Adopted by Order No V-12/18 of 28 September 2018 of the CEO of Compensa Life Vienna Insurance Group SE, Lithuanian Branch

SPECIAL TERMS AND CONDITIONS: ADDITIONAL INSURANCE AGAINST CRITICAL ILLNESSES No. 004
Effective from 1 October 2018

1. GENERAL PROVISIONS

1.1. These special terms and conditions: Additional insurance against critical illnesses No. 004 (hereinafter referred to as the Special Terms and Conditions) lay down the terms and conditions and requirements to be applied to the agreements between the Policyholder and the Insurer regarding Additional insurance against critical illnesses concluded in addition to the principal life insurance contract and shall be considered as an integral part of such contracts.

1.2. The Special Terms and Conditions shall be applied only in conjunction with the General Insurance Terms and Conditions of the Insurer. In the event of any conflict between the Special Terms and Conditions and the General Insurance Terms and Conditions, the Special Terms and Conditions shall prevail.

1.3. The terms used in these Special Terms and Conditions shall be defined in the General Insurance Terms and Conditions and/or Special Terms and Conditions.

1.4. The additional insurance shall be the integral part of the principal life insurance contract and shall be invalid without it. The additional insurance shall be subject to the Special Terms and Conditions of the respective principal life insurance to the extent they are not in contradiction of the provisions of these Special Terms and Conditions.

1.4. The Insurance Object shall be the property interests related to the harm to the health of the Insured.

2. ADDITIONAL DEFINITIONS

2.1. In addition to the terms defined in the General Insurance Terms and Conditions, the following capitalized terms used in the Contract and in the communications sent by the parties during performance of the Contract shall have the specific meanings defined in the Contract and its annexes and/or particular content and shall be interpreted respectively, unless the context obviously requires otherwise and/or otherwise provided in the Contract or the respective communications between the parties:

2.1.1. **A critical Illness** shall mean one of the illnesses or conditions indicated in the List of Critical Illnesses selected by the Policyholder.

2.1.2. **The List of Critical Illnesses** shall mean the list of illnesses or statuses indicated in Annexes No. 1, 2 and/or 3 to these Special Terms and Conditions.

2.1.3. **The Additional Insured** shall mean the juvenile children, adopted children, or children in ward of the Principal Insured, who are under 16 as of the date of entering into the Insurance Contract.

3. INSURABLE EVENTS

3.1. The Insured Event shall be considered as the first diagnosis of the Critical Illness from the List of Critical Illnesses selected by the Policyholder or provided for by the Special Terms and Conditions for the Insured or the Additional Insured within the validity period of the Contract.

3.2. The Insurance Indemnity in the event of the Critical Illness shall be paid only 1 (once), despite of the number and type of the Critical Illnesses diagnosed to the Insured or the Additional Insured.

3.3. If several persons (both the Insured and the Additional Insured persons) are insured by the same Contract, then, upon paying the Insurance Indemnity to one Additional Insured, Insurance Coverage will continue to be effective for both the Insured and other Additional Insured persons (is applicable) and the Sum Insured will not be reduced (will continue to be the same). If the Insurance Indemnity is paid to the Insured, the Insurance Coverage shall cease to be effective for the Additional Insured.

3.4. Having regard to the development of medical science or changes in morbidity rate, the Insurer shall be entitled to unilaterally amend and/or supplement the definitions of the Critical Illnesses and/or diagnosing criteria within the validity period of the Contract by giving the written notice of this change to the Policyholder in accordance with the procedure and within the time limits laid down in clauses 13.3.2 and 13.3.4 of the General Insurance Terms and Conditions. The Policyholder shall be entitled to raise the objection to the intended amendments or supplements in accordance with the procedure and within the time limits laid down in clause 13.3.6 of the General Insurance Terms and Conditions. If the Policyholder does not agree with the future amendments or supplements, he shall be entitled to amend the Contract free of charge by waiving the Additional Insurance against Critical Illnesses.

3.5. The date of the Critical Illness or its diagnosing shall be determined by the Insurer's medical officer upon comprehensive examination of all circumstances related to an event, the status of health of the Insured and in accordance with the terms and conditions and requirements set forth in the List of Critical Illnesses.

4. UNINSURABLE EVENTS

4.1. The Insurer shall not pay the Insurance Indemnity due to occurrence of the following Uninsurable Events:

4.1.1. The illness or personal injury of the Insured/the Additional Insured or any consequence thereof which is related to a War or any state of emergency as well as caused by the conscious and voluntary involvement of the Insured/the Additional Insured in any abuse or terrorist act;

4.1.2. The illness or personal injury of the Insured/the Additional Insured or any consequence thereof which is related to Radiation or use of chemical or biological substances for non-peaceful purposes;

4.1.3. The personal injury of the Insured/the Additional Insured or any consequence thereof caused by an attempted suicide or self-inflicted wound;

4.1.4. The illness or personal injury of the Insured/the Additional Insured or any consequence thereof which is related to mass disasters caused by natural disasters or calamities;

4.1.5. The illness or personal injury of the Insured/the Additional Insured or any consequence thereof caused by the deliberate act of the Insured, the Additional Insured, the Beneficiary, Policyholder or any other person who is interested in receipt of the Insurance Indemnity; the attempt to commit a criminal act, or direct or indirect involvement in any criminal act, except for the cases when these deliberate acts or omission have any social value (self-defence, performance of civic duty, etc.);

4.1.6. The Critical Illness of the Insured/the Additional Insured caused by any illness resulting from HIV or AIDS, if HIV or AIDS was diagnosed for the Insured/the Additional Insured before concluding the Contract or during the period of validity of the Contract.

4.1.7. The personal injury of the Insured/the Additional Insured or any consequence thereof, if it occurred as a result of the influence of alcohol, narcotic drugs, psychotropic or toxic substances or medicines used to treat disorders of the central nervous system which, however, had not been prescribed by a doctor to the Insured/the Additional Insured or which had been prescribed but were used without following the instructions given by a doctor on the Insured/the Additional Insured or as a result poisoning of the Insured/the Additional Insured caused by abuse of the abovementioned substances;

4.1.8. The personal injury of the Insured/the Additional Insured or any consequence thereof which is directly or indirectly related to involvement of the Insured/the Additional Insured in the Dangerous Hobbies and participation of the Insured/the Additional Insured in any sport or leisure activities where motorized land, air and water vehicles are used, unless otherwise provided in the Contract.

4.1.9. The illness or personal injury of the Insured/the Additional Insured or any consequence thereof occurred during performance of any Military Service;

4.1.10. The personal injury of the Insured/the Additional Insured or any consequence thereof resulting from control of any vehicle or self-propelled machinery by the Insured/the Additional Insured without the appropriate driving licence, adequate powers or under the influence of alcohol (when the blood alcohol concentration is over the permitted values fixed by applicable law), toxic substances or narcotic drugs;

4.2. The Critical Illness shall not be considered as the Insured Event, if:

4.2.1. the Critical Illness or the disease which caused the Critical Illness was diagnosed within the period of less than 90 days from the date of the beginning of the validity period of the Insurance Coverage, which is indicated in the Insurance Certificate (Policy). This period shall be also applicable in the event if, during the validity period of the Contract, the Sum Insured is increased(applicable with regard to the increased share of the Sum Insured only), the List of Critical Illnesses is amended (this provision shall be only applicable to the newly enlisted Critical Illnesses), or the validity of the Insurance Coverage is suspended, terminated, or expires;

4.2.2. The Insured/the Additional Insured died within 30 (thirty) days from the date of diagnosis of one of the Critical Illnesses;

4.2.3. the Critical Illness is not in compliance with the definitions of the Critical Illnesses and/or diagnosing criteria thereof, which are included in these Lists of Critical Illnesses, or is not included in the applicable List of Critical Illnesses;

4.2.4. the Critical Illness or the disease which caused the Critical Illness arises before the date when the Additional Insured attains the age of full three years or before the date when the Insurance Coverage comes into effect.

4.3. The Insurer shall also be entitled to reduce the Insurance Indemnity or refuse to pay it in cases laid down in clause 11.13 of the General Insurance Terms and Conditions.

5. BENEFICIARY

5.1. The Beneficiary under this Additional insurance contract may be only the Insured/the Additional Insured himself, unless otherwise provided in the Contract.

6. CHARGES

6.1. Charges for the Additional Insurance shall be deducted in accordance with the procedure and within the time limits laid down in the General Insurance Terms and Conditions, the Special Terms and Conditions and/or the Pricelist.

7. INSURANCE INDEMNITY

7.1. Upon occurrence of the Insurable Event under these Special Terms and Conditions, the payable Insurance Indemnity shall be paid out as the Sum Insured. If during the term of validity of the Contract the Sum Insured of Critical Illnesses was increased, then, if the Insured/the Additional Insured becomes ill with the Critical Illness within 90 (niety) days after increase of the Sum Insured of Critical Illnesses, the Insurer shall pay the Insurance Indemnity amounting to the Sum Insured that was fixed and was applicable prior to respective increase of the Sum Insured.

8. CLAIM TO INSURANCE INDEMNITY

8.1. The Beneficiary, the Policyholder or their legal successors shall inform the Insurer of the Insurable Event under the procedure established in the General Insurance Terms and Conditions and shall submit the following documents the form and content of which is acceptable to the Insurer:

8.1.1. a notice on an event/ the application for payment of the Insurance Indemnity executed in the form established by the Insurer;

8.1.2. documents confirming the personal identity of a person who has the right to the Insurance Indemnity and/or documents confirming respective rights;

8.1.3. documents confirming the fact and consequences of the Insurable Event (e.g., the documents issued by a health care institution. Which indicate a diagnosis, an anamnesis, the description of analyses and the treatment prescribed which would allow for determination whether the diagnosis accurately meets the definitions and/or diagnosing criteria of Critical Illnesses indicated in the List of Critical Illnesses);

8.1.4. on request of the Insurer – other additional documents or information required for investigation of the Insurable Event or payment of the Insurance Indemnity (e. g., the original of the Insurance Certificate (Policy), the medical documents issued by health care institutions, the certificates, opinions or decisions issued by law enforcement or other competent institutions and etc.).

9. EXPIRATION OF THE ADDITIONAL INSURANCE CONTRACT

9.1. The Additional Insurance Contract expires or the Insurance Coverage ceases to be effective as indicated below:

9.1.1. if the Insurer makes the decision to pay the Critical Illness Insurance Indemnity under these Special Terms and Conditions unless the Special Terms and Conditions stipulate otherwise;

9.1.2. in the event of the death of the Insured (in the event of the death of the Additional Insured, the Insurance Coverage ceases to be effective with respect to the Additional Insured only);

9.1.3. when the Insured/the Additional Insured attains the age of 18 (eighteen) years, the Insurance Coverage ceases to be effective with respect to the Insured/the Additional Insured on the last day of the month of his birthday;

9.1.4. in the event of termination or expiration of the principal life insurance contract;

9.1.5. on other grounds for expiration of the Contract laid down in the General Terms and Conditions appear.

10. OTHER PROVISIONS

10.1. When entering into the Contract, the Policyholder shall select the Insurance Coverage for the Insured – an adult according to any List of

Critical Illnesses indicated either in Annex No. 1 or in Annex No. 2 to these Special Terms and Conditions.

10.2. On request of the Policyholder an Additional Insured may be additionally insured in accordance with these Special Terms and Conditions.

10.3. If both the Principal Insured and the Additional Insured is a minor, the Contract concluded shall only provide for the Insurance Coverage according to the List of Critical Illnesses indicated in Annex No. 3 to these Special Terms and Conditions.

10.4. If the Policyholder selects the List of Critical Illnesses indicated in Annex No. 2 to these Special Terms and Conditions, not more than 2 (two) Additional Insured may be insured by the same Contract without additional risk and management Charges so that they would provided with the Insurance Coverage according to the List of Critical Illnesses indicated in Annex No. 3 to the Special Terms and Conditions. To take advantage of the conditions provided for in this clause, the Policyholder shall fill in the application on entering into the Contract in the form prescribed by the Insurer.

10.5. The Sum Insured which falls on each Additional Insured indicated in the Contract shall amount to 25 percent of the Sum Insured of Critical Illnesses which falls on the Principal Insured. However, this sum insured in any event shall not be over EUR 6,500 (six thousand and five hundred euro).

10.6. The Insurance Coverage according to the List of Critical Illnesses indicated in Annex No. 3 to these Special Terms and Conditions shall be effective until the date when the respective Insured/the Additional Insured attains the age of 18 years.

SPECIAL TERMS AND CONDITIONS: ADDITIONAL INSURANCE AGAINST CRITICAL ILLNESSES No. 004

Annex No. 1

Effective from 1 October 2018

CRITICAL ILLNESSES, THEIR DEFINITIONS AND DIAGNOSING CRITERIA

1. Principal List of Critical Illnesses

1.1. Myocardial infarction
1.2. Cerebral infarction (insult)
1.3. Cancer
1.4. Kidney failure
1.5. Visceral organ transplantation
1.6. Coronary artery graft-bypass surgery
1.7. Prosthesis of heart valves
1.8. Amputation, loss of limb function
1.9. Third-degree burns
1.10. Blindness
1.11. Multiple sclerosis

2. General provisions
2.1. The definitions and diagnosing criteria of the Critical Illnesses may be amended in the events and in accordance with the procedure laid down in the Special Terms and Conditions.
2.2. The date of diagnosing a Critical Illness shall mean one of the following dates depending on the type of the Critical Illness:
2.2.1. In the event of coronary artery graft-bypass surgery and prosthesis of heart valves – the date of performance of surgery on the Insured;
2.2.2. In the event of visceral organ transplantation – the date when the Insured is placed on the official register of patients for the transplantation of specific organs or the date when visceral organ transplantation surgery is performed on the Insured provided that the Insured is not placed on the register of patients for visceral organ transplantation.
2.2.3. In the event of a cancer – the date of sampling for histologic examination on the basis of which the medical officer diagnoses a cancer;
2.2.4. In the events of other Critical Illnesses provided for by this Annex No. 1 – the date of diagnosing a Critical Illness for the Insured.

3. Definitions and diagnosing criteria of Critical Illnesses

3.1. MYOCARDIAL INFARCTION
This is the acute irreversible injure of heart muscle (necrosis) due to occlusion of an adequate artery, which prevents the blood flow to an area of myocardium. Myocardial infarction must be supported by a rise and/or fall of cardiac biomarkers (troponin or CK-MB enzymes) to levels considered diagnostic for myocardial infarction provided that at least two of the following criteria are found:
- Ongoing angina pectoris (protracted cardiac angina);
- Electrocardiogram changes indicative of new myocardial ischemia (new ST-T changes or a new left bundle-brunch block);
- development of pathological Q waves in the ECG.
The diagnosis must be confirmed by a cardiologist.

For the above definition, the following are not covered:
- Elevations of troponin in absence of overt ischemic heart disease (e. g., myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, and drug toxity);
- Myocardial infarction with normal coronary arteries or caused by coronary vasospasm, myocardial bridging or drug abuse;
- Myocardial infarction that occurs within 14 (fourteen) days after coronary angioplasty or graft-bypass surgery.

3.2. CEREBRAL INFARCTION (PARALYTIC STROKE)

This means the death of brain tissue due to acute cerebrovascular event caused by intra-cranial vessels thrombosis, blood haemorrhage (including subarachnoid haemorrhage or embolism from extra-cranial sources) which causes acute onset of new neurological symptoms and a new neurological deficit.
The Insurance Benefit shall be paid only if the fixed neurological deficit persists for more than 3 (three) months after cerebral infarction (paralytic stroke). The fixed neurological deficit must be confirmed by a neurologist and supported by imaging findings (MRT; CT, and others).

For the above definition, the following are not covered:
- Reversible cerebral ischemic attack (RCIA) and reversible ischemic neurologic deficit (RIND);
- Traumatic injury to brain tissue or blood vessels;
- Neurologic deficit due to general hypoxia, infection, inflammatory disease, migraine, or medical intervention;
- Incidental imaging findings(computer tomography or magnetic resonance tomography) without clearly related clinical cerebral infarction symptoms (silent stroke).

3.3. CANCER
This means the uncontrolled growth and spread of malignant cells and the invasion of tissue.
The Insurance Benefit shall be paid only when the irrefutable proof of the invasion of tissues is provided and malignancy of cells is supported by histological findings. The diagnosis must be confirmed by an oncologist.
The definition of cancer shall also cover leukaemia and malignant lymphoma and myelo-dysplastic syndrome. In these cases, the diagnosis must be confirmed by an oncologist or haematologist.
The Insurance Benefit shall not be paid for:
- Localised non-invasive tumours classified as pre-malignant, non-invasive (carcinoma in situ), including ductal and lobular carcinoma in situ of the breast, cervical dysplasia, cervical intraepithelial neoplasia (CIN-1, CIN-2 and CIN-3);
- Chronic lymphocytic leukaemia unless having progressed to at least Binet Stage B;
- Any prostate cancer unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
- Basal cell carcinoma and squamous cell carcinoma of the skin and malignant melanoma stage IA (T1aN0M0) unless there is evidence for metastases
- Papillary thyroid cancer less than 1 cm in diameter and histologically described as T1N0M0
- Papillary micro-carcinoma of the bladder histologically described as Ta
- Polycythemia rubra vera and essential thrombocythemia
- Monoclonal gammopathy of undetermined significance
- Gastric MALT Lymphoma (gastric extranodal lymphoma of the basal border) if the condition can be treated with Helicobacter- eradication
- Gastrointestinal stromal tumour (GIST) stage I and II according to the AJCC Cancer Staging Manual, Seventh Edition (2010)
- Cutaneous lymphoma unless the condition requires treatment with chemotherapy or radiation
- Microinvasive carcinoma of the breast (histologically classified as T1mic) unless the condition requires mastectomy, chemotherapy or radiation
- Microinvasive carcinoma of the cervix uteri (histologically classified as stage IA1) unless the condition requires hysterectomy, chemotherapy or radiation.

3.4. KIDNEY FAILURE
The end-stage kidney failure due to irreversible failure of both kidneys to function leading to the necessity of regular haemodialysis or peritoneal dialysis.
The dialysis must be confirmed by a nephrologist and supported by the findings of kidney function analyses.
The Insurance Benefit shall not be paid for an acute reversible kidney failure (when temporary renal dialysis is required).

3.5. VISCERAL ORGAN TRANSPLANTATION
The Insured is subject to visceral organ transplantation surgery as a recipient of an allograft or isograft transplant of one or more of the following: heart, kidney (-s), liver (including split liver and living donor liver transplantation), lung (including living donor lobe or single-lung transplantation), bone marrow (allogenic hematopoietic stem cell transplantation proceeded by total bone marrow ablation), the transplantation of small bowel, pancreas, partial or full face, hand, arm and leg transplantation(composite tissue allograft transplantation). The condition of the Insured subject to payment of the Insurance Benefit shall be the completion of visceral organ transplantation surgery or the

condition of the Insured leading to transplantation must be deemed untreatable by any other means, and a specialist should confirm that the Insured has been placed on the official waiting list of patient for visceral organ transplantation.

The Insurance Benefit shall not be paid for:
- Transplantation of other organs, body parts, or tissues (including cornea and skin);
- Transplantation of other cells (including islet cells and stem cells other than hematopoietic).

3.6. CORONARY ARTERY GRAFT-BYPASS SURGERY

Open-heart coronary artery surgery to correct narrowing or blockage of two or more coronary arteries with bypass grafts (any superficial vein of a leg, internal thoracic artery or other suitable artery).
The Insurance Benefit shall be only paid when surgery is determined to be necessary by a cardiologist or a cardiac surgeon and supported by angiographic findings.
The Insurance Benefit shall not be paid in the event of:
- Coronary artery graft-bypass surgery to treat narrowing or blockage (thrombus) coronary artery;
- Coronary artery angioplasty or stent-placement.

3.7. PROSTHESIS OF HEART VALVES

A cardiac surgery to replace or repair one or more defective heart valves with artificial valves.
This definition covers the following procedures:
- Heart valve replacement or repair with full sternotomy (vertical division of the breastbone), partial sternotomy or thoracotomy;
- Ross-procedure;
- Transcatheter correction of coronary arteries (catheter-based valvuloplasty);
- Transcatheter aortic valve implantation (TAVI).

The surgery must be determined to be medically necessary by a cardiologist or a cardiac surgeon and supported by echocardiogram or cardiac catheterization findings.

The Insurance Benefit shall not be paid for transcatheter mitral valve clipping.

3.8. AMPUTATION, LOSS OF LIMB FUNCTION

Total and irreversible loss of two or more limbs or their function due to injury or illness of spinal marrow and brain. Amputation shall mean loss of limbs above the elbow or knee joints.

The Insurance Benefit shall be paid provided that the loss of the limb function is present for more than 3 (three) months and is confirmed by a neurologist and supported by clinical symptoms and diagnostic findings.

The Insurance Benefit shall not be paid for:
- Paralysis due to self-harm or psychological disorders;
- Guillain-Barre syndrome;
- Periodic (reversible) hereditary paralysis.

3.9. THIRD-DEGREE BURNS

Burns affecting all layers of the skin (third-degree burns) and covering at least 20% of the body surface area.
The Insurance Benefit shall be paid provided that this is confirmed by a surgeon.
The body surface area could be determined either by the “Rule of Nines” or the “Lund and Browder Chart”, or the “Rule of Palms” (1% of the body surface area is equivalent to the surface area of the palm of arm of the Insured (both the palm and fingers)).

3.10. BLINDNESS

Total and irreversible loss of vision in both eyes as a result of injury or illness, which cannot be treated by refractive correction, medicines or surgery. The diagnosis must be supported by the findings of objective tests and the conclusion of the commission of medical experts. Profound vision loss is evidenced by either a visual acuity of 3/60 or less (0.05 or less in the decimal notation) in the better eye after best correction or a visual field of less than 10º diameter in the better eye after best correction.

The Insurance Benefit shall not be paid for:
- Loss of vision in one eye only;
- Different reversible vision disorders.

3.11. MULTIPLE SCLEROSIS

Diagnosis of multiple sclerosis must be approved by a neurologist following the detailed inpatient neurological examination based on clinical symptoms and following criteria:
- Multiple neurological deficit is present for more than 6 months;
- Magnetic resonance imaging (MRI) findings (showing at least two lesions of demyelination in the brain or spinal cord characteristic of multiple sclerosis).

For the above definition, the following are not covered:
- Possible multiple sclerosis and neurologically or radiologically isolated syndromes suggestive but not diagnostic of multiple sclerosis;
- Isolated optic neuritis and neuromyelitis optica.

Annex No. 2

Effective from 1 October 2018

CRITICAL ILLNESSES, THEIR DEFINITIONS AND DIAGNOSING CRITERIA

1. Extended List of Critical Illnesses

1.1. Myocardial infarction
1.2. Cerebral infarction (paralytic stroke)
1.3. Cancer
1.4. Kidney failure
1.5. Visceral organ transplantation
1.6. Coronary artery graft-bypass surgery
1.7. Prosthesis of heart valves
1.8. Amputation, loss of limb function
1.9. Third-degree burns
1.10. Blindness
1.11. Multiple sclerosis
1.12. Surgery of the aorta
1.13. Alzheimer's disease
1.14. Benign brain tumour
1.15. Coma
1.16. Deafness
1.17. Loss of speech
1.18. Idiopathic Parkinson's disease
1.19. Viral encephalitis

2. General provisions

2.1. The definitions and diagnosing criteria of the Critical Illnesses may be amended in the events and in accordance with the procedure laid down in the Special Terms and Conditions.

2.2. The date of diagnosing a Critical Illness shall mean one of the following dates depending on the type of the Critical Illness:

2.2.1. In the event of coronary artery graft-bypass surgery and prosthesis of heart valves – the date of performance of surgery on the Insured;

2.2.2. In the event of visceral organ transplantation – the date when the Insured is placed on the official register of patients for the transplantation of specific organs or the date when visceral organ transplantation surgery is performed on the Insured provided that the Insured is not placed on the register of patients for visceral organ transplantation.

2.2.3. In the event of a cancer – the date of sampling for histologic examination on the basis of which the medical officer diagnoses a cancer;

2.2.4. In the events of other Critical Illnesses provided for by this Annex No. 2 – the date of diagnosing a Critical Illness for the Insured.

3. Definitions and Diagnosing Criteria of the Critical Illnesses

3.1. MYOCARDIAL INFARCTION

This is the acute irreversible injure of heart muscle (necrosis) due to occlusion of an adequate artery, which prevents the blood flow to an area of myocardium. Myocardial infarction must be supported by a rise and/or fall of cardiac biomarkers (troponin or CK-MB enzymes) to levels considered diagnostic for myocardial infarction provided that at least two of the following criteria are found:
- Ongoing angina pectoris (protracted cardiac angina);
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- Development of pathological Q waves in the ECG.

The diagnosis must be confirmed by a cardiologist.

For the above definition, the following are not covered:
- Elevations of troponin in absence of overt ischemic heart disease (e. g., myocarditis, apical ballooning, cardiac contusion, pulmonary embolism, and drug toxity);

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3.8. AMPUTATION, LOSS OF LIMB FUNCTION

Total and irreversible loss of two or more limbs or their function due to injury or illness of spinal marrow and brain. Amputation shall mean loss of limbs above the elbow or knee joints.

The Insurance Benefit shall be paid provided that the loss of the limb function is present for more than 3 (three) months and is confirmed by a neurologist and supported by clinical symptoms and diagnostic findings.

The Insurance Benefit shall not be paid for:
- Paralysis due to self-harm or psychological disorders;
- Guillain-Barre syndrome;
- Periodic (reversible) hereditary paralysis.

3.9. THIRD-DEGREE BURNS

Burns affecting all layers of the skin (third-degree burns) and covering at least 20% of the body surface area.
The Insurance Benefit shall be paid provided that this is confirmed by a surgeon.
The body surface area could be determined either by the “Rule of Nines” or the “Lund and Browder Chart”, or the “Rule of Palms” (1% of the body surface area is equivalent to the surface area of the palm of arm of the Insured (both the palm and fingers)).

3.10. BLINDNESS

Total and irreversible loss of vision in both eyes as a result of injury or illness, which cannot be treated by refractive correction, medicines or surgery. The diagnosis must be supported by the findings of objective tests and the conclusion of the commission of medical experts. Profound vision loss is evidenced by either a visual acuity of 3/60

or less (0.05 or less in the decimal notation) in the better eye after best correction or a visual field of less than 10º diameter in the better eye after best correction.

The Insurance Benefit shall not be paid for:
- Loss of vision in one eye only;
- Different reversible vision disorders.

3.11. MULTIPLE SCLEROSIS
Diagnosis of multiple sclerosis must be approved by a neurologist following the detailed inpatient neurological examination based on clinical symptoms and following criteria:
- Multiple neurological deficit is present for more than 6 months;
- Magnetic resonance imaging (MRI) findings (showing at least two lesions of demyelination in the brain or spinal cord characteristic of multiple sclerosis).

For the above definition, the following are not covered:
- Possible multiple sclerosis and neurologically or radiologically isolated syndromes suggestive but not diagnostic of multiple sclerosis;
- Isolated optic neuritis and neuromyelitis optica.

3.12. SURGERY OF THE AORTA
The undergoing of surgery to treat narrowing, obstruction, aneurysm or dissection of the aorta.
Minimally invasive procedures like endovascular repair are covered under this definition. The surgery must be determined to be medically necessary by a consultant cardiac surgeon and supported by imaging findings.
For the above definition, the following are not covered:
- Surgery to any branches of the thoracic or abdominal aorta (including aortofemoral or aortoiliac bypass grafts);
- Surgery of the aorta related to hereditary connective tissue disorders (e.g. Marfan syndrome, Ehlers–Danlos syndrome);
- Surgery following traumatic injury to the aorta.

3.13. ALZHEIMER'S DISEASE
A definite diagnosis of Alzheimer's disease evidenced by all of the following:
- Illness is diagnosed before age 65;
- Illness is supported by typical neuropsychological and nervous system imaging findings (e. g., computer momography, magnetic resonance tomography);
- Loss of intellectual capacity involving impairment of memory and executive functions (sequencing, organizing, abstracting, and planning), which results in a significant reduction in mental and social functioning;
- Personality change;
- Gradual onset and continuing decline of cognitive functions;
- No disturbance of consciousness;
- Need for constant supervision (24 hours daily);
The diagnosis and the need for supervision must be confirmed by a Consultant Neurologist.

For the above definition does not cover other forms of dementia due to brain or systemic disorders or psychiatric conditions.

3.14. BENIGN BRAIN TUMOR
A definite diagnosis of a benign brain tumour, which is defined as a non-malignant growth of tissue located in the cranial vault (limited to the brain, meninges or cranial nerves).
The dignosis must be confirmed by a neurologist and a neurosurgeon and supported by imaging findings.
The Insurance Benefir shall be paid provided that the tumour must be treated with at least one of the following:
- Complete or incomplete surgical removal;
- Stereotactic radiosurgery;
- External beam radiation.
If none of the treatment options is possible due to medical reasons, the tumour must cause a persistent neurological deficit, which has to be documented for at least 3 months following the date of diagnosis.

For the above definition, the following are not covered:
- The diagnosis or treatment of any cyst, granuloma, hamartoma or malformation of the arteries or veins of the brain;
- Tumours of the pituitary gland.

3.15. COMA
A definite diagnosis of a state of unconsciousness.
The Insurance Benefit shall be paid provided all the following conditions are satisfied:
- No reaction or response from the Insured to external stimuli or internal needs (results in a score of 8 or less on the Glasgow coma scale) or no response to internal needs for at least 96 (ninety six) hours;
- Need for the use of life support systems;
- Results in a persistent neurological deficit which must be assessed at least 30 days after the onset of the coma.
The diagnosis must be confirmed by a Consultant Neurologist.

For the above definition, the following are not covered:
- Medically induced coma;
- Any coma due to self-inflicted injury, alcohol or drug use.

3.16. DEAFNESS
A definite diagnosis of a permanent and irreversible loss of hearing in both ears as a result of sickness or accidental injury.
The diagnosis must be confirmed by a Consultant ENT specialist and supported by an average auditory threshold (of more than 90 db at 500, 1000 and 2000 hertz in the better ear using a pure tone audiogram).

3.17. LOSS OF SPEECH
A definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease not subject to correction by any medical treatment means provided that this condition is present for a continuous period of at least 6 months. The diagnosis must be confirmed by a Consultant ENT Specialist.

The Insurance Benefit shall not be paid for Loss of speech due to psychiatric disorders or diseases.

3.18. IDIOPATHIC PARKINSON'S DISEASE
The definite primary diagnosis must be confirmed by a Consultant Neurologist.
The Insurance Benefit shall be paid provided that all the following conditions are satisfied:
a) Diagnosis is confirmed at age before 65;
b) At least two out of the following clinical manifestations are present:
- Muscle rigidity;
- Tremor;
- Bradykinesia (abnormal slowness of movement, sluggishness of physical and mental responses);
c) Total inability to perform, by oneself, at least 3 out of 6 Activities of Daily Living for a continuous period of at least 3 months despite adequate drug treatment:
- Washing – the ability to wash in the bath or shower (including getting into and out of the bath or shower) or wash satisfactorily by other means;
- Getting dressed and undressed – the ability to put on, take off, secure and unfasten all garments and, if needed, any braces, artificial limbs or other surgical appliances;
- Feeding oneself – the ability to feed oneself when food has been prepared and made available;
- Maintaining personal hygiene – the ability to maintain a satisfactory level of personal hygiene by using the toilet or otherwise managing bowel and bladder function;
- Getting between rooms – the ability to get from room to room on a level floor;
- Getting in and out of bed – the ability to get out of bed into an upright chair or wheelchair and back again.
The implantation of a neurostimulator to control symptoms by deep brain stimulation is, independent of the Activities of Daily Living, covered under this definition of Critical Illnesses. The implantation must be determined to be medically necessary by a Consultant Neurologist or Neurosurgeon.

For the above definition, the following are not covered:
- Secondary parkinsonism (including drug- or toxin-induced parkinsonism);
- Essential tremor;
- Parkinsonism related to other neurodegenerative disorders.

3.19. VIRAL ENCEPHALITIS
A definite diagnosis of encephalitis (cerebral hemispheres, cerebral trunk, cerebellum) due to viral infection.
The diagnosis must be confirmed by a consultant neurologist and supported by inpatient typical clinical symptoms and cerebrospinal fluid or brain biopsy findings.
The Insurance benefit shall be paid provided that all the following conditions are present:

- Neurological deficit; ir
- Neurological deficit is documented for at least 3 months following the date of diagnosis.

For the above definition, the following are not covered:
- Encephalitis in the presence of HIV;
- Encephalitis caused by bacterial or protozoal infections;
- Paraneoplastic encephalomyelitis.

Annex No. 3

CRITICAL ILLNESSES, THEIR DEFINITIONS AND DIAGNOSING CRITERIA

Effective from 1 October 2018

1. Children's list of critical illnesses

1.1. Cancer
1.2. Encephalitis
1.3. Bacterial meningitis and meningoencephalitis
1.4. Insulin-dependent diabetes mellitus
1.5. Blindness
1.6. Deafness
1.7. Coma
1.8. Benign brain tumour
1.9. Amputation/loss of limb function
1.10. Visceral organ transplantation
1.11. Kidney failure

2. General provisions

2.1. The definitions and diagnosing criteria of the Critical Illnesses may be amended in the events and in accordance with the procedure laid down in the Special Terms and Conditions.

2.2. The date of diagnosing a Critical Illness shall mean one of the following dates depending on the type of the Critical Illness:

2.2.1. In the event of visceral organ transplantation – the date when the Insured is placed on the official register of patients for the transplantation of specific organs or the date when visceral organ transplantation surgery is performed on the Insured provided that the Insured is not placed on the register of patients for visceral organ transplantation.
2.2.2. In the event of a cancer – the date of sampling for histologic examination on the basis of which the medical officer diagnoses a cancer;
2.2.3. In the events of other Critical Illnesses provided for by this Annex No. 3 – the date of diagnosing a Critical Illness for the Insured.

3. Definitions and Diagnosing Criteria of the Critical Illnesses

3.1. CANCER

This means the uncontrolled growth and spread of malignant cells and the invasion of tissue.
The Insurance Benefit shall be paid only when the irrefutable proof of the invasion of tissues is provided and malignancy of cells is supported by histological findings. The diagnosis must be confirmed by an oncologist.
The definition of cancer shall also cover leukaemia and malignant lymphoma and myelo-dysplastic syndrome. In these cases, the diagnosis must be confirmed by an oncologist or haematologist.
The Insurance Benefit shall not be paid for:
- Localised non-invasive tumours classified as pre-malignant, non-invasive (carcinoma in situ), including ductal and lobular carcinoma in situ of the breast, cervical dysplasia, cervical intraepithelial neoplasia (CIN-1, CIN-2 and CIN-3);
- Chronic lymphocytic leukaemia unless having progressed to at least Binet Stage B;
- Any prostate cancer unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0.
- Basal cell carcinoma and squamous cell carcinoma of the skin and malignant melanoma stage IA (T1aN0M0) unless there is evidence for metastases
- Papillary thyroid cancer less than 1 cm in diameter and histologically described as T1N0M0
- Papillary micro-carcinoma of the bladder histologically described as Ta
- Polycythemia rubra vera and essential thrombocythemia

- Monoclonal gammopathy of undetermined significance
- Gastric MALT Lymphoma (gastric extranodal lymphoma of the basal border) if the condition can be treated with Helicobacter- eradication
- Gastrointestinal stromal tumour (GIST) stage I and II according to the AJCC Cancer Staging Manual, Seventh Edition (2010)
- Cutaneous lymphoma unless the condition requires treatment with chemotherapy or radiation
- Microinvasive carcinoma of the breast (histologically classified as T1mic) unless the condition requires mastectomy, chemotherapy or radiation
- Microinvasive carcinoma of the cervix uteri (histologically classified as stage IA1) unless the condition requires hysterectomy, chemotherapy or radiation.

3.2. ACUTE VIRAL ENCEPHALITIS

A definite diagnosis of viral encephalitis (cerebral hemispheres, cerebral trunk, cerebellum) due to viral infection. The diagnosis must be confirmed by a consultant neurologist and supported by inpatient typical clinical symptoms and cerebrospinal fluid or brain biopsy findings.
The Insurance benefit shall be paid provided that all the following conditions are present:
- Neurological deficit; and
- Neurological deficit is documented for at least 3 months following the date of diagnosis.

For the above definition, the following are not covered:
- Encephalitis in the presence of HIV;
- Encephalitis caused by bacterial or protozoal infections;
- Paraneoplastic encephalomyelitis.

3.3. BACTERIAL MENINGITIS AND MENINGOENCEPHALITIS

Inflammation of cranial or spinal pia mater due to bacterial infection.
The diagnosis must be confirmed by a Consultant Neurologist by in-patient treatment (clinical symptoms and cerebrospinal fluid or brain biopsy findings).
The Insurance Benefit shall be paid provided that within at least 3 (three) months following the onset of the illness all the following conditions are present:

- Neurological deficit that is lasting
- Permanent inability to perform at least three (3) of the Activities of Daily Living.

3.4. INSULIN-DEPENDENT DIABETES MELLITUS

The diagnosis must be confirmed by a Consultant Endocrinologist.
The Insurance Benefit shall be paid provided that all the following conditions are present:
- Insulin deficiency must be approved by laboratory tests;
- Treatment of insulin therapy is necessary for life;
- Permanent use of insulin injections that must have continued for a period of at least 3 (three) months.

The diagnosis must be confirmed by a Consultant Endocrinologist.
The Insurance Benefit shall be paid provided that all the following conditions are present:
- Insulin deficiency must be approved by laboratory tests;
- Treatment of insulin therapy is necessary for life;
- Permanent use of insulin injections that must have continued for a period of at least 3 (three) months.

3.5. BLINDNESS

Total and irreversible loss of vision in both eyes as a result of injury or illness, which cannot be treated by refractive correction, medicines or surgery. The diagnosis must be supported by the findings of objective tests and the conclusion of the commission of medical experts. Profound vision loss is evidenced by either a visual acuity of 3/60 or less (0.05 or less in the decimal notation) in the better eye after best correction or a visual field of less than 10º diameter in the better eye after best correction.

The Insurance Benefit shall not be paid for:

- Loss of vision in one eye only;

- Different reversible vision disorders.

3.6. DEAFNESS

A definite diagnosis of a permanent and irreversible loss of hearing in both ears as a result of sickness or accidental injury.
The diagnosis must be confirmed by a Consultant ENT specialist and supported by an average auditory threshold (of more than 90 db at 500, 1000 and 2000 hertz in the better ear using a pure tone audiogram).

3.7. COMA

A definite diagnosis of a state of unconsciousness.
The Insurance Benefit shall be paid provided all the following conditions are satisfied:
- No reaction or response from the Insured to external stimuli or internal needs (results in a score of 8 or less on the Glasgow coma scale) or no response to internal needs for at least 96 (ninety six) hours;
- Need for the use of life support systems;
- Results in a persistent neurological deficit which must be assessed at least 30 days after the onset of the coma.
The diagnosis must be confirmed by a consultant neurologist.

For the above definition, the following are not covered:
- Medically induced coma;
- Any coma due to self-inflicted injury, alcohol or drug use.

3.8. BENIGN BRAIN TUMOR

A definite diagnosis of a benign brain tumour, which is defined as a non-malignant growth of tissue located in the cranial vault (limited to the brain, meninges or cranial nerves).
The dignosis must be confirmed by a neurologist and a neurosurgeon and supported by imaging findings.
The Insurance Benefir shall be paid provided that the tumour must be treated with at least one of the following:
- Complete or incomplete surgical removal;
- Stereotactic radiosurgery;
- External beam radiation.
If none of the treatment options is possible due to medical reasons, the tumour must cause a persistent neurological deficit, which has to be documented for at least 3 months following the date of diagnosis.

For the above definition, the following are not covered:
- Diagnosis or treatment of any cyst, granuloma, hamartoma or malformation of the arteries or veins of the brain;
- Tumours of the pituitary gland.

3.9. AMPUTATION, LOSS OF LIMB FUNCTION

Total and irreversible loss of two or more limbs or their function due to injury or illness of spinal marrow and brain. Amputation shall mean loss of limbs above the elbow or knee joints.

The Insurance Benefit shall be paid provided that the loss of the limb function is present for more than 3 (three) months and is confirmed by a neurologist and supported by clinical symptoms and diagnostic findings.

The Insurance Benefit shall not be paid for:
- Paralysis due to self-harm or psychological disorders;
- Guillain-Barre syndrome;
- Periodic (reversible) hereditary paralysis.

3.10. VISCERAL ORGAN TRANSPLANTATION

The Insured is subject to visceral organ transplantation surgery as a recipient of an allograft or isograft transplant of one or more of the following: heart, kidney (-s), liver (including split liver and living donor liver transplantation), lung (including living donor lobe or single-lung transplantation), bone marrow (allogenic hematopoietic stem cell transplantation proceeded by total bone marrow ablation), the transplantation of small bowel, pancreas, partial or full face, hand, arm and leg transplantation(composite tissue allograft transplantation). The condition of the Insured subject to payment of the Insurance Benefit shall be the completion of visceral organ transplantation surgery or the condition of the Insured leading to transplantation must be deemed untreatable by any other means, and a

specialist should confirm that the Insured has been placed on the official waiting list of patient for visceral organ transplantation.

The Insurance Benefit shall not be paid for:

- Transplantation of other organs, body parts, or tissues (including cornea and skin);
- Transplantation of other cells (including islet cells and stem cells other than hematopoietic).

3.11. KIDNEY FAILURE

The end-stage kidney failure due to irreversible failure of both kidneys to function leading to the necessity of regular haemodialysis or peritoneal dialysis. The dialysis must be confirmed by a nephrologist and supported by the findings of kidney function analyses.

The Insurance Benefit shall not be paid for an acute reversible kidney failure (when temporary renal dialysis is required).

SPECIAL TERMS AND CONDITIONS: ADDITIONAL INSURANCE AGAINST CRITICAL ILLNESSES No. 004

Annex No. 4

PRICE LIST

Effective from 1 October 2018

1. Charges for additional services

Service	Charge
Amendments to the Contract: reduction of the Sum Insured, an amendment to the Insurance Period or etc..* *Note: this fee charge be calculated for each amendment to the provision of the Contract separately.	**EUR 5.00**
Termination of the Contract, if only the Additional Insurance is terminated, while the principal life insurance remains in effect.	**EUR 7.00**

2. Other provisions

2.1. Minimum sum of the Additional Insurance: EUR 2,000.00.