. Up to three broken or dislocated bones caused by the same insured event shall be indemnified.	
2.49.	Surgery for foot bone fractures or dislocations Remarks. 1. If payment is made for surgery for tarsal bone fractures in accordance with item 2.46, no benefit under this item shall be provided for surgery for foot bones fractures. 2. The amount of the benefit does not depend on the number of bones operated on.	2%
2.50.	Pseudoarthrosis resulting from a fracture of the clavicle, humerus, forearm bones, femur or tibia, and lasting more than 9 months from the date of occurrence of the insured event	50% of the insurance benefit paid for that bone fracture
2.51.	Repeated fracture at the same site within 6 months of the initial fracture	50% of the insurance benefit paid for that bone fracture
2.52.	Impaction or stress fracture of any bone (except femur and tibia)	1%
2.53.	Impaction or stress fracture of femur and tibia	5%
2.54.	Primary bone dislocation in the wrist, elbow, shoulder, tarsus, knee, hip joints, resulting in:	
	a) splint for a period of 14 days or more after a dislocation repair	5%
	b) surgery	8%
	Remarks. 1. Where the fracture and dislocation of the same bone occurred, the insurance benefit shall be provided either for the bone fracture or its dislocation (whichever is greater). 2. Recurrent dislocations or subluxations shall not be deemed to be insured events and shall not give rise to insurance benefits. 3. If benefit payment is provided for a fracture of the posterior edge of the tibia or inner ankle according to item 2.39 or a fracture of the outer ankle according to item 2.40, no payment shall be provided for dislocation of bones in the ankle joint under this item.	
2.55.	Syndesmolysis (symphysis rupture)	4%
2.56.	Surgery for syndesmolysis Remark. If payment is made for surgery for tarsal bone fractures, no benefit shall be provided for surgery for syndesmolysis.	4%

3. Loss of limbs or their functions

Remarks.

1. The irreversible loss of function of a limb or part of a limb shall be assessed at least 9 months and no more than 18 months after the date of occurrence of the insured event (if the irreversible loss of function of the limb or part of a limb is certain, the benefit shall be paid without waiting the 9-month time limit).
2. Irreversible loss of function of a limb or part of a limb shall be defined as the loss of movement of a limb or part of a limb.
3. The insurance benefit for partial loss of function of a limb or part of a limb shall be equal to 50% of the payable insurance benefit in respect of the loss of that limb or part of that limb.
4. No benefit shall be paid if the loss of function of the limb or part of the limb is less than 50%.
5. Total loss of function of a limb shall be equivalent to the loss of a limb.
6. The insured event shall be deemed to be only a long-term and permanent disability or a reduction in the insured person's ability to work, as evidenced by a certificate from the Disability and Working Capacity Assessment Office under the Ministry of Social Security and Labour, or, where this is not available due to the insured person's age, by other medical documents that confirm the impairment of the insured person health condition for at least two years.
7. Limb and joint mobility impairments (contractures and ankylosis) shall be treated as partial loss of limb and joint function.
8. Where replantation (reattachment of the lost limb or its part) is performed due to loss of a limb or its part, the insurance benefit shall be paid only for loss of function in the limb or its part.

3.1.	Loss of the only arm above the elbow joint	100%
3.2.	Loss of the arm with other bones of the shoulder girdle (scapula, clavicle or part thereof)	80%
3.3.	Loss of the arm above elbow joint	75%
3.4.	Loss of the arm through the elbow joint (exarticulation)	70%
3.5.	Loss of the arm above wrist joint	65%
3.6.	Loss of hand	60%
3.7.	Loss of 1st finger (thumb) together with the metacarpal bone	25%
3.8.	Loss of 1st finger (thumb)	20%
3.9.	Loss of distal phalanx of 1st finger (thumb)	10%
3.10.	Loss of distal phalanx of part of 1st finger (thumb)	5%
3.11.	Loss of all three phalanges of 2nd finger (index)	15%

3.12.	Loss of two phalanges of 2nd finger (index)	10%
3.13.	Loss of distal phalanx of 2nd finger (index)	5%
3.14.	Loss of 3rd, 4th or 5th (middle, ring or little) finger	10%
3.15.	Loss of two phalanges of 3rd, 4th or 5th (middle, ring or little) finger	8%
3.16.	Loss of distal phalanx of 3rd, 4th or 5th (middle, ring or little) finger	4%
3.17.	Loss of 1st finger (thumb) and one other – 3rd, 4th or 5th (middle, ring or little) – finger and the corresponding metacarpal bones	30%
3.18.	Loss of 1st, 2nd (thumb, index) fingers and the corresponding metacarpal bones	35%
3.19.	Loss of 1st finger (thumb) and two other – 3rd, 4th or 5th (middle, ring or little) – fingers and the corresponding metacarpal bones	35%
3.20.	Loss of three fingers, except 1st (thumb), and the corresponding metacarpal bones	25%
3.21.	Loss of the only leg above the knee joint	100%
3.22.	Loss of leg above knee joint	80%
3.23.	Loss of leg at the knee joint (exarticulation)	70%
3.24.	Loss of leg above ankle joint	60%
3.25.	Loss of leg at the ankle joint (exarticulation)	50%
3.26.	Loss of foot below the ankle joint	45%
3.27.	Loss of foot in the metatarsal region	35%
3.28.	Loss of foot in the region of the phalangeal-metatarsal joints	25%
3.29.	Loss of one toe (except 1st (big) toe)	3%
3.30.	Loss of 1st (big) toe	8%
3.31.	Loss of distal phalanx of 1st (big) toe	5%
3.32.	Loss of four toes, except 1st (big) toe	10%

4. Visual organs

Remarks.
1. Injury to the only seeing eye shall be treated as an injury to both eyes.
2. The decrease of visual acuity shall be established no earlier than 3 months and no later than a year of the date of occurrence of the trauma.
3. Where an artificial lens is implanted due to the trauma or a corrective lens is used, the payable insurance benefit shall be determined according to the visual acuity present prior to implantation or insertion of the lens.
4. Loss of visual acuity due to retinal detachment shall be considered an insured event and the insurance benefit shall be paid only if the retinal detachment is caused by direct trauma to the eye (contusion, injury, orbital fracture). If the retina detaches due to a disease (severe myopia, hypertension or other diseases), lifting a heavy object, sudden or unusual movement, or impact to any other part of the body, no benefit shall be paid.

4.1.	Non-perforating lesions of the eyeball (eyeball contusion, traumatic corneal erosion, corneal detachment, anterior chamber spillage, 1st degree burns)		2%
4.2.	Perforating injury of one eye, 2nd or 3rd degree burn of the eye		5%
4.3	Loss of visual acuity (without correction) due to trauma:		
	Visual acuity before injury	Visual acuity after injury	
a)	1	0.7	1%
		0.6	3%
		0.5	5%
		0.4	10%
		0.3	15%
		0.2	20%
		0.1	30%
		< 0.1	40%
		0	50%
b)	0.9	0.6	1%
		0.5	3%
		0.4	5%
		0.3	10%
		0.2	20%
		0.1	30%
		< 0.1	40%
		0	50%
c)	0.8	0.5	1%
		0.4	5%
		0.3	10%
		0.2	20%
		0.1	30%
		< 0.1	40%
		0	50%

d)	0.7	0.5	1%
		0.4	5%
		0.3	10%
		0.2	15%
		0.1	20%
		< 0.1	30%
		0	40%
e)	0.6	0.4	1%
		0.3	5%
		0.2	10%
		0.1	15%
		< 0.1	20%
		0	30%
f)	0.5	0.3	1%
		0.2	5%
		0.1	10%
		< 0.1	15%
		0	20%
g)	0.4	0.2	3%
		0.1	5%
		< 0.1	10%
		0	20%
h)	0.3	0.1	3%
		< 0.1	10%
		0	20%
i)	0.2	0.1	3%
		< 0.1	5%
		0	20%
j)	0.1	< 0.1	5%
		0	20%
k)	< 0.1	0	10%
	Remarks. 1. When payment of the insurance benefit under this item is provided, the insurance benefit paid under item 4.2 or item 4.4(a) shall be deducted. 2. If visual acuity is decreased in both eye due to the trauma, each eye shall be assessed separately, while the percentages shall be added. 3. Where there is no information on the insured person's visual acuity before the injury, it shall be assumed that vision was normal (1.0), however no better than in the uninjured eye.		
4.4.	Post-traumatic consequences in one eye:		
	a) iris defect, pupillary malformation, lens dislocation (displacement), remaining unremoved foreign bodies in the eyeball, adjacent tissues and the orbit causing post-traumatic diseases and complications, damage to the function of the lacrimal ducts as a result of injury, vitreous lesions		10%
	b) complete ptosis, severe lacrimal duct dysfunction, diplopia, marked reduction in vision (both eyes) or traumatic strabismus		15%
	Remarks. 1. The consequences of the trauma under this item shall be assessed no earlier than 3 months after the date of injury. 2. Foreign bodies on the surface of the eye, not caused by post-traumatic diseases or complications, which do not affect the function of the eye, shall not give rise to insurance benefits.		

5. Hearing organs

Remark.
1. The consequences of the insured event, as set out in items 5.2 and 5.3, shall be assessed no earlier than 3 months and no later than 12 months after the occurrence of the insured event.

5.1.	Traumatic rupture of ear drum, if the diagnosis is confirmed by the symptoms of recent trauma Remark. If an ear drum rupture occurred as a result of a basal skull fracture, the insurance benefit shall not be paid.	3%

5.2.	Hearing loss in one ear when the diagnosis is based on signs of recent trauma Remarks. 1. Hearing impairment is confirmed by audiogram and impendansometry.	5%
	2. When payment of the insurance benefit under this item is provided, the insurance benefit paid under item 5.1 shall be deducted.	
5.3.	Total loss of hearing:	
	a) in one ear	15%
	b) in both ears	60%
	Remark. When payment of the insurance benefit for loss of hearing under this item is provided, the insurance benefit paid under item 5.1 or item 5.2 shall be deducted.	

6. Central nervous system

6.1.	Cerebral injuries:	
	a) concussion (contusion, commotion) when treated only on an outpatient basis (at least 10 days) or on an inpatient basis for at least 1-2 days	2%
	b) concussion (concussion, commotion) resulting in hospitalisation for at least 3 days	4%
	c) subarachnoid (located between the arachnoid and pia mater) haemorrhages	5%
	d) cerebral contusion, compression, epidural (above the dura mater) haematoma, when the diagnosis is based on a CT scan or MRI scan during hospitalisation	10%
	e) subdural (under the dura mater) haematoma and/or intracerebral (located within the brain tissue) haematoma, when the diagnosis is based on a CT scan or MRI scan during hospitalisation	20%
	Remark. No benefit shall be paid for concussion (contusion, commotion) if the insured person had cerebrovascular pathology or a more severe brain injury before the injury.	
6.2.	Disruption of the structure of the brain, protrusion of the brain outward through a traumatic opening	50%
6.3.	Craniotomy (opening of skull) due to cerebral trauma) Remark. When insurance benefit is provided due to craniotomy under this item, no benefit shall be paid in respect of cranial bone surgery under item 2.3.	10%
6.4.	Spinal cord injuries:	
	a) commotion with at least 3 days of hospitalisation	3%
	b) contusion, compression, haemorrhage into the spinal cord, when the diagnosis is based on computed tomography or magnetic resonance imaging, during hospitalisation	15%
	c) partial rupture, cross-sectional lesion of half of the spinal cord (Brown-Séquard syndrome), partial traumatic myelitis of the spinal cord	50%
	d) complete interruption of the spinal cord, total myelitis	100%
6.5	Spinal cord injury surgery Remarks. 1. In the case of an insurance benefit in respect of a surgery under this item, no insurance benefit shall be paid in respect of a surgery on the cervical, thoracic or lumbar spine in accordance with item 2.12. 2. When the surgery is for an intervertebral disc herniation and its consequences, no insurance benefit shall be provided.	15%
6.6.	Consequences of damages to the central nervous system at least 9 months after the date of injury:	
	a) traumatic epilepsy with or without seizures, if the epilepsy was not present before the injury	15%
	b) traumatic hydrocephalus, post-traumatic parkinsonism in persons under 40 years of age (if the disease was not present before the injury)	20%
	c) paresis of one limb (monoparesis)	25%
	d) paresis of two or more limbs (hemiparesis, paraparesis)	45%
	e) paralysis of one limb (monoplegia)	50%
	f) dementia	75%
	g) paralysis of one side of the body (hemiplegia); paralysis of the lower or upper limbs (paraplegia)	80%
	h) hemiplegia or paraplegia with total function impairment in pelvic organs	90%
	i) paralysis of the upper and lower limbs (tetraplegia), decortication (cortex removal)	100%
	Remarks. When payment of the insurance benefit in respect of the consequences of central nervous system injury under this item is provided, the insurance benefit paid under Chapter 3 or items 6.1-6.5 shall be deducted.	

7. Cranial and peripheral nerves

7.1.	A cranial nerve injury for which reconstructive surgery has been performed or there is evidence of neuropathy for more than 9 months from the date of occurrence of the insured event:	
	a) unilateral	5%
	b) bilateral	10%
	Remarks. 1. The insurance benefit due to injuries of cranial nerves under this item shall be paid only once, irrespective of the number of injured nerves on one side. 2. If an insurance benefit is paid in respect of a fracture of the skull under item 2.1 or item 2.2, no benefit shall be paid under this Article. 3. If the benefit is paid in respect of impairment of the visual organs under item 4.3, item 4.4 or as a result of asphyxia under item 5.3, the insurance benefit under the present item shall not be paid.	
7.2.	Peripheral nerve integrity damage leading to reconstructive surgery or, 9 months after the date of injury, persistent neuropathy:	
	(a) forearm, wrist, shin and ankle area	5%
	(b) upper arm, elbow, femur, knee area	10%
	(c) plexus area	25%
	Remarks. 1. For nerve injuries to the hand and foot, see item 8.8. 2. If several nerves are damaged in one limb, the insurance benefit shall be paid only for one injury of the nerve. 3. No benefit shall be paid under this item if the insurance benefit has been paid under Chapter 3.	

8. Soft tissues

Remarks.
1. If several muscles, tendons, ligaments and/or nerves are damaged in a single limb during a single insured event, the benefit shall be paid as if it were a single injury.
2. The insurance benefit for repeated injury to the soft tissues or meniscus of the same joint shall be paid no earlier than 12 months after the last injury. Repeated injuries to the soft tissues of the same joint or to the menisci shall result in a 50% reduction in the benefit.
3. When an insurance benefit is paid for a bone fracture and/or dislocation, no insurance benefit shall be provided for a soft tissue injury (trauma) in the same area.
4. No insurance benefit shall be provided for abrasions, scratches and similar damage to the integrity of the skin.
5. The insurance benefit due to scars after open fractures, surgery and amputation shall not be paid.
6. When calculating the insurance benefit under the respective item, the measurements (sizes) of scars resulting from injuries sustained during a single incident shall be summed up.
7. 1% of the body surface is equal to the metacarpal surface area of the insured person's hand (palm and II-V fingers). This area shall be calculated in square centimetres: hand length measured from carpo-metacarpal joint to apex of 3rd finger distal phalanx, is multiplied by palm width, measured in the line of II-V metacarpal bone heads.
8. When payment of the insurance benefit for scars according to the relevant item of the table, the insurance benefit paid under item 8.1(a), 8.2(a), 8.3(a) or 8.4(a-e) shall be deducted.

8.1.	Lesion of soft tissues of the face, neck anterior and lateral surface, under-jaw area, due to which:	
	a) the tissues had to be stitched (stapled) (irrespective of the number of simultaneous lesions/wounds or stitches)	1%
	b) at the end of the healing period, a linear scar of between 1 cm and 3 cm or larger than 1 cm^2 was formed	2%
	c) at the end of the healing period, a linear scar of 3 cm or longer; or larger than 2 cm^2 or a pigmented spot of 3 cm^2 or larger was formed	3%
	d) at the end of the healing period, a linear scar of 5 cm or longer and 3 cm or larger than 3 cm^2 was formed	5%
	e) at the end of the healing period, a pigmented spot of 5 cm^2 or larger was formed	10%
	f) at the end of the healing period, a linear scar of 8 cm or longer and 5 cm^2 or larger was formed	15%
	g) at the end of the healing period, disfigurement of half of the face has persisted, altering its natural appearance - presence of massive contrasting spots or scars, which detracts from the appearance of the face	20%
	h) at the end of the healing period, disfigurement of the entire face that has altered its natural appearance - deformity or disfigurement of the face, with contrasting spots or scars of an unusual colour that interfere with facial expressions; loss of nose	40%
	Remarks. 1. Scars and spots under item 8.1(b), (c), (d), (e) and (f) shall be assessed at least 3 months after the date of injury. 2. Scars and spots under item 8.1(g) and (h) shall be assessed at least 6 months after the date of injury.	
8.2.	Damage to the soft tissues of the scalp (due to mechanical, chemical, thermal or other acute violent impact), due to which:	
	a) the tissues had to be stitched (stapled) (irrespective of the number of simultaneous lesions/wounds or stitches)	1%
	b) at the end of the healing period, a linear scar of 5 cm or longer and 3 cm or larger than 3 cm^2 was formed	2%
	c) at the end of the healing period, a linear scar of 10 cm or longer was formed	3%
	d) at the end of the healing period, scarring of more than 0.5% of the body surface area was formed; partial scalping	6%
	e) scalping	15%
	Remark. Scars and spots under this item shall be assessed at least 3 months after the date of injury.	

8.3.	Damage to the soft tissues of the torso and limbs (due to mechanical, chemical, thermal or other acute violent impact), due to which:	
	a) the tissues had to be stitched (stapled) (irrespective of the number of simultaneous lesions/wounds or stitches)	1%
	b) at the end of the healing period, scarring of between 5 m^2 up to 0.5% of the body surface area or a pigmented spot of between 0.5 and 1% of the body surface area was formed	2%
	c) at the end of the healing period, scarring of between 0.5 and 1% of the body surface area or a pigmented spot of between 1 and 10% of the body surface area was formed	3%
	d) at the end of the healing period, scarring of between 1 and 10% of the body surface area or a pigmented spot of between 10% and more of the body surface area was formed	5%
	e) at the end of the healing period, scarring larger than 5% of the body surface area was formed	10%
	f) at the end of the healing period, scarring larger than 10% of the body surface area was formed	20%
	g) at the end of the healing period, scarring larger than 15% of the body surface area was formed	30%
	Remark. Scars and spots under this item shall be assessed at least 3 months after the date of injury.	
8.4.	Thermal and chemical burns, frostbite:	
	a) II-degree burns of at least 1% of the body surface area	3%
	b) III-degree burns up to 2% of the body surface area	4%
	c) II-degree burns of at least 5% of the body surface area or third-degree frostbite of at least 2% of the body surface area	5%
	d) III-degree burns of at least 2% of the body surface area	6%
	e) burn disease (burn shock, burn intoxication, anuria, acute burn toxaemia, acute burn septicotoxemia)	15%
8.5.	Loss of nail plate, finger soft tissue defect, with (permanent) tissue loss Remark. Where the insurance benefit is paid under this item, the area of the remaining scar shall not be included in the total scar area in accordance with item 8.3.	1%
8.6.	Effects of an injury to one auricle:	
	a) stitching of an auricle wound or an auricle wound, where at the end of the healing period a linear scar of 1 cm or longer, 1 cm^2 or larger is formed	1%
	b) traumatic deformation of the auricle or loss of up to ⅓ of the auricle	5%
	c) loss of more than ⅓ but less than ½ of the auricle	10%
	d) loss of more than ½ or total loss of an auricle	20%
	Remark. Scarring under point (a) shall be assessed at least 1 month after the injury.	
8.7.	Traumatic loss of integrity of a muscle, tendon or ligament (strain, partial tear, tear) (except tendons and ligaments of the foot and hand), due to which: a) the person has been undergoing medical treatment or has lost working capacity/unable to attend educational institution for more than 7 days b) the person has been unable to work or attend educational institution for at least 14 days c) the person was immobilised in a plaster cast (splint) for a period of at least 14 days d) performance of reconstructive surgery.	1% 2% 3% 5%
8.8.	Traumatic loss of integrity of a muscle, tendon or ligament of hand and foot, due to which: a) the person has been unable to work or attend educational institution for at least 14 days b) the person was immobilised in a plaster cast (splint) for a period of at least 14 days c) performance of reconstructive surgery.	1% 2% 5%
8.9.	Damage to the integrity of the Achilles tendon resulting in surgery Remark. If the surgery due to the injury was not performed, the benefit shall be paid in accordance with item 8.7.	8%
8.10.	Bruises for which immobilisation was applied for at least 14 days, or the person was unable to work/attend an educational institution for at least 14 days	1%
8.11.	Haemarthrosis (accumulation of blood in the joint cavity), confirmed by puncture	1%
8.12.	Autotransplantation (skin, bone) performed due to the insured event	5%
8.13.	Rupture or tear of the meniscus of the knee joint, confirmed by surgery, arthroscopy or magnetic resonance imaging Remarks. 1. If indemnification is provided under this item, additional indemnification for surgery shall not be provided. 2. Where rapture of both menisci of the same knee joint occurred due to one trauma, the insurance benefit shall be paid for one meniscus rapture. 3. In the event of a rupture of the cruciate ligaments in the same injury, the benefit shall be paid only under this item. 4. The benefit shall be paid when the exact date of the injury is documented in the records issued by a medical institution. 5. No benefit shall be provided, if the meniscus tears as a result of arthrosis of the knee or degenerative diseases of the joint.	5%

9. Thoracic organs

9.1.	Thoracic organ injury, resulting in performance of:	
	a) thoracentesis, drainage, pericardiocentesis, thoracoscopy,	5%
	b) thoracotomy	10%
	Remark. If several procedures listed in item 9.1 have been carried out, the insurance benefit shall be paid as if it were one procedure (which pays the highest percentage of the sum insured).	

Respiratory system

9.2.	Lung injury, contusion, subcutaneous emphysema, haemothorax (exudation of blood from the lung), pneumothorax (air in the lung cavity), traumatic pneumonia, exudative pleuritis (wet pleurisy):	
	a) unilateral	5%
	b) bilateral	10%
	Remarks. 1. The insurance benefit shall be paid if the specified consequences are due to direct trauma to the chest or its organs. If these effects (diseases) are due to other causes (e.g. cold, organ surgery other than chest injuries or complications), no benefit shall be paid. 2. The insurance benefit shall be paid only once, regardless of the number of consequences from the insured event. 3. When acute pneumonia is caused by accidental acute poisoning with respiratory irritant chemicals or pneumotoxic poisons, an insurance benefit shall be paid.	
9.3.	Injury of organs resulting in tracheostomy.	10%
9.4.	Injury to the larynx (or vocal cords alone), thyroid cartilage, trachea, bronchi, fracture of the hyoid-bone, upper respiratory tract burn or similar injury, traumatic bronchoscopy, traumatic mediastinal injury, unremoved foreign body in the chest cavity	5%
9.5.	Injury of lung, resulting in removal of:	
	a) 1-2 lung segments	20%
	b) lung lobe or part (up to half) of lung	30%
	c) more than half of lung or whole lung	40%
	Remark. When insurance benefit for lung injury is provided under this item, no benefit shall be paid in respect of the procedures provided in item 9.1.	
9.6.	Injury to the respiratory system organs resulting in the following consequences 9 months after the date of occurrence of the insured event:	
	a) significant hoarseness of voice	15%
	b) complete loss of voice	45%
	c) functional tracheostoma	40%
	d) pulmonary insufficiency (II-degree)	40%
	e) pulmonary insufficiency (III-degree)	60%
	Remarks. 1. If insurance benefit is provided for lung failure benefit under item 9.6(d) and (e), the benefit paid in respect of the procedures provided in item 9.1 or in respect of the lung injury provided in item 9.5 shall be deducted. 2. If insurance benefit is provided for functioning tracheostoma under item 9.6(c), the benefit paid under item 9.3 shall be deducted.	

Cardiovascular system

9.7.	Damaged integrity of large blood vessels, resulting in a reconstructive surgery:	
	a) forearm, wrist, shin and ankle	5%
	b) upper arm, elbow, femur and knee	10%
	c) neck, chest, abdominal cavity or retroperitoneal space	15%
	Remark. If several blood vessels are injured in the same limb or area, the injury shall be treated as an injury to one blood vessel.	
9.8.	Heart and cardiac tissue injury	10%
9.9.	Heart, cardiac tissue or blood vessel injury resulting in cardiac or blood vessel function insufficiency 9 months after the date of occurrence of the insured event:	
	a) cardiovascular insufficiency of II-degree III functional class	40%
	b) cardiovascular insufficiency of III-degree IV functional class	60%
	Remarks. 1. When insurance benefit under this item is provided, the benefit paid in respect of the procedures provided in item 9.1 and in respect of injury to the heart and its tissues under item 9.8 shall be deducted. 2. The insurance benefit under this item shall depend on the functional tests and indicators confirming the blood flow insufficiency degree.	

10. Abdominal organs

10.1.	Abdominal organ injury, resulting in performance of:	
	a) paracentesis (puncture of the abdominal cavity)	3%
	b) laparoscopy (endoscopic examination of the abdominal cavity)	5%
	c) laparotomy (open abdomen)	10%
	d) relaparotomy (repeat laparotomy)	10%
	Remarks. 1. If several procedures listed in item 10.1 have been carried out, the insurance benefit shall be paid as if it were one procedure (which pays the highest percentage of the sum insured). 2. The benefit under point 10.1(d) is paid only once, regardless of the number of relaparotomies.	

Digestive organs

10.2.	Jaw injury resulting in the loss of the following:	
	a) part of a jaw, resulting in chewing disorder	30%
	b) the entire jaw	60%
	Remark. When insurance benefit under this item is provided, insurance benefits in respect of the same injury under item 2.5 for fracture of the jaw and/or under items 10.4 and 10.5 for loss of teeth at the site of the fracture shall not be paid or, if paid, they shall be deducted.	
10.3.	Injury to the tongue and oral cavity, resulting in:	
	a) stitches	1%
	b) scarring	3%
	c) loss of tongue up to distal third, however no less than ¼ of tongue	15%
	d) loss of tongue in the middle third	40%
	e) loss of tongue in the proximal third (root) area or the whole tongue	70%
	Remarks. 1. Scarring under this item shall be assessed at least 1 month after the injury. 2. When payment of the insurance benefit for scars according to the relevant item of the table, the insurance benefit paid for wound suturing/stapling.	
10.4.	Traumatic dental injury (tooth subluxation, impaction into the alveolus, chipping of at least a quarter of the crown of the tooth)	2% per tooth damaged, up to a maximum of 6%
	Remarks. 1. Insurance benefit shall not be paid for damage to teeth while eating. 2. For traumatic damage to a tooth, the benefit shall be reduced by 50% if the tooth has been damaged by caries, bruxism or other disease of the tooth's hard tissues, or pathology of the periapical and periodontal tissues. 3. In the event of fracture or damage to dentures, implants or restorations due to trauma, no benefit shall be paid. The insurance benefit in the event of damage to the bridge restoration shall be provided taking into account only the loss of the supporting teeth due to the injury. 4. In the event of accidental loss of teeth due to medical manipulation, the benefit shall only be paid if the manipulation is due to the consequences of an insured event. 5. The insurance benefit shall not be paid for traumatic damage of milk teeth as a result of injury in children above 6 years of age.	
10.5.	Traumatic loss of the entire tooth crown or entire tooth, accompanied by soft tissue injury:	
	a) 1 tooth	4%
	b) 2-3 teeth	8%
	c) 4-5 teeth	10%
	d) 6-9 teeth	15%
	e) 10 and more teeth	20%
	Remarks. 1. Insurance benefit shall not be paid for damage to teeth while eating. 2. For traumatic damage to a tooth, the benefit shall be reduced by 50% if the tooth has been damaged by caries, bruxism or other disease of the tooth's hard tissues, or pathology of the periapical and periodontal tissues. 3. In the event of fracture or damage to dentures, implants or restorations due to trauma, no benefit shall be paid. The insurance benefit in the event of damage to the bridge restoration shall be provided taking into account only the loss of the supporting teeth due to the injury. 4. In the event of accidental loss of teeth due to medical manipulation, the benefit shall only be paid if the manipulation is due to the consequences of an insured event. 5. The insurance benefit shall not be paid for loss of milk teeth as a result of injury in children above 6 years of age.	
10.6.	Injury (wound, laceration, burn) to the pharynx, salivary glands, oesophagus, stomach - intestine (any part), and oesophagogastroscopy to remove foreign bodies from the oesophagus or stomach	5%
10.7.	Traumatic injury to the spleen:	
	a) subcapsular rupture that did not require surgery	5%
	b) subcapsular rupture that required surgery	10%
	c) requiring removal of the spleen	20%
10.8	Injury to the oesophagus causing narrowing of the oesophagus, resulting in the following, at least 9 months after the date of occurrence of the insured event:	
	a) difficulty swallowing solid foods	10%
	b) difficulty swallowing liquid and/or soft foods	40%
	c) esophageal obstruction resulting in formation of permanent gastrostoma (external opening into the stomach through the abdominal wall)	80%
	Remark. If an insurance benefit is paid under this item, no benefit shall be paid under item 10.6 for oesophageal injury.	
10.9	Traumatic injury (contusion, laceration) to the liver (capsule), gallbladder, subcapsular haematoma, not requiring surgery	5%

10.10.	Traumatic injury of digestive system organs resulting in:	
	a) removal of gall-bladder, performance of liver resection	15%
	b) removal of a liver section or a larger part	20%
	c) removal of part of the stomach or part of the intestine; removal of part of the pancreas; injury to extrahepatic bile ducts	25%
	d) two of the consequences listed in point (c) are present	35%
	e) three of the consequences listed in point (c) are present	40%
	f) injury to the pancreas resulting in traumatic necrotizing pancreatitis leading to repeated surgery or removal of the pancreas	45%
	g) removal of the entire stomach	50%
	h) removal of the entire stomach and part of the intestine (mesentery)	70%
	i) removal of the entire stomach (part of stomach) with part of intestines and pancreas (part of pancreas).	80%
	Remarks. 1. If an insurance benefit is paid under this item, no benefit shall be paid under item 10.1. 2. When insurance claim under this item is provided, no insurance benefits in respect of that event shall be paid under items 10.7 and 10.9 or, if paid, they shall be deducted.	
10.11.	Hernia at the site of an injury to the anterior abdominal wall or diaphragm or at the site of a post-operative scar (if surgery was performed as a result of an insured event):	
	a) if the hernia has not been operated on	5%
	b) if the hernia has been operated on	10%
10.12	Injury to organs of the digestive system (excluding the oesophagus), which occurs at least 9 months after the insured event:	
	a) stenosis of digestive organs, except oesophagus, as a result of scars	10%
	b) adhesive disease, resulting in a surgery	15%
	c) internal or external fistulas	20%
	d) stoma (external opening of colon)	30%
	e) a permanent stoma is formed (external opening of the bowel through the abdominal wall)	40%
	f) complete (III-degree) bowel incontinence	50%
	Remarks. 1. The benefit under this item shall be provided in addition to the paid benefits in respect of the procedures provided in item 10.1 or in respect of injury to the digestive organs under item 10.7, item 10.9 and/or item 10.10. 2. If insurance benefit under item 10.12(e) is provided, no benefit shall be paid under item 10.12(d) in respect of that event, or, if paid, it shall be deducted.	
10.13.	Consequences of a pancreatic injury, which occur at least 9 months after the insured event:	
	a) pancreatogenic malabsorption syndrome	5%
	b) development of insulin dependent diabetes	40%
10.14.	Liver injury resulting in II- or III-degree hepatic function insufficiency persisting longer than 9 months of the date of the insured event (in case of increase blood and urine enzymes and pigments values: bilirubin, urobilin, GGT, ALT, AST, LDH, etc.) Remark. When insurance benefit under this item is provided, the sum paid under item 10.9 or 10.10(b) shall be deducted.	60%

Urogenital system

10.15.	Traumatic injury of kidney:	
	a) contusion resulting in haematuria (blood in the urine); damage to the integrity of the parenchyma not operated on; paranephric haematoma	5%
	b) if surgery has been performed: kidney tamponade, drainage, kidney stitching	15%
	c) removal of part of kidney	30%
	d) removal of the whole kidney	60%
	Remark. If insurance benefit under this item is provided, no benefit shall be paid under item 10.1, except in the case of a relaparotomy.	
10.16.	Damages to integrity of ureter	5%
10.17.	Traumatic or toxic injury to the kidney (including burn disease, positional compression syndrome) resulting in haemodialysis, puncture (trochanteric) or surgical cystostomy, cystotomy	10%

10.18.	Urinary organs injuries, which resulted in the following consequences persisting for more than 9 months from the date of the insured event:	
	a) blockage of ureter or urethra, functional epicystostomy, uro-genital fistulas	20%
	b) Renal insufficiency (II-degree)	30%
	c) severe urinary incontinence	35%
	d) Renal insufficiency (III-degree), systematic haemodialysis, or performance of transplantation	80%
	Remarks. 1. When insurance benefit under item 10.18(a) is provided, the benefit paid in respect of the procedures provided in item 10.1 shall be deducted, except for the relaparotomy. 2. When insurance benefit under item 10.18(b) and (d) is provided, the benefit paid in respect of the procedures provided in item 10.1 or for injury to the kidney or ureter under items 10.15 and 10.16 shall be deducted, except for the benefit for relaparotomy..	
10.19.	Injury to the urinary or genital organs (laceration, burn, frostbite, accidental acute poisoning), in the absence of the consequences (complications) for which higher benefits are provided under the other items	2%
10.20.	Traumatic injury of genital system organs, resulting in women in:	
	(a) removal of one ovary and/or one Fallopian tube	15%
	(b) removal of both ovaries (or the only functioning one) or removal of both fallopian tubes and/or uterus	50%
	Remark. If insurance benefit under this item is provided, no benefit for procedures provided under item 10.1 shall be paid, except in the case of a relaparotomy.	
10.21.	Traumatic injury of genital system organs, resulting in men in:	
	a) removal of one testicle	15%
	b) removal of part (at least ¼) of penis	30%
	c) removal of both testicles and/or whole penis	50%

11. Other consequences of the insured events

11.1.	Insured events for which the insured person has been hospitalised for at least 3 days, where no benefit is paid under other items in this table:	
	a) 3-4 days	3%
	b) 5-14 days	5%
	c) 15-21 days	8%
	d) 22 days or longer	10%
	Remarks. 1. The insurance benefit shall not be paid for inpatient treatment due to illness, surgeries performed due to illness, pregnancy and childbirth. 2. If the insurance benefit was provided under this item, and it was later established that a higher benefit must be paid under other items, upon payment thereof, the insurance benefit paid under this item shall be deducted.	
11.2.	Non-resorbed haematoma that required surgery (haematoma puncture, drainage) or bodily injury with multiple subcutaneous haemorrhages covering at least three body areas and loss of working capacity for at least 3 weeks, if the insurance benefit is not paid under other items of this table	1%
11.3.	Lyme disease, tick-borne encephalitis and other diseases caused by insect or animal bites, due to which the person has lost working capacity or was prevented from attending an educational institution for at least 14 days	2%
11.4.	Animal bites where rabies treatment or immunoprophylaxis has been applied	3%
11.5.	Traumatic, post-haemorrhagic, anaphylactic shock, fat embolism if the diagnosis has been confirmed in hospital	10%

ADDITIONAL INSURANCE CONDITION NO 400: DEATH DUE TO AN ACCIDENT

Insured events

400.1. The insured event shall mean an accident occurring to the insured person while the coverage is valid if, as a result of bodily injuries sustained in the course of that accident, the insured person dies within 180 days. An accident is considered to be a sudden, unexpected occurrence, the time and place of which can be determined, during which a physical force (including chemical, thermal, poisonous gas or other physical effects) exerted from outside the body against the insured person's will, damages the health of the insured person. Accidents are also considered to be accidental acute poisoning of the insured person of moderate or severe degree with food, medicines, chemicals, gases, vapours, poisonous plants or mushrooms that occur against the will of the insured person. An infectious disease shall not be considered an accident.
400.2. If the insured person is declared dead by a court, this shall be considered an insured event if the court's decision states that the insured person disappeared under life-threatening circumstances and gave rise to a presumption of death as a result of the insured event, and if the date of the insured person's disappearance and the date of the presumption of death are within the period of validity of the insurance coverage. If a court declares the insured person to be missing, this shall not constitute an insured event.
400.3. An event shall be considered insured if it occurred while the insurance coverage is valid, and if it is confirmed by official documents and appropriate evidence.

Exclusions

400.4. The exclusion shall mean an accident or health impairment of the insured person related to:
400.4.1. the insured person's deliberate self-inflicted bodily injury, poisoning or attempted suicide.
400.4.2. the insured person's intoxication with alcohol, toxic, narcotic, psychotropic or other substances affecting the central nervous system, or the use of medicines without the appropriate prescription by a doctor;
400.4.3. a deliberate act by the insured person that renders him/her liable to administrative or criminal prosecution;
400.4.4. war (whether declared or undeclared), hostilities, participation in riots or revolutions, and exposure to radioactive radiation;
400.4.5. the insured person's participation in and/or initiation of a fight (except where the limit of self-defence is not exceeded, or the use of physical force is directly related to the performance of official duties);
400.4.6. surgery, treatment or other medical procedures, unless these procedures were carried out for the treatment of a medical condition arising from the insured event.

Insurance benefit due to an insured event

400.5. In case of occurrence of an insured event, the sum insured specified in the insurance contract shall be paid in the event of accidental death.

Insurance benefit in case of an exclusion

400.6. In the event of occurrence of an exclusion or an event occurring after insurance coverage has been suspended, the insurer shall not pay any insurance benefits.

Deadlines for reporting an insured event

400.7. The insurer must be notified about the insured event in writing as soon as possible and in any case within one month of the insured person's death or within one month of the entry into force of the court's decision declaring the insured person dead.

Documents to be submitted when applying for an insurance benefit

400.8. When contacting the insurer for payment of insurance benefit, the following documents must be provided:
400.8.1. the document certifying the identity of the person claiming the insurance benefit;
400.8.2. the document certifying the designation of the beneficiary, if signed separately;
400.8.3. notification of the insured person's death, specifying the date, place and nature of the insured event, as well as the bank account to which the sum insured should be paid;
400.8.4. detailed documentation from the medical institution describing the accidence, exact diagnosis of the illness or injury that led to the insured person's death, medical history, tests and treatment administered;
400.8.5. the insured person's medical death certificate or an extract of the death record issued by the state civil registry. If the insurer uses the data from the state civil registry, the insurer may not require provision of a death certificate or extract;
400.8.6. the certificate of inheritance, if there are legal heirs claiming the insurance benefit;
400.8.7. the occupational accident report, if one has been drawn up;
400.8.8. the accident report drawn up by the police, if any, the investigation report, the court decision, if criminal proceedings were initiated due to the accident, or if the accident is related to the event for which proceedings were initiated.
400.9. The insurer may, at its discretion, require other documents not listed in paragraph 400.8 of these insurance terms and conditions, which are necessary to establish the validity of the insurance benefit and the amount of the benefit.
400.10. If the document is issued by a foreign authority, the insurer may require a duly certified translation of the document into Lithuanian. The insurer shall not reimburse translation costs.

Beneficiary of the insurance benefit

400.11. The insurance benefit shall be paid to the last designated beneficiary known to the insurer. If no beneficiary has not been designated, the insurance benefit shall be paid to the legal heirs of the deceased insured person.
400.12. If the information about the designation/replacement/cancellation of the beneficiary is submitted after the payment of the insurance benefit, the insurer will not settle the claims of the persons who submitted the information and will not pay any additional benefits.
400.13. If the only designated beneficiary died at the same time, during occurrence of the insured event, or died before the insured event and no other beneficiary was designated, the insurance benefit due to the death of the insured person shall be paid to the insured person's legal heirs. If one of the designated beneficiaries died at the same time, during occurrence of the insured event, or died before the insured event and no other beneficiary was designated in his/her place, the insurance benefit shall be paid to the other designated beneficiaries, proportionally increasing the share of the benefit due to them.

400.14. No insurance benefit can be paid to a person whose deliberate act (as determined by a court of law) led to the insured person's death. In this case, the part of the insurance benefit due to the guilty person shall be paid to:
400.14.1. other designated beneficiaries, with a proportional increase in their share of the benefit;
400.14.2. the insured person's legal heirs, if no other beneficiaries have been designated.
400.15. If, after the insured event, the beneficiary dies before receiving the insurance benefit, the insurance benefit shall be paid to the deceased beneficiary's legal heirs.

ADDITIONAL INSURANCE CONDITION NO 500: CRITICAL ILLNESSES

Insured events

500.1. An insured event shall mean a critical illness stated in the list of critical illnesses, diagnosed during the period of validity of the insurance coverage, or a treatment or surgery stated in the list, performed while the insurance coverage is valid. The list of critical illnesses and the criteria for diagnosis are set out in Annex No 1 to this *Additional Insurance Condition*. The diagnosis of critical illness must fully comply with the requirements set out in Annex No 1.
500.2. An event shall be considered insured if it occurred while the insurance coverage is valid, and if it is confirmed by official documents and appropriate evidence.
500.3. In case of occurrence of an insured event, this *Additional Insurance Condition* shall cease to apply.

Exclusions

500.4. A critical illness shall be considered an exclusion if:
500.4.1. diagnosed within the first 3 months of validity of this *Additional Insurance Condition* or, if the insurance coverage has been suspended and renewed, within the first 3 months after the insurance coverage has been renewed. This time limitation shall not apply to Critical Illnesses resulting from an accident occurring during the period of validity of this *Additional Insurance Condition*;
500.4.2. related to the insured person's deliberate bodily injury, poisoning or attempted suicide;
500.4.3. the insured person died within 30 days of the diagnosis of the critical illness;
500.4.4. related to war (whether declared or undeclared), hostilities, participation in riots or revolutions, and exposure to radioactive radiation.

Insurance benefit due to an insured event

500.5. In case of occurrence of an insured event, a lump sum equal to the sum insured specified in the insurance contract shall be paid in the event of a critical illness.
500.6. If the sum insured for critical illness has been increased, then if the insured event occurs in the first 3 months after the increase in the sum insured, and if the event is not the result of an accident, the sum insured shall be equal to the lowest of the sum insured for critical illness valid during the last 3 months.
500.7. The critical illness benefit shall be paid only once, regardless of the number and type of critical illnesses the insured person is diagnosed with.
500.8. During the term of validity of the insurance contract, the insurer shall have the right to amend the list of critical illnesses set out in Annex No 1 to this *Additional Insurance Condition* no more than once per calendar year by adding new illnesses or deleting existing ones, as well as to amend the criteria for diagnosing critical illnesses, by giving the policyholder a written notice at least one month prior to the planned amendment of Annex No 1. If the policyholder does not agree with the change, the policyholder must notify the insurer about it in writing. In this case, the policyholder shall have the right to modify the terms and conditions of the insurance contract in relation to this *Additional Insurance Condition* or to terminate the insurance contract free of charge. If the policyholder fails to contact the insurer in writing regarding the termination of the insurance contract or amendment of the terms and conditions by the date specified in the notification, it shall be deemed that the policyholder has agreed to the change.

Insurance benefit in case of an exclusion

500.9. In the event of occurrence of an exclusion or an event occurring after insurance coverage has been suspended, the insurer shall not pay any insurance benefits.

Deadlines for reporting an insured event

500.10. The insurer must be notified about the insured event in writing as soon as possible and in any case within one month of the date of diagnosis or the last day of the hospital treatment leading to the diagnosis.

Documents to be submitted when applying for an insurance benefit

500.11. When contacting the insurer for payment of insurance benefit, the following documents must be provided:
500.11.1. the document confirming the identity of the person claiming the insurance benefit;
500.11.2. the document confirming the designation of the beneficiary, if separately signed;
500.11.3. an application indicating the date, place of the insured event, the nature and duration of inpatient or outpatient treatment, as well as the beneficiary's bank account to which the benefit is to be transferred;
500.11.4. detailed medical certificates from the healthcare institution(s) with a precise confirmed diagnosis, a description of the medical history, tests and treatment administered to determine whether the diagnosis corresponds exactly to the criteria set out in Annex No 1 to this *Additional Insurance Condition*;
500.11.5. document constituting proof of disability or incapacity for work, if the insured person has been issued one.
500.12. The insurer may require other documents not listed in paragraph 500.11 of these insurance terms and conditions, which are necessary to establish the validity of the insurance benefit and the amount of the benefit.
500.13. The insurer may require the diagnosis to be confirmed at the insurer's expense by a health care institution specified by the insurer.
500.14. If the document is issued by a foreign authority, the insurer may require a duly certified translation of the document into Lithuanian. The insurer shall not reimburse translation costs.

Beneficiary of the insurance benefit

500.15. The insurance benefit shall be paid to the insured person, unless the insurance contract specifies a separate beneficiary entitled to the benefits of this *Additional Insurance Condition*.

500.16. No insurance benefit can be paid to a person whose deliberate act (as determined by a court of law) led to the occurrence of an insured event. In this case, the part of the insurance benefit due to the guilty person shall be paid to:

500.16.1. other designated beneficiaries, with a proportional increase in their share of the benefit;

500.16.2. the insured person if no other beneficiaries have been designated.

500.17. If, after the insured event, the beneficiary dies before receiving the insurance benefit, the insurance benefit shall be paid to the deceased beneficiary's legal heirs.

ADDITIONAL INSURANCE CONDITION NO 500 ANNEX NO 1: LIST OF CRITICAL ILLNESSES

1. Cancer
2. Myocardial infarction
3. Stroke
4. Coronary heart bypass surgery
5. Replacement or restoration of function of a heart valve
6. Cardiomyopathy
7. Aortic surgery
8. Primary pulmonary hypertension
9. Benign brain tumour
10. Motor neurone disease
11. Muscular dystrophy
12. Brain damage
13. Coma
14. Encephalitis
15. Bacterial meningitis
16. Neuroborreliosis
17. Multiple sclerosis
18. Parkinson's disease
19. Alzheimer's disease
20. Type 1 diabetes mellitus
21. Aplastic anaemia
22. Pulmonary insufficiency
23. Hepatic insufficiency
24. Renal insufficiency
25. Internal organ transplantation
26. Loss of limbs/loss of limb function
27. III-degree burns
28. Blindness
29. Deafness
30. Aphasia
31. Total and permanent disability

1. Cancer

Cancer is the uncontrolled growth, spread and penetration of malignant cells into tissues. Cancer definition also includes leukaemias and lymphomas. The insurance benefit shall be paid only if there is indisputable evidence of tissue invasion and when the malignancy of the cells is confirmed histologically. No benefit shall be paid for localised non-invasive tumours with only early malignant changes (carcinoma in situ), pre-cancerous diseases and tumours, where the insured person has been diagnosed with HIV/AIDS, and any skin cancer other than malignant melanoma.

2. Myocardial infarction

A myocardial infarction shall mean an irreversible damage (necrosis) to part of the heart muscle, which develops when there is a sudden loss of sufficient blood supply to the area of the heart muscle in question.
The diagnosis must be based on at least two of the three criteria listed below:
1) Typical chest pain;
2) New electrocardiographic abnormalities characteristic of myocardial infarction;
3) Increase in blood levels of biochemical markers specific for myocardial infarction.

3. Stroke

Acute non-traumatic cerebral circulatory disorder resulting in irreversible death of brain tissue due to intracranial haemorrhage, thrombosis of an intracranial blood vessel or embolism. The insurance benefit shall only be paid if the **permanent neurological deficit*** persists for at least 3 months after the stroke.

4. Coronary heart bypass surgery

Open heart surgery to correct narrowing or occlusion of one or more of the coronary vessels of the heart using shunt(s). Narrowing or occlusion of the coronary heart vessels must be documented by angiography.
No insurance benefit shall be paid for angioplasty, other intra-arterial or laser procedures.

5. Replacement or restoration of function of a heart valve

Surgery to replace or restore the function of one or more heart valves. The insurance benefit shall be provided for both open and minimally invasive procedures, such as endovascular surgery.

6. Cardiomyopathy

A definite diagnosis of primary cardiomyopathy confirmed using the diagnostic methods available at the time of diagnosis. The insurance benefit shall be paid if the insured person is diagnosed with Class III-IV heart failure (according to the New York Heart Association (NYHA) Classification of Heart Failure).
No insurance benefit shall be paid for secondary (ischaemic, arrhythmogenic, metabolic, toxic or hypertensive) cardiomyopathies.

7. Aortic surgery

Surgery to remove an aneurysm, stenosis, blockage or unblocking of the aorta. The definition of the aorta includes the thoracic and abdominal parts of the aorta, but not its branches. The insurance benefit shall be provided for both open and minimally invasive procedures, such as endovascular surgery.

8. Primary pulmonary hypertension

A definite diagnosis of primary pulmonary hypertension confirmed using the diagnostic methods available at the time of diagnosis. The insurance benefit shall be paid if the insured person is diagnosed with Class III-IV heart failure (according to the New York Heart Association (NYHA) Classification of Heart Failure).
No insurance benefit shall be paid for secondary pulmonary hypertension.

9. Benign brain tumour

A non-malignant tumour of the brain, cranial nerves or meninges, resulting in any of the following:
1) the tumour causes a **permanent neurological deficit*** that persists for at least 3 months;
2) invasive surgery to remove all or part of the tumour;
3) stereotactic radiosurgery or chemotherapy to destroy tumour cells.

No insurance benefit shall be paid in cases of cysts, granulomas, haematomas, malformations of the cerebral arteries or veins, tumours of the pituitary gland, or if the insured person has been diagnosed with HIV/AIDS.

10. Motor neurone disease

A definite diagnosis of motor neurone disease confirmed using the diagnostic methods available at the time of diagnosis. The insured person must have permanent motor function impairment.
The insurance benefit shall be paid if the condition lasts for at least 3 months.
The benefit shall be paid for all motor neurone diseases, including progressive spinal muscular atrophy.

11. Muscular dystrophy

A definite diagnosis of muscular dystrophy confirmed using the diagnostic methods available at the time of diagnosis. The insured person must have progressive muscle weakness and wasting characteristic of the disease.

12. Brain damage

Brain damage resulting from an accident causing a **permanent neurological deficit*** that persists for at least 3 months from the date of the accident. No insurance benefit shall be paid if the accident is caused by the abuse of alcohol, medicines, drugs or other psychotropic substances.

13. Coma

A profound loss of consciousness with no response to any external stimuli. The insurance benefit shall be paid if the coma lasts for at least 96 (ninety-six) hours and results in a **permanent neurological deficit*** that persists for at least 30 days from the start of the coma. No insurance benefit shall be paid if coma is caused by the abuse of alcohol, medicines, drugs or other psychotropic substances, or if the coma is induced by medication for therapeutic purposes.

14. Encephalitis

A definite diagnosis of encephalitis leading to a **permanent neurological deficit*** that persists for at least 3 months after diagnosis. The diagnosis must be based on typical clinical symptoms and the results of cerebrospinal fluid tests.
No insurance benefit shall be paid when the insured person has been diagnosed with HIV/AIDS, and myalgic or paraneoplastic encephalomyelitis.

15. Bacterial meningitis

A definite diagnosis of bacterial meningitis leading to a **permanent neurological deficit*** that persists for at least 3 months after diagnosis.
The diagnosis must be based on typical clinical symptoms and the results of cerebrospinal fluid tests. No insurance benefit shall be paid for all other forms of meningitis, including viral meningitis.

16. Neuroborreliosis

Neurological manifestations of tick-borne Lyme disease. The insurance benefit shall be paid only if there is a definite diagnosis of neuroborreliosis and if the disease causes a permanent neurological deficit* that persists for at least 3 months after diagnosis.

17. Multiple sclerosis

A definite diagnosis of multiple sclerosis that meets all of the following criteria:
1) clinically confirmed impairment of motor or sensory functions, persisting continuously for at least 6 months.
2) diagnosis must be confirmed by the diagnostic criteria for multiple sclerosis in force at the date of diagnosis.

18. Parkinson’s disease

A definite diagnosis of Parkinson’s disease confirmed using the diagnostic methods available at the time of diagnosis. The insured person must have permanent motor function impairment and associated tremor or muscle rigidity.
The insurance benefit shall be paid if the condition lasts for at least 3 months.
No insurance benefit shall be paid for Parkinson’s syndromes, including those caused by toxic agents or alcohol or drug abuse.

19. Alzheimer's disease

A definite diagnosis of Alzheimer's disease confirmed using the diagnostic methods available at the time of diagnosis. The illness must be manifested by persistent symptoms and must be supported by evidence of a progressive loss of the ability to remember, reason and perceive, understand, express and implement ideas.

20. Type 1 diabetes mellitus

A definite diagnosis of Type 1 diabetes, requiring regular insulin injections. No insurance benefit shall be paid for Type 2 diabetes (including Type 2 diabetes treated with insulin), gestational diabetes and other glucose tolerance disorders.

21. Aplastic anaemia

A definite diagnosis of aplastic anaemia confirmed using the diagnostic methods available at the time of diagnosis. The insurance benefit shall be paid if the insured person is diagnosed with irreversible bone marrow failure with anaemia, neutropenia and thrombocytopenia.
No insurance benefit shall be paid for temporary aplastic anaemia.

22. Pulmonary insufficiency

Chronic lung disease with respiratory failure. The insurance benefit shall be paid if the diagnosis meets all of the following criteria:

1) Daily use of oxygen therapy for at least 3 months is required;
2) Forced vital capacity (FVC) is less than 50% of norm;
3) Forced expiratory volume in 1 second (FEV1) is 50% below the age-standard. The decrease in forced expiratory volume shall be determined in at least two measurements with a minimum interval of one month between measurements.

23. Hepatic insufficiency

Irreversible hepatic insufficiency due to liver cirrhosis.
The insurance benefit shall be paid if the insured person suffers from any of the following symptoms:

1) Persistent jaundice;
2) Ascites;
3) Hepatic encephalopathy.

No insurance benefit shall be paid if irreversible hepatic insufficiency is caused by the abuse of alcohol, medicines, drugs or other psychotropic substances.

24. Renal insufficiency

Chronic and end-stage renal insufficiency, requiring regular dialysis on a permanent basis. No insurance benefit shall be paid for acute renal failure requiring only temporary dialysis.

25. Internal organ transplantation

Bone marrow, heart, kidney, liver, lung or pancreas transplant surgery where the insured person is the recipient, or the insured person is placed on an official waiting list for this procedure. The insurance benefit shall not be paid to donors.

26. Loss of limbs/loss of limb function

Total and permanent loss of two or more limbs due to an accident or disease. Loss of a limb shall be defined as the loss of a limb or its function above the wrist or ankle joint. In some cases, the loss of limb function may be temporary, in which case the benefit shall be paid if the loss of limb function persists for 3 months after diagnosis and is confirmed by a specialist doctor on the basis of clinical symptoms and diagnostic tests.

27. III-degree burns

III-degree burns, which cover at least 20% of the body's surface area and destroy all layers of skin. The diagnosis and the total affected area must be confirmed by a medical specialist using standardised, clinically acceptable methods for measuring body surface area.

28. Blindness

Permanent and irreversible loss of vision in both eyes due to an accident or disease. Loss of vision shall mean a situation where at the time of the examination, even with the use of visual correction, the visual acuity of the better-seeing eye is less than 6/60 measured in the metric system or 0.1 on the decimal scale of visual acuity, or there is a reduction of 20° or less in the field of vision of both eyes. No insurance benefit shall be paid if the condition can be corrected by therapeutic or surgical treatment.

29. Deafness

Permanent and irreversible hearing loss in both ears due to an accident or illness. Hearing loss shall mean a situation where an audiometric test reveals a hearing threshold of at least 90 dB in the better-hearing ear across all frequency ranges. No insurance benefit shall be paid in cases where the condition can be corrected by medical means, including hearing aids or surgical procedures.

30. Aphasia

Total, permanent and irreversible loss of the ability to speak due to an accident or illness. The insurance benefit shall also be paid in cases of loss of speech due to surgery or medical treatment for a medical condition. The diagnosis of aphasia must be confirmed by a medical specialist. The insurance benefit shall be paid if the total loss of speech persists for 6 months after the diagnosis. No benefit shall be paid if the loss of the ability to speak is due to a mental disorder.

31. Total and permanent disability

Significant loss of physical or mental capacity caused by an accident or illness, which severely limits the insured person's ability to perform any work or self-care.
If the insured person is aged 18 or over, the benefit shall be paid if the competent Lithuanian state authority determines that the insured person has a level of incapacity for work of 25% or less. If the insured person younger than 18, the benefit shall be paid if the competent Lithuanian state authority determines a severe level of disability for the insured person.
The benefit shall be paid only if the level of incapacity for work of 25% or less or the severe disability lasts for a continuous period of 12 months or more.
No insurance benefit shall be paid if the loss of the level of incapacity for work or severe disability is due to a mental or behavioural disorder. In the event of a change in the official methodologies for determining the level of incapacity for work or severe disability in Lithuania, the insurer may use the revised criteria for determining the level of incapacity for work or severe disability in case of occurrence of an insured event.

*** Permanent neurological deficit** refers to symptoms of neurological impairment identified by a neurologist during a clinical examination. Symptoms include numbness, hyperaesthesia (increased sensitivity), paralysis, local weakness, dysarthria (speech impairment), aphasia (inability to speak), dysphagia (difficulty in swallowing), visual impairment, difficulty in walking, lack of coordination, tremors, convulsions, lethargy, dementia, delirium and coma.