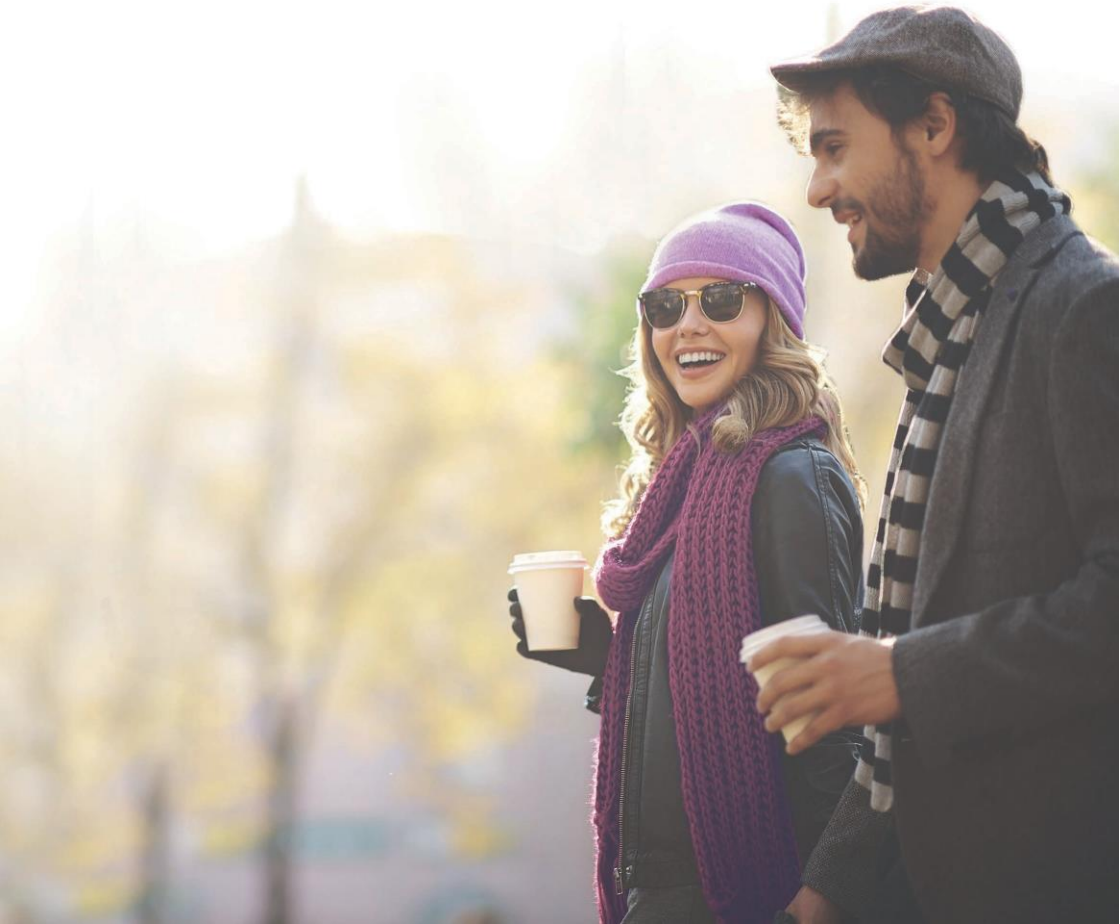
LIETUVOS DRAUDIMAS

HEALTH INSURANCE
TERMS AND CONDITIONS NO 68-6

(Recast version of 21/01/2020, valid as of 27/01/2020)



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DEAR CLIENT,

Thank you for choosing Lietuvos draudimas. We have extensive experience in carrying out insurance activities, and we continuously seek to ensure the best insurance services for our clients. Our hopes are that you will be satisfied with our insurance coverage the entire year.

Health is the foundation of a good life. Therefore, it is important to take care of it continuously. Our health insurance aims to provide you with top quality health care services quickly and in a convenient manner so that you could have access to both private and state medical institutions at a place convenient for you, ensuring shorter wait in queues without additional financial losses.

We know that you wish to have security of high-quality insurance coverage. Therefore, we kindly ask you to read the insurance Terms and Conditions thoroughly. In these Terms and Conditions we have defined the cases and conditions in which the health insurance shall apply, and most importantly – in which it does not. Please read them carefully, and should you find any paragraph of these Terms and Conditions unclear, feel free to contact the representative of your Lietuvos draudimas branch, or call at 1828, and we will gladly answer any of your questions.

These Terms and Conditions define all possible insurance Terms and Conditions and options allowing employer to select those that are the most relevant. You will find the exact Terms and Conditions of the services that apply specifically to you in the guide which you will receive together with a health insurance card. Comply with these Terms and Conditions and guide at all times.

We hope that Lietuvos draudimas will help you take care of your health in a simple and convenient manner.

Please note that this address does not constitute an integral part of the insurance Terms and Conditions.

NOTE

Our health insurance is designed in a way allowing in case of an illness to generate maximum value for the customer's convenience within the shortest time possible – should you have any questions related to the coverage, referral to medical institutions or payment for services, please call us at 1828 and our consultants will kindly offer their assistance.

The insurance company has concluded contracts with health care institutions (medical institutions, pharmacies, institutions providing optical, nursing, rehabilitation and other health care services) that can provide health care services to the Insured whenever necessary.

There is a possibility to pay for the medical services by specially developed Lietuvos draudimas health insurance card issued to all the Insured. When payment to the treatment institutions is made using the health insurance card of Lietuvos draudimas, the payment for the services provided shall be made directly under the Terms and Conditions set out in the insurance contract.

There might be cases when the Insured will have to pay for medical services himself. In such cases, it is necessary to submit documentation or information by email or self-service portal Savas LD within 30 days. More information is available in present Terms and Conditions.

For more information, please call us at 1828.

EALTH INSURANCE TERMS AND CONDITIONS NO 68-6
(Recast version of 21/01/2020, valid as of 27/01/2020)

APPROVED BY
Decision No 008/2020 of Insurance Risk Assessment
Committee of Lietuvos draudimas AB of 21/01/2020

POLICYHOLDER, INSURER AND INSURED

1. *Insurer* shall mean Lietuvos draudimas AB.
2. *Policyholder* shall mean a person who has applied to the Insurer for conclusion of an insurance contract, or who has received an offer from the Insurer to conclude an insurance contract, or who has concluded an insurance contract with the Insurer on the basis of Health Insurance Terms and Conditions (hereinafter referred to as T&C).
3. *Insured* shall mean a person related to the Policyholder by employment relations. The Insured shall only be the persons who are specified in the Health Insurance Contract and who have signed a consent allowing the Insurer to process their personal data of special categories. In individual cases, upon agreements with the Insurer, the Insured may be considered a to be a foreign national working in Lithuania, family members of the Policyholder's employee, and other persons.
4. *Indemnity beneficiary* shall mean the Insured or a third party that provided the Insured with health care services, as well as pharmacy, optical, wellness or other institutions that directly or indirectly provide services related to health.

INSURANCE SUBJECT AND COVERAGE

5. *Insurance subject* shall mean the proprietary interest related to the health and health care services of the Insured to whom the coverage shall be granted under these T&C.
6. Health insurance terms and conditions shall be provided in the insurance policy and/or Annexes to the insurance contract.
7. If the terms and conditions provided in the insurance policy do not conform to these insurance T&C, the terms and conditions provided in the insurance policy shall take precedence.
8. In all cases, the coverage shall be related to the following:
   8.1. Medical indications. Medical indications shall mean the symptoms or signs indicating that treatment, diagnosis or medication are necessary.
   8.2. Health disorders. Health disorder shall mean an acute or chronic disease or injury diagnosed by a doctor, which the Insured complains about and which requires an examination or treatment.
   8.3. Health care services. Health care services shall mean inpatient or outpatient treatment of acute or chronic disease treatment services set out in the contract and provided to the Insured according to medical indications, as well as medical examinations and long-term health monitoring services. Treatment shall mean the physician's consultations and medical procedures used to treat a disease or evaluate the health condition. Diagnostics shall mean the laboratory tests, ultrasound scans, X-rays and other diagnostic tests used to evaluate the health condition.
   8.4. Other services listed in these T&C or in the insurance contract.
9. When the Insured receives treatment at the partner health care institutions or other partner institutions, the Insurer shall pay directly to those institutions for the health care or other services provided to the Insured considering the amount of the indemnity granted to the Insured. *Health care institution-partner* shall mean the institution carrying out health care or wellness activities, with which the Insurer concluded a cooperation contract. Other institution-partner shall mean the institution with which Insurer concluded a cooperation contract (the list of institutions-partners is available on Lietuvos draudimas AB website www.ld.lt)
10. In cases provided for in the T&C and/or insurance contract, when seeking treatment, the Insured should have a doctor's referral, issued in accordance with the procedure set forth by the legal acts of the Republic of Lithuania.

SUM INSURED AND DEDUCTIBLES

11. *Sum insured* shall mean a maximum non-recoverable sum of coverage of the insurance scope group or insurance scope group service to each Insured specified in the insurance contract within the limits of which the Insurer provides insurance benefits during the insurance contract period. *Insurance scope group* shall mean a group of services, the insured and non-insured events of which, as well as the maximum benefit are specified in these T&C. Having paid out a part of indemnity, the Insurer's responsibility to pay indemnities shall remain in relation to the remaining part of the relevant Insured's sum insured.
12. The sums insured for outpatient treatment services (insurance scope group A) upon medical indications and in case of health disorders, as well as the employee health check-up (insurance scope group F) shall not be limited.
13. *Deductible* shall mean the sum of money which in each case shall be deducted from the indemnity by the Insurer. The deducted amount shall be paid by the Insured.

UNDERINSURANCE, ADDITIONAL AND DOUBLE

14. Underinsurance shall not be applied in accordance with these T&C.
15. Double insurance is considered to be the case where the same object is insured under several insurance contracts by several Insurers. Each Insurer shall indemnify the loss in proportion to his share of liability, however, the total sum of indemnities shall not exceed the sum of loss.
16. If the insurance contract upon these insurance T&C grants coverage of only a part of the risk (insurance) value, the Policyholder or the Insured shall have the right to conclude a supplementary insurance contract with the same or another Insurer. However, the total sum insured under all insurance contracts shall not exceed the insurable value.
17. The coverage granted under these T&C shall be a voluntary health insurance. The Insurer shall indemnify expenses for specific services, if they cannot be indemnified to the Insured from the Compulsory Health Insurance Fund of the Republic of Lithuania.

INSURANCE COVERAGE TERRITORY

18. The coverage shall be applied in the territory of the Republic of Lithuania, unless the Policyholder and Insurer agree otherwise.
19. Indemnity shall be paid for the expenses due to the insured event specified in the insurance contract incurred in the territory of the Republic of Lithuania, unless the Insurance Contract stipulates otherwise.

VALIDITY PERIOD OF THE INSURANCE CONTRACT. COMMENCEMENT OF THE

20. The insurance policy shall specify the validity period of the insurance contract. Insurance period shall mean the period for which the parties agree to enter into an insurance contract. Usually it is a period of one year.
21. The insurance coverage shall commence on the inception date of the insurance period identified in the insurance certificate, except the cases when the Insured delays to pay the premium due. In such this case, the insurance contract shall become effective according to the procedure specified in paragraph 83.2 of T&C.

INSURED AND EXCLUSIONS

22. The insured event shall mean the event specified in the insurance contract according to these terms and conditions when the Policyholder or the Insured during the contract period assumes the obligation to pay for the health care services in case of health disorders or treatment, diagnosis or other services due to health condition.
23. It shall be required to obtain a prior written confirmation of the Insurer's confirmation in the following cases:
    - Day surgery;
    - Inpatient rehabilitation treatment;
24. General exclusions shall always be considered the following:
    24.1. Health disorders which were directly or indirectly caused by war and force majeure, radiation, acts of terror, as well as mass disasters caused by natural disasters;
    24.2. Health disorders caused by pandemics;
    24.3. Deliberate actions of the Policyholder's or the Insured;
    24.4. Health disorders in case of kidnapping of the Insured or keeping him/her as a hostage;
    24.5. Health disorders caused by deliberate termination or modification of the treatment prescribed by the doctor;
    24.6. Health disorders caused or aggravated due to consumption of alcohol (when more than 1 promille of ethyl alcohol was found in blood) and/or narcotic, toxic or psychotropic substances;
    24.7. Health disorders caused or aggravated due to poisoning with toxic substances, unless it occurs when performing working functions or domestically;
    24.8. Treatment of congenital diseases and complications thereof;
    24.9. Health care services which are not specified (not selected) in the insurance contract;
    24.10. Tests for determination of presence of medicines (except where it necessary for treatment), alcohol and narcotic substances, including heavy metals but except for the cases related to poisoning when performing working functions or domestically;
    24.11. Treatment in case of disorders of the Insured person's health when performing or preparing to commit a deliberate crime;
    24.12. Pregnancy termination (including treatment of complications after this procedure) in the absence of medical indications;
    24.13. Cases where according to documents provided by the Insured, it is impossible to determine the date of the event and circumstances, and the amount of expenses incurred;
    24.14. Treatment of health disorders or prescription of diagnostic tests without medical indications;
    24.15. Health disorders diagnosis, treatment or prevention performed by using non-traditional medical methods or diagnosis and treatment methods unlicensed in the Republic of Lithuania, and when the diagnosis and/or treatment services were provided by the health care institutions unlicensed in the Republic of Lithuania;
    24.16. Cases when the Policyholder and/or the Insured failed to provide information which could have impact on the conclusion of the contract, risk evaluation, and occurrence of the known losses and/or insured event;
    24.17. Cases when the description of the health care services provided (when the Insured submits an application for loss indemnification) is illegible and it is impossible to determine accurately the event, diagnosis, prescribed treatment or any other important information according to the documents provided. In this case, the Insured can within 30 (thirty) calendar days contact the health care service provider with a request to provide accurate, legible information about the services provided;
    24.18. Cases when the services and/or products were provided and/or sold not to the Insured but another person, or provided and/or sold to the Insured, which, however, by their nature were intended for another person;
    24.19. Treatment and diagnosis of health disorders suffered while doing professional sports;
    24.20. Treatment of addictions.
25. Insured person's exclusions when purchasing the following:
    25.1. Medicines for treatment of addictive disorders;

25.2. Antineoplastic medicines (medication for treatment of oncology and oncohaemathological diseases) except for the first stage oncology diseases;
25.3. Medicines not registered in the Register of Medicinal Products of the State Medicines Control Agency under the Ministry of Health or the EU Community Register of Medicinal Products;
25.4. Medicines and contraceptives affecting sex hormones and sexual system, as well as medicines to increase potency;
25.5. Medicines for the systemic enzyme therapy;
25.6. Dental aligners (bleaching, myorelaxation, sports, treatment of bruxism);
25.7. Hygiene products, except the cases of post-surgical treatment;
25.8. Hearing aids, scales, thermometers and blood pressure monitors;
25.9. Spectacle care accessories (spectacle cases, cleaners, etc.), sunglasses (photochromic corrective lenses shall not be considered sunglasses), frames (if purchased separately without lenses).

26. The Insurer shall not provide indemnification of the following health care services:
26.1. Prenatal care, childbirth and care after childbirth;
26.2. Health disorders caused by pregnancy, childbirth and breast-feeding and/or which developed or were aggravated after childbirth (gynaecological, breast and neurological pathology);
26.3. Chronic degenerative disease diagnosis and treatment (multiple sclerosis, Alzheimer's disease, muscular dystrophy, Parkinson's disease);
26.4. Systemic and autoimmune disease diagnosis and treatment (rheumatism, rheumatoid arthritis, systemic lupus erythematosus, progressive systemic sclerosis or scleroderma, dermatomyositis, autoimmune thyroiditis and autoimmune hepatitis);
26.5. Consultations on family planning and contraception, insertion, control or removal of contraceptive devices, diagnostic examination prior to prescription of contraceptives and testing in order to prevent complications due to use of these contraceptives;
26.6. Plastic aesthetic surgical treatment, aesthetic dermatology therapy (including phototherapy, photodynamic therapy, pulsed light therapy, laser), as well as acne and comedonal acne, pigmentation disorders, and other aesthetic services;
26.7. AIDS, HIV, syphilis, gonorrhoea, trichomoniasis, chlamydia, ureaplasma, human papillomavirus, genital herpes (herpes genitalis) and other sexually transmitted diseases diagnosis and treatment;
26.8. Chemotherapy and radiation treatment of oncology diseases;
26.9. Psychotherapeutic treatment of more than 10 sessions;
26.10. Infertility, impotence diagnosis and treatment, IVF procedures;
26.11. Organ transplantation surgeries, bone marrow transplantations, hemodialysis procedures, stem-cell therapy;
26.12. Organ and joint replacement surgeries;
26.13. Therapeutic and surgical treatment of obesity, treatment of excessive weight, colonic hydrotherapy, food intolerance tests);
26.14. Treatment and/or removal of benign tumours, warts, papillomas and other lipomas (dysplastic nevi treatment shall be paid);
26.15. Surgical treatment of spider veins and varicose veins in legs (surgery, sclerotherapy, radiofrequency treatment);
26.16. Nail fungus laser treatment.

INSURED RISKS

27. Insured risks are grouped into relevant insurance scope groups from A to K.
28. Selected insurance scope is indicated in the insurance contract.
29. All or part of the group risks may be selected.
30. If the Insurer and the Policyholder agree upon insurance of other risks insurance not provided in these T&C, then the coverage and terms and conditions thereof shall be set out in the insurance contract.

A. OUTPATIENT TREATMENT

31. The sum insured for outpatient services shall not be limited.
32. The deductible shall be indicated in the insurance contract.
33. The referral shall not be required in order to register for a specialist's consultation. The referral is necessary in the following cases:
    - When referring for laboratory and other diagnostic tests (e.g., ultrasound scans, endoscopic tests, ECG, röntgen, etc.);
    - When referring to another specialist for the same disease (second opinion), where no less than 1 month has elapsed since the first referral.
34. The following outpatient treatment and diagnostic services are possible:
    34.1. Specialists' services:
        a) General physician, internal medicine specialist consultations;
        b) Nursing services;
        c) Specialist consultations and procedures;
        d) Psychotherapist services.
    34.2. Laboratory tests:
        a) General blood test, urinary and coprological tests;
        b) Biochemical blood tests;
        c) Thyroid gland and other hormone tests;
        d) Allergy tests;
        e) Bacteriological and viral tests;
        f) Immunological tests;
        g) Blood specific markers;
        h) Cytopathological and histological tests.
    34.3. Diagnostic tests and procedures:
        a) X-rays, ECG (electrocardiograms);
        b) Ultrasound scans;
        c) Endoscopic tests;
        d) Functional and other diagnostic tests;
        e) MRI (magnetic resonance imaging), CT (computed tomography), angiography.
35. Insured events and exclusions of outpatient services:
    35.1. The insured event is considered to be the outpatient treatment of the Insured person's health disorders provided for in the insurance contract, and diagnosis thereof, other health care services indicated in the contract and related to the diagnosis and treatment of the Insured;
    35.2. The event shall be deemed insured only if a doctor or a nurse providing health care services acts in accordance with the procedure established by law within his/her competences and possesses a valid license issued by the State Health Care Accreditation Agency;
    35.3. The physiotherapy (ultrasound therapy, electrostimulation, light therapy, non-surgical laser treatment, etc.) and rehabilitation (kinesiotherapy, massage, manual therapy, etc.) services shall not be compensated.
    35.4. The outpatient dentistry services, such as odontologist consultations, procedures, diagnostic tests of dental diseases (X-rays, etc.) shall not be compensation.
    35.5. Common exclusions are valid in accordance with paragraphs 24–26.

B. INPATIENT TREATMENT

36. The sum insured and deductible for inpatient treatment are indicated in the insurance contract.
37. Inpatient treatment shall mean the services provided by private and/or public hospitals (services provided by doctors and nurses, diagnostic tests and medicinal products). Inpatient treatment includes the following:
    a) Non-surgical treatment;
    b) Surgical treatment;
    c) One- or two-bed ward;
    d) Day inpatient services, including surgical treatment;
    e) Catering in a health care institution;

f) Individual inpatient treatment services (services set out in the supplementary terms and conditions of the insurance contract).

38. Insured events and exclusions of inpatient treatment:
    38.1. The insured event is considered to be the inpatient treatment of the Insured indicated in the insurance contract;
    38.2. The event shall be deemed insured only if a doctor or a nurse providing health care services acts in accordance with the procedure established by law within his/her competences and possesses a valid license issued by the State Health Care Accreditation Agency;
    38.3. Day inpatient service shall mean the scheduled treatment and/or diagnostic personal health care of up to 8 hours;
    38.4. Day surgical services must conform with the list of day inpatient services approved by the order of the Minister of Health of the Republic of Lithuania (at the moment of approval of T&C, Order No V-668 of 21 August 2009 was in force);
    38.5. Common exclusions are valid in accordance with paragraphs 24–26;
    38.6. Additional exclusions of inpatient treatment:
        - Inpatient rehabilitation treatment;
        - Aesthetic plastic surgery;
        - Aesthetic dermatology therapy (including phototherapy, photodynamic therapy, pulsed light therapy, laser), as well as acne and comedonal acne, pigmentation disorders, nevi, warts and papilloma treatment;
        - Cosmetic procedures;
        - Treatment of foot bone deformations;
        - Vision correction procedures and surgery;
        - Tissue and organ transplant surgery;
        - Endoprosthesis acquisition and joint endoprosthesis surgery;
        - Palliative care and care in specialised inpatient institutions (permanent, long-term care for the elderly, disabled people and patients with chronic diseases, nursing services, including nursing at home, in a nursing care institution, medical centre and social welfare institution).

C. DENTAL TREATMENT

39. The sum insured and deductible for dental treatment are provided for in the insurance contract.
40. Dental treatment shall include the following:
    a) Dental treatment and oral hygiene services;
    b) Dental prosthetic services;
    c) Orthodontic treatment.
41. Insured events and exclusions of dental services:
    41.1. The insured event shall be considered to be the outpatient treatment and diagnosis necessary to the Insured upon medical indications;
    41.2. Common exclusions are valid in accordance with paragraphs 24–26;
    41.3. Excluded dental treatment costs:
        a) When indemnity is requested without using the service;
        b) Aesthetic tooth whitening and filling expenses;
        c) Acquisition of supplementary hygiene products.

D. REHABILITATION TREATMENT

42. The sum insured and deductible for rehabilitation services are indicated in the insurance contract. The number of rehabilitation services (listed in parts a, b and c of paragraph 43) may be limited by the insurance contract.
43. Rehabilitation services include:
    a) Physiotherapy procedures;
    b) Occupational therapy, kinesiotherapy sessions;

c) Halotherapy;
d) Water and mud procedures;
e) Manual therapy sessions;
f) Massages;
g) Inpatient rehabilitation treatment after hospitalisation;
h) Rent of crutches and walkers;
i) Rehabilitation equipment (functional bed, wheelchair) rent;

44. Insured events and exclusions of rehabilitation services:
44.1. The insured event shall be the rehabilitation outpatient and/or inpatient treatment necessary to the Insured upon medical indications (with a doctor's referral), other health care services provided for in the contract which are subject to coverage;
44.2. Common exclusions are valid in accordance with paragraphs 24–26;
44.3. The rehabilitation services expenses shall not be indemnified in the following cases:
- There is no clear pathology or established diagnosis (listed in ICD-10 code) due to which the rehabilitation treatment is necessary;
- Under the present insurance T&C, this disease in considered to be an exclusion. Therefore, the rehabilitation treatment of complications or symptoms of this disease are considered to be an exclusion;
- Long-term health disorders caused by degeneration changes and osteochondrosis;
- Inpatient rehabilitation services were provided without the Insurer's professional doctor's written approval prior to provision of the service.

E. MEDICINES AND MEDICAL AIDS

45. The sum insured and deductible for the medicines and medical aids are indicated in the insurance contract.
46. Medicines and medical aids indemnity shall include the following:
a) Premiums for medicines and medical aids reimbursable from the funds of the Compulsory Health Insurance Fund budget (prescribed and issued by the reimbursable medicine prescription) (deductible shall not apply to these premiums);
b) Prescription medicines and medical aids which are not indemnified by Compulsory Health Insurance Funds (prescribed and issued by the regular prescription);
47. Insured events and exclusions of medicines and medical aids shall include the following:
47.1. The insured event shall be considered to be the purchase of medicines or medical aids prescribed to the Insured according to medical indications (medicines must be registered in the State Medicines Control Agency and have the ATC (Anatomical Therapeutic Chemical) code);
47.2. Common exclusions are valid in accordance with paragraphs 24–26.
47.3. The Insurer shall not indemnify the expenses for the following medication and medical aids:
- Medication for addiction treatment;
- Antidiabetic medicines;
- Antineoplastic medicines (used to treat cancer);
- Contraceptive medicine and medical aids;
- Sex steroids;
- Weight loss medicines;
- Potency enhancing medicines;
- Food supplements and additives, homeopathic medicines not included in register of medicinal products;
- Medicines for the systemic enzyme therapy;
- Spectacle frames, spectacle care products and accessories (spectacle cases, cleaners etc.), sunglasses;
- Rehabilitation measures (wheelchairs, functional beds);
- Hygiene and cosmetic products;
- Thermometers, inhalers, testers, warmers, hearing aids, scales and blood pressure monitors;
- Medicines with illegible prescriptions.

F. PREVENTIVE EMPLOYEE HEALTH CHECK

48. The sum insured for preventive employee health check-up services shall not be limited.
49. Preventive employee health check-up services shall include preventive employee health checks required by the law.
50. Only the services provided by medical institutions indicated in the insurance contract shall be indemnified.
51. Insured events and exclusions of preventive employee health checks:
    51.1. The insured event shall be considered to be the preventive health checks of the Policyholder's employees provided for in the insurance contract and required in accordance with the requirements of the legal acts;
    51.2. The event shall be considered insured only if preventive services were provided in the institution specified in the insurance contract;
    51.3. The preventive health checks shall not be indemnified if performed more frequently than required by the legal acts.

G. OPTICAL SUPPLIES AND SERVICES

52. The sum insured and deductible for optical supplies and services are indicated in the insurance contract.
53. Optical supplies and services include the following:
    a) Service of spectacle selection;
    b) Purchase of one pair of spectacle lenses during the validity period of the insurance contract;
    c) Purchase of one spectacle frame (including lenses) during the validity period of the insurance contract;
    d) Purchase of contact lenses during the validity period of the insurance contract;
    e) Spectacle repairs expenses;
    f) Costs of producing of one pair of spectacles during validity period of the insurance contract;
54. Insured events and exclusions of optical supplies and services:
    54.1. The insured event shall be considered to be the purchase of spectacles or corrective lenses prescribed to the Insured by a doctor according to medical indications and related costs of selection, production and/or repair;
    54.2. Common exclusions are valid in accordance with paragraphs 24–26;
    54.3. The following optical supplies and services expenses shall not be indemnified:
        - Spectacle care products, non-corrective spectacle lenses and accessories (spectacle cases, cleaners, napkins, chains and other products);
        - Sunglasses (except photochromic and corrective lenses);
        - Optical aids not intended for the Insured.

H. WELLNESS SERVICES

55. The sum insured and deductible for wellness services are indicated in the insurance contract.
56. Wellness services shall include the following services provided by the health care institutions:
    a) Kinesiotherapy sessions, kinesiotherapist consultations;
    b) Therapeutic massages, manual therapy sessions;
    c) Water and mud procedures;
    d) Halotherapy;
57. The list of wellness services is exhaustive and specified in paragraph 56.
58. Insured events and exclusions of wellness services:
    58.1. Common exclusions are valid in accordance with paragraphs 24–26;
    58.2. If long-term wellness services membership is provided and its duration is longer than the date of the insurance contract expiry, expenses for such membership for the period following expiration of the insurance contract shall not be indemnified, and the benefit shall be reduced proportionally to the validity period of the insurance coverage.

59. If long-term wellness services membership is provided and its duration is longer than the date of the insurance contract expiry, expenses for such membership for the period following expiration of the insurance contract shall not be indemnified, and the benefit shall be reduced proportionally to the validity period of the insurance coverage.

I. PRENATAL CARE

60. The sum insured and deductible for prenatal care services are indicated in the insurance contract.
61. Prenatal care services include the following:
    a) Prenatal check-ups, doctors' consultations, pregnancy monitoring tests;
    b) Prenatal exercise and water aerobics;
    c) Prenatal complications diagnosis and treatment;
    d) Childbirth care;
    e) One- or two-bed ward during childbirth and after childbirth.
62. Insured events and exclusions of prenatal care:
    62.1. The insured event shall be considered to be the expenses for the necessary prenatal care services provided to the Insured upon medical indications;
    62.2. Common exclusions are valid in accordance with paragraphs 24–26 (except the events provided in 26.1 and 26.2);
    62.3. Expenses on prenatal care services, which are not included in the list provided in paragraph 61 and/or are not additionally listed in the insurance contract, shall be excluded;
    62.4. When the Insured is a male, the insured event shall be considered to be only the payment for separate ward services for the mother during the childbirth period, and after the mother gives birth to a child whose father he is;
    62.5. Exclusions of prenatal care services:
        - Abortion (including treatment of complications following this procedure) in the absence of medical indications;
        - Childbirth care in an unlicensed heath care institution or at home.

J. ADDITIONAL MEDICAL SERVICES

63. The sum insured and deductible for additional medical services are provided in the insurance contract.
64. The following additional medical and wellness services and aids shall be indemnified:
    a) Health care services which were provided without a doctor's referral or without providing all medical documentation, preventive check-ups and consultations;
    b) B-E, G-I services selected when the limits of these services are exceeded;
    c) B-E, G-J services selected by a general limit, if separate service limits are not specified and/or those limits are exceeded, if specified;
    d) Individual medical services (services set out in the additional terms and conditions of the insurance contract);
    e) Medicines, vitamins, nutritional supplements and medical aids purchased at pharmacies;
    f) Vaccines (vaccinations);
    g) Nursing services not in treatment or rehabilitation institutions in case of an illness when a doctor's regime was prescribed (purchase of medicines purchased, injection of medicine, procedures).
65. Insured events and exclusions of additional medical services:
    65.1. The insured event shall be considered to be the expenses incurred by the Insured on the medical services and aids listed in paragraph 64;
    65.2. The Insured event shall be considered to be the expenses incurred by the Insured on individual services (if they are not insured under any other relevant insurance risks scope group), agreed upon individually and listed in the additional terms and conditions of the Insurance Contract;
    65.3. Common exclusions are valid in accordance with paragraphs 24–26 (except the events provided in 24.14);
    65.4. Exclusions of additional medical services:
        - Purchase of medical aids;
        - Purchase hygiene and cosmetic products;
        - Sports activities without medical indications;

- Purchase of beauty and aesthetics products and services;
- Accommodation costs.

K. OTHER SERVICES

66. The compliance with the taxation procedures of insurance of other services shall be the duty of the Policyholder. The insurance premium, sum insured and deductible for other services are indicated in the insurance contract.
67. The following other services shall be indemnified:
    a) Sports activities (without medical indications) in sports and wellness clubs, non-therapeutic massages;
    b) Transport cost to/from the medical institution (by taxi or ambulance) (only in cases of an acute illness or trauma);
    c) Parking costs at the medical institution (only in cases of an acute illness or trauma);
    d) Transportation of children to school by taxi (only in case of incapacity for work);
    e) Delivery of rehabilitation aids (in cases of trauma or disease when such aids are necessary and mandatory);
    f) other individual services (services provided in the additional terms and conditions of the insurance contract).
68. Insured events and exclusions of other services:
    68.1. The insured event shall be considered to be the expenses indicated in paragraph 67, incurred by the Insured;
    68.2. Common exclusions are valid in accordance with paragraphs 24–26;
    68.3. Exclusions of other services:
        - Purchase hygiene and cosmetic products;
        - Purchase of beauty and aesthetics products and services;
        - Amusement aqua arks, sport and wellness entertainment complexes;
        - Accommodation costs;
        - Any other expenses which may be indemnified upon selection of A–J (inclusive) insurance scope groups.

PRE-CONTRACTUAL RIGHTS AND OBLIGATIONS OF THE PARTIES

69. Prior to conclusion of the insurance contract, the Policyholder and/or the Insured shall provide to the Insurer all known information on the circumstances that could have significant impact on the insurance risk. The substantial circumstances, which should be notified to the Insurer by the Policyholder, shall be considered to be the information provided in the application (if it is completed upon the Insurer's request); other information that should be provided in writing upon the Insurer's request, and circumstances indicated in T&C.
70. Prior to conclusion of the insurance contract, the Insurer shall introduce the Policyholder with T&C and present a copy thereof.
71. Prior to conclusion of the insurance contract, the Insurer shall have the right:
    71.1. To request that the Policyholder provides all the information specified in the application necessary to assess the insurance risks (insurance risks shall mean any probable threat to the Insured within the scope of the present T&C (health disorders or illness));
    71.2. To refuse to conclude the insurance contract without stating the reasons.

CONCLUSION OF THE INSURANCE CONTRACT

72. In order to conclude an insurance contract, the Policyholder shall submit an application to the Insurer or otherwise express his intention to conclude an insurance contract. The application should provide the minimum Insurer’s requested information, necessary to conclude the insurance contract. Application shall mean a document of the format determined by the Insurer.
73. The Policyholder shall be responsible for the accuracy of the data provided in the application.

74. The Policyholder shall be obliged to inform all the Insured persons regarding the conclusion of the insurance contract and that detailed information on processing of personal data is published on www.ld.lt and is available at the customer service points.
75. The Insurance Terms and Conditions shall be determined upon the agreement between the Insurer and the Policyholder considering the information and documents provided by the Policyholder.
76. The insurance contract shall be concluded in writing and its conclusion shall be approved by the insurance policy issued by the Insurer.
77. The indemnity beneficiary may be the Insured or health care institutions, institutions providing wellness services, pharmacies, optician's, as well as the institutions providing planned assistance services and institutions that have concluded cooperation contracts on relevant services with the Insurer. In exceptional cases, an indemnity beneficiary may be the Policyholder, if he paid for the services provided to the Insured to the institutions above. Where the insurance scope group F (Preventive employee health check) is selected, an indemnity beneficiary may be the Policyholder or health care institutions.
78. Inclusion or exclusion of the Insured persons into/from the list of Insured:
    78.1. The coverage of the Insured shall be terminated only in cases where during the validity period of the insurance contract the employee is dismissed or on the special long-term leave; the insurance coverage shall be terminated as of the date of termination of the employment relations or from the start of the special long-term leave. Upon request of the Policyholder, the coverage of the Insured who were dismissed or on a long-term leave, may continue to be valid; in this case, the Insured shall not be removed from the list of Insured, and the Policyholder shall continue payment of the premiums for the Insured. The exclusion of the Insured from the list of Insured shall be documented upon a request provided no later than within 7 calendar days.
    78.2. If during the validity period of the insurance, the Policyholder wants to add additional employees to the list of Insured, such employees shall be included upon an application. The coverage of additionally included Insured shall be provided in the amended insurance contract.
79. In order to conclude the insurance contract, the Policyholder shall present to the Insurer the personal ID number, name and surname of the Insured person, indicate the coverage selected, sums insured and deductibles.

CALCULATION AND PAYMENT OF THE INSURANCE PREMIUMS

80. The amount of the premium shall be determined by the Insurer according to the information required for the assessment of the insurance risk that was provided by the Policyholder.
81. The insurance premium and payment terms thereof shall be stated in the insurance contract.
82. The Policyholder shall be obliged to pay the insurance premiums in due time:
    82.1. If the Policyholder fails to provide payment of the first premium or a part thereof, or one of the scheduled premium payments or a part thereof, the payment of which is not related to the coming into force of the insurance contract, before the time indicated in the insurance contract, the Insurer shall notify the Policyholder about it and state that if the Insurer fails to provide payment of the premium or a part thereof within 30 calendar days of the dispatch of this notification, the coverage shall be terminated and resumed only upon payment of the insurance premium or a part thereof by the Policyholder. Upon occurrence of the insured event during the suspension period of the insurance coverage, the Insurer shall not be obliged to pay the insurance benefits.
    82.2. If the Policyholder fails to provide payment of the first premium, the payment of which is related to the coming into force of the insurance contract (in cases where the indicated premium payment deadline is earlier or the same as the effective date of the contract), the insurance contract shall not come into force as of the effective date indicated in the insurance contract. If in such case the premium is paid with delay but no later than within 30 calendar days of the effective date specified in the insurance contract, the insurance contract shall enter into force on the day following the payment of the premium, however, the insurance validity period specified in the insurance contract shall not be extended.
    82.3. Provided that the premium is paid in cash, the payment moment of the premium or a part thereof shall be considered to be the date indicated in the payment document, unless otherwise provided in the insurance contract. Provided that the premium is paid by a bank transfer or automatic debit from the Policyholder's bank account, the moment of payment of the premium or a part thereof shall be considered to be:
        - the date on which the credit institution (bank) credits the funds into the Insurer's account, if the Policyholder's and Insurer's credit institutions are the same;

- the date on which the Insurer's credit institution (bank) receives the funds under the payment order from the Policyholder's credit institution, where the credit institutions of the Policyholder and the Insurer are different banks;
- The signing of an application for an e-invoice or consent to the bank to debit the funds from the Policyholder's bank account automatically shall not be considered to be the premium payment. Where payment is provided by the said methods, the Policyholder shall ensure that the account, from which the insurance premium or a part thereof will be debited, has a sufficient balance to execute the payment. If an incomplete insurance premium or a part thereof is paid (debited) in prejudice to what is stated in the insurance contract, it shall be considered that the insurance premium has not been paid and the amount transferred shall be returned to the Policyholder.

OBLIGATIONS OF THE PARTIES DURING THE VALIDITY PERIOD OF THE INSURANCE CONTRACT

83. During the term of validity of the Insurance contract the Policyholder shall have the following rights:
    83.1. To request that the Insurer terminates or modifies the insurance contract;
    83.2. Upon occurrence of an insured event, to demand that the Insurer provides indemnity in accordance with the procedure set forth by the law and/or insurance contract.
84. During the validity period of the insurance contract, the Insured shall have the following rights:
    84.1. To obtain information on the progress of investigation of the insured event in accordance with the procedure laid down by the law;
    84.2. To familiarise with the personal data processed by the Insurer and require to correct any incomplete, incorrect, inaccurate personal data or to present a legally reasonable objection to the processing of personal data, as well as to implement other rights stipulated in the General Data Protection Regulation
85. During the validity period of the insurance contract, the Policyholder shall have the following duties:
    85.1. To familiarise the Insured persons with the Health Insurance Terms and Conditions and inform them regarding the conclusion of the insurance contract and that detailed information on processing of personal data is published on www.ld.lt and is available at the customer service points;
    85.2. Following the change of the registered address of the Insured indicated in the insurance contract, to notify the Insurer about it in writing within 5 (five) business days;
    85.3. To furnish the Insurer with all information known on the circumstances which may have significant impact on the insurance risk. The substantial circumstances, which the Policyholder should notify the Insurer of, shall be specified in the T&C, application, or the Insurer shall request in writing to notify of them;
    85.4. Upon occurrence of the event, the Policyholder, Insured and Indemnity Beneficiary shall do the following:
        - To notify the Insurer in writing about the event and its circumstances no later than within 30 (thirty) calendar days following the insured event. If the Insured is undergoing inpatient treatment in the health care institution, the insured event and circumstances thereof should be reported not later than within 30 (thirty) calendar days following the last inpatient treatment day of the Insured.
        - To facilitate the Insurer or its authorised representative with the possibility to assess whether the Policyholder complies with the terms and conditions set out in the insurance contract;
        - To facilitate the Insurer or his authorised representative with the possibility to assess whether the Policyholder complies with the requirements to mitigate the insurance risks, where the parties agreed thereupon during conclusion of the insurance contract or during validity thereof, and stated the said in the insurance contract, or where it is required by the law.
86. Upon a written request of the Insurer, the Insured shall be obliged to do the following within 30 (thirty) calendar days:
    86.1. To refund the indemnity or overpaid sum to the Insurer, if after indemnity payment it becomes apparent that pursuant to the terms and conditions provided for in the insurance contract, the indemnity should not have been paid or should have been reduced;
    86.2. To refund the indemnity or overpaid sum to the Insurer, which the Insurer provided to the health care institution or another approved institution, where it becomes apparent that according to the conditions stipulated in the contract, the benefit should not have been paid or should have reduced;

87. During the validity period of the insurance contract, the Indemnity Beneficiary shall have the right:
    87.1. To obtain information on the course of the investigation of the insured event;
    87.2. To request to pay insurance benefit in accordance with the procedure established by the insurance contract;
88. During the validity period of the insurance, Indemnity Beneficiary shall provide the Insurer with all the documents and information regarding the insured event's circumstances and consequences indicated in T&C and required to determine the amount of the indemnity.
89. During the validity term of the insurance contract, the Insurer shall have the right:
    89.1. In case of decrease or increase of the insurance risks, to request to recalculate the premium and/or amend the conditions of the insurance contract; if the Policyholder fails to notify the Insurer about increase of the insurance risks, the Insurer shall have the right to request termination of the insurance contract and loss indemnification, if it is not covered by the premium received;
    89.2. If the insurance contract is terminated upon the initiative of the Policyholder, the contract conclusion and performance expenses shall be deducted from the refundable part of the premium and the benefits provided under the contract;
    89.3. To refuse to include a newly proposed person in the list of Insured and grant the coverage;
    89.4. In case of an insured event:
        - To request additional information and documents from health care and other institutions;
        - To verify accuracy and authenticity of the provided data and documents.
90. During the validity term of the insurance contract, the Insurer shall have the following duties:
    90.1. Not to disclose any information pertaining to the Policyholder, Insured and Indemnity Beneficiary, except in cases established by the law. This Insurer's obligation shall remain both during the validity period of the insurance contract and upon expiry thereof;
    90.2. Having received all the information relevant for determination of the fact, circumstances and outcomes of an insured event, as well as the amount of the indemnity, to pay the indemnity no later than within 15 (fifteen) calendar days;
    90.3. To notify the Policyholder and the Indemnity Beneficiary regarding the course of the insured event investigation pursuant to the procedure established by law;
    90.4. If the event was acknowledged as an insured event, and the Policyholder and the Insurer cannot reach an agreement regarding the amount of the indemnity, the Insurer shall, upon the Policyholder's request, pay an amount equal to the uncontested amount of the indemnity, if accurate determination of the amount of damages takes more than 3 (three) months.
91. The additional rights and obligations of the Policyholder, Insurer and Indemnity Beneficiary shall be defined in the insurance contract, the Civil Code of the Republic of Lithuania, the Republic of Lithuania Law on Insurance and other legal acts.

TERMINATION AND MODIFICATION OF THE INSURANCE CONTRACT

92. The insurance contract may be terminated before the effective date set forth therein and/or during the validity thereof:
    92.1. If following conclusion of the insurance contract, the possibilities for the insured event to occur have disappeared or the insurance risk ceased due to the circumstances unrelated to the insured event. The Insurer shall have the right to a part of premium which is proportional to the period of validity of the insurance contract;
    92.2. Upon request of the Parties to the insurance contract, if one Party notifies the other Party of termination of the insurance contract in writing not later than one month in advance:
        - If the insurance contract is terminated at the initiative of the Insurer upon the consent of the Policyholder, the Insurer shall be entitled to a part of the premium which is proportionate to the insurance contract's period of validity;
        - If the insurance contract is terminated at the initiative of the Insurer, the Policyholder shall be entitled to receive the premium for the remaining validity period of the insurance contract less the costs of conclusion and enforcement of the contract, i.e. 30 %. of the premium shall be refunded to the Policyholder, however, no less than EUR 200. Where it is impossible to deduct the costs of conclusion and enforcement of the insurance contract, these expenses shall be borne by the Policyholder.
    92.3. Following 30 (thirty) calendar days of the moment of notification by one Party to the insurance contract to the other Party of the substantial breach of the insurance contract:

92.3.1. where the insurance contract is terminated upon the Insurer's request because the Policyholder has substantially breached the insurance contract, premiums shall not be returned to the Policyholder;

92.3.2. Having terminated the insurance contract upon the Policyholder's request because the Insurer has subsequently breached the insurance contract, a part of the premium proportional to unused contract period shall be returned to the Policyholder without deducting the expenses on the insurance contract conclusion and execution.

93. The insurance contract shall lapse:

93.1. If the Policyholder fails to provide payment of the first insurance premium or a part thereof before the term set forth in the insurance contract, the payment of which is related to entry into force of the insurance contract, for longer than 30 (thirty) calendar days, unless otherwise provided for in the insurance contract;

94. The insurance contract shall end:

94.1. Upon expiration of the validity period of the insurance contract;

94.2. When the Insurer pays out all the sums insured specified in the insurance contract;

94.3. Upon agreement between the Parties to the insurance contract;

94.4. On the other grounds set forth by law.

95. Upon a written agreement between the Insurer and the Policyholder, the insurance contract may be amended and an amended insurance policy shall be issued.

DOCUMENT SUBMISSION FOLLOWING THE EVENT

96. When the Insured uses the health care service card of Lietuvos draudimas AB to pay for the health care services, the Insured shall not need to submit medical and financial documentation to the Insurer: treatment institution shall submit medical services documents to the Insurer.

97. In other cases, the indemnity shall be paid only after provision of duly recorded legible documents provided below or copies thereof of an acceptable content and form to the Insurer. All the documents or copies thereof shall be provided electronically or by regular mail or via the self-service portal of Lietuvos draudimas AB. Upon request of the Insurer, the request for compensation of expenses of an established format and the documents listed in paragraphs 97.1–97.6 shall be provided;

97.1. The doctor's referral for consultation, tests and procedures;

97.2. The medical documents or copies thereof which reasonably prove the fact and circumstances of the insured event, disease code according to the International Classification of Diseases ICD-10-AM, as well as other information requested by the Insurer to investigate the insured event properly and completely. The documents shall be endorsed by the doctor's signature, stamp and seal of the health care institution;

97.3. The document proving payment for the health care and other services provided in the contract – cash receipt (or other payments document provided for by law) and invoice (or another document proving that the services have been provided to the Insured). The documents shall clearly specify goods purchased or services provided to the Insured;

97.4. The prescriptions or copies thereof to purchase medicines, spectacle lenses or contact lenses;

97.5. A child's certificate of birth;

97.6. A copy of a business license, if the services were provided by the service provider acting in accordance with a business license.

98. By providing the Insurer with paper and electronic documents, the Insured shall be responsible for their accuracy, completeness and timely provision to the Insurer. In cases when copies of the document are provided to the Insurer, the Insured shall retain the original documents at least of a period of one year and provide them to the Insurer upon his request.

CALCULATION AND PAYMENT OF THE INSURANCE BENEFITS

99. The insurance benefit shall be provided no later than within 30 (thirty) calendar days of the date the Insurer receives all information required to establish the fact, circumstances and amount of the insurance benefit of the insured event.
    99.1. If the Insured received the service and used the health insurance card of Lietuvos draudimas AB, pursuant to the terms set forth in the cooperation agreements, the payment for the services shall be provided directly to the treatment institution;
    99.2. If the Insured received services in the institution either acknowledged or not acknowledged by the Insurer and he paid for the medical services himself, and submitted the necessary documents to the Insurer by email or regular mail or via Lietuvos draudimas AB self-service portal, the indemnity shall be paid out within 15 (fifteen) calendar days.
100. The Insurer shall pay the indemnity after deducting the deductible sum and applying other limits of indemnity calculation and/or payment provided for in the insurance contract.
101. The Indemnity Beneficiary shall bear indemnity bank transfer costs related to the charges applied to bank transfers.
102. Any advance write-offs of the sums insured initiated by the treatment institution without providing services shall be considered an exclusion.
103. The indemnities shall be paid directly to the Insurer's acknowledged institutions under the cooperation agreement after deducting the deductibles provided in the insurance contract.
104. If the Insured contacts the treatment institution not acknowledged by the Insurer and pays for the medical services himself, the Insurer (unless agreed otherwise) shall indemnify expenses considering basic prices for personal health care services approved by the Ministry of Health of the Republic of Lithuania, which, however, shall not be exceeded more than four times.
105. If the Policyholder or the Insured fails to fulfil the contract or fulfils it inadequately and it increases the probability of occurrence of the insured event or increase of loss (expenses) due to the insured event, the Insurer shall have the right to reduce the indemnity payable or refuse to pay it altogether.
106. The gym memberships shall be indemnified when purchased upon receipt of the information regarding the visit date and services provided from the service provider or the Insured. If a gym membership purchased is valid for a period longer than for 3 (three) months, the expenses for the first three months shall be indemnified after the purchase date. The later expenses shall be indemnified every 3 (three) months. If a gym membership is longer than the period of validity of the insurance contract, the expenses for the period following expiration of the contract shall not be indemnified and the benefit shall be reduced proportionately to the period of insurance coverage.
107. Other medicines and medical aids shall be indemnified considering the deductible provided in the insurance contract.
108. Massages, water treatments, manual therapy sessions and physical therapy sessions shall be indemnified following provision of the service(s) upon receipt of the information from the service provider or the Insured regarding a visit date and services provided.
109. The decision to pay out the indemnity to the specific Insured person may be deferred, if the Insured has not provided a written consent to process his/her personal data, including sensitive personal data until such consent of the Insured is received.

DISPUTE RESOLUTION AND APPLICABLE LAW

110. The disputes arising in relation to the insurance contract shall be resolved by means of negotiation, and in case of disagreement, the disputes shall be resolved in the courts of the Republic of Lithuania.
111. The Bank of Lithuania (hereinafter – the Supervisory Authority) (correspondence address: Totorių St. 4, LT-01121 Vilnius, www.lb.lt) is competent to resolve disputes between the Insurer and the Policyholder,

if disputes arise in from the insurance relations and the Policyholder (the Insured, the Beneficiary and the aggrieved third party) is a natural person who is concluding or has concluded the contract with the Insurer to meet the personal, family or household needs. The State Data Protection Inspectorate (correspondence address: L. Sapiegos St. 17, LT-10312 Vilnius; www.vdai.lrv.lt) is competent to examine the claims of the infringements of the General Data Protection Regulation.

112. In all the cases not covered by the present T&C and the insurance contract, the provisions of the Republic of Lithuania Law on Insurance and other legal acts shall apply, unless otherwise agreed in writing between the parties to the insurance contract.

TRANSFER OF RIGHTS AND OBLIGATIONS UNDER THE INSURANCE CONTRACT

113. Upon a written contract and receipt of the authorisation of the Supervisory Authority, the Insurer shall have the right to transfer his rights and obligations under the insurance contract to another insurance company or insurance company branch in accordance with the procedure set forth by law of the Republic of Lithuania.
114. In the Insurer's notice to the Policyholder regarding the intention to cede rights and obligations under the insurance contract, a term no shorter than 2 (two) months should be provided. During this term, the Policyholder shall have the right to make written claims to the Insurer regarding objections in respect of the intention to transfer rights and obligations assumed under the insurance contract.
115. If the Policyholder does not agree with the transfer of the rights and obligations under the insurance contract, the Policyholder shall have the right to terminate the insurance contract by a written notice of termination to the Insurer within one month of transfer of the rights and obligations. The insurance contract shall be terminated on the date of receipt of the notice of termination.
116. Following termination of the insurance contract in accordance with this paragraph, a part of the premium for the remaining coverage period shall be returned to the Policyholder.

NOTIFICATIONS

117. Any notification that must be provided by one party to the contract to another party, shall be submitted in writing.
118. The notice sent by regular, registered mail or email at the Insured person's address indicated in the insurance contract, sent by fax to the Insured person's fax number indicated in the insurance contract, if the Insured has chosen such method of receipt of the notices, shall be considered duly delivered in accordance with the present T&C, except for the cases provided in these T&C. The notice shall be deemed to have been duly delivered after a reasonable period of time has elapsed following its dispatch.
119. The Policyholder shall have the right to select the methods of receipt of the documents: receive them free of charge, upon arrival at any Insurer's division or by logging to a self-service portal. If none of the said document receipt methods have been selected, the documents will be sent by mail – fee EUR 0.87. In this case, the documents shall mean the invoices, insurance contracts (insurance policies), notices of overdue premium(s) and notices of contract termination due to unpaid premiums.

Lietuvos draudimas AB
Chairman of the Board

Kęstutis Šerpytis