

## Annex No. 1 "Critical (crisis) illness ABC coverage

to Insurance regulations "Compensa Accident Insurance Regulations No. NGA 20"

Approved on 16.06.2020 at the meeting of the Board of Compensa Vienna Insurance Group ADB Latvian Branch.

# Seesam Critical illness insurance regulations No. KS 14

Approved on 30.06.2020 at the meeting of the Board of Compensa Vienna Insurance Group ADB Latvian Branch.

Valid from July 1st, 2020.

## 1. The Insurer

Compensa Vienna Insurance Group ADB Latvian branch (hereinafter – "the Insurer").

## 2. The Policyholder

A natural person who concludes an insurance contract in favor of himself or another natural person, or a legal entity who concludes a critical illness insurance contract in favor of his employee(s) and employee(s)' relatives.

## 3. The Insured person

A natural person (hereinafter referred to as the "Insured") who has an insurable interest and in whose favor an insurance contract has been concluded. The insured may be a minor child, provided that the minor child is insured together with the child's provider, an employee of the policyholder who has an employment contract with the policyholder. The insured, based on the employment contract for the performance of work duties, receives wages and the Policyholder makes tax payments. The insured may also be relatives of the policyholder's employees – spouse, parents, children, foster children, adopted children, brother, sister, foster parents. Relatives are included in the insurance contract only upon agreement with the Insurer.

## 4. Insurance contract

4.1. The insurance contract consists of the critical illness insurance policy, insurance policy annexes, amendments, program descriptions and insurance regulations.

4.2. The rights and obligations of the Parties to the insurance contract apply to the Insurer, the Insured and the Policyholder.

4.3. Conclusion and operation of the insurance contract:

4.3.1. The insurance contract is considered concluded and becomes effective on the date and time specified in the insurance policy, provided that the insurance premium has been paid on time and in accordance with the conditions specified in the insurance contract.

4.3.2. The amount of the insurance premium is determined by the Insurer, according to the information submitted by the Policyholder and/or the Insured. The amount of the premium and the procedure for paying the insurance premium are specified in the insurance policy.

4.3.3. If the parties agree in writing that the insurance premium (or its first part) is to be paid after the date of conclusion of the insurance contract, then if the insurance premium (or its first part) is paid within the term and amount determined by the Insurer, it is considered that the insurance contract has entered into force with the start date of the insurance period specified in the insurance policy.

4.3.4. If, contrary to what is stated in the insurance policy, the insurance premium (or its first part) is not paid within the specified term and amount, then it is considered that the insurance contract has not entered into force from the date of its conclusion. A separate notification that the insurance contract has not entered into force is not sent to the Policyholder. Insurance cases that occurred during this time are not considered.

4.3.5. Payment of the insurance premium or its first part after the payment term specified in the insurance policy does not oblige the Insurer to assume any obligations.

4.3.6. Any kind of oral information or oral agreement is not binding on the Insurer. When concluding an insurance contract, upon mutual agreement between the Policyholder and the Insurer, any provision of the insurance contract may be amended, excluded or supplemented in writing. If an annex on changes to the insurance contract is prepared and an additional payment of the premium is determined, then the payment must be made by the date specified in the invoice.

4.3.7. The insurance contract is concluded in Latvian, in accordance with the laws and regulations in force in the Republic of Latvia. If the terms of the insurance contract have been translated and disagreements arise due to the translation, then the insurance contract in Latvian will be considered decisive.

4.4. Termination of the insurance contract:

4.4.1. The Insurer and/or the Policyholder may terminate the insurance contract in accordance with the requirements of the laws and regulations of the Republic of Latvia.

4.4.2. Termination of the insurance contract does not affect the Insurer's right to demand from the Policyholder the insurance premium or its part for the period when the insurance contract was in force.

4.4.3. An insurance contract concluded with a natural person is terminated:

4.4.3.1. if the Insured received a positive diagnosis of a critical illness during the waiting period, the unused insurance premium is refunded to the Policyholder, deducting administrative costs under procedures specified in the Law "On Insurance Contract";

4.4.3.2. if the Insured dies during the survival period, the paid insurance premium is not refunded to the Policyholder;

4.4.3.3. when the Insurer has fulfilled its obligations and paid the insurance indemnity provided for in the insurance contract due to the occurrence of an insured event during the insurance period.

4.4.4. An insurance contract concluded with a legal entity is terminated:

4.4.4.1. if the Insured falls ill with a critical illness during the insurance period, and the Insurer has paid the insurance indemnity provided for in the insurance contract, the insurance contract for this Insured is completely terminated, but the insurance contract remains valid for the other Insured persons;

4.4.4.2. if an insured event occurs during the waiting period for any Insured, the insurance coverage for this Insured is completely terminated, but the insurance contract remains valid for the other Insured persons. The unused insurance premium for this Insured is reimbursed to the Policyholder, deducting administrative costs under procedures specified in the Law "On Insurance Contract";

4.4.4.3. if the Insured dies during the survival period, he/she is excluded from the list of insured by drawing up a written annex to the insurance contract; the paid insurance premium for this person is not refunded;

4.4.5. The policyholder must inform the Insurer in writing about the early termination of the insurance contract in relation to the Insured, accordingly, the operation of the insurance contract is terminated. The insurer has the right not to add this person to this insurance contract a second time.

4.4.6. If, upon termination of the insurance contract, the prescribed premium has not been paid in full for the Insured, and an indemnity has been paid for the insured event, the Policyholder is obliged to pay the remaining part of the premium.

4.4.7. If the current payment of the insurance premium specified in the insurance contract has not been paid within the specified term and amount, the insurer sends the policyholder a written Warning about the untimely and/or incomplete current payment of the insurance premium, with an invitation to pay the insurance premium in accordance with the terms of the insurance contract, by the date specified in the warning. If the payment is not made, the operation of the insurance contract is suspended or terminated under procedure established by the Law "On Insurance Contract". If the insurance contract is terminated, a separate notification is not sent to the policyholder.

## 5. Insurance period

The duration of the insurance contract, agreed upon by the parties before the conclusion of the insurance contract.

## 6. Territory of the insurance contract

Insured risks are valid 24/7 worldwide.

## 7. Obligations and rights of the policyholder and/or the Insured

7.1. The Insured is obliged to submit a health statement, as well as to perform certain additional medical examinations, which are necessary for the additional evaluation of the insured risk, at the medical institution specified by the Insurer. It is the duty of the insured to provide true information about his/her health condition and medical examinations performed.

7.2. The Policyholder and/or the Insured are obliged to immediately, as soon as possible, notify the Insurer in writing of all circumstances that may increase the probability of occurrence of the insured risk or the amount of possible losses, as well as to notify of any changes in the initially provided information. Regarding such notification, the Insurer reserves the right not to include these changes in the insurance contract or to include them in the calculation of the additional insurance premium if the insured risk increases as a result of these changes.

7.3. It is the duty of the Policyholder and/or the Insured to notify the Insurer of other valid insurance contracts that refer to the same insurance object.

7.4. It is the duty of the Policyholder to inform the Insured, if he is not the Policyholder, that the Insured is insured in accordance with a certain insurance contract, the conditions of which the Policyholder has agreed with the Insurer, and the Insured is bound by and must comply with these conditions.

7.5. It is the duty of the policyholder and/or the Insured to become familiar with, observe and fulfill all the requirements of the insurance contract provisions set forth by the Insurer.

7.6. The insured must take care of his/her health.

7.7. The insured must undergo mandatory and recommended health examinations, in accordance with the requirements of the laws and regulations of the Republic of Latvia.

7.8. The Insured and/or the Policyholder, the Insured's representative or the beneficiary must inform the Insurer about the occurrence of the insured risk immediately, as soon as it is practically possible, but no later than within 30 (thirty) days after the doctors' initial or final diagnosis in case of critical illness.

7.9. In the event of an insured event, the insured must follow all the instructions of the attending physician.

7.10. The Insured is obliged to submit all the necessary documents requested by the Insurer for consideration of indemnity and making a decision.

7.11. In the event of the death of the Policyholder and/or the Insured, or the Insured – it is the duty of the beneficiary or an heir to ensure the Insurer's requirement to establish and assess the conditions of critical illness.

7.12. The burden of proving the occurrence of the insured event lies with the Insured, and in the event of his/her death – with the beneficiary or an heir, if the beneficiary is not specified in the insurance contract.

7.13. The insured event can be applied for electronically on the Insurer's website [www.compensa.lv](http://www.compensa.lv) or sent to e-mail address: [veselib@compensa.lv](mailto:veselib@compensa.lv). The application for insurance indemnity and other documents

confirming the insurance case can also be submitted in person at the Insurer's office.

7.14. The Insured has the right to submit a complaint to the Insurer regarding the decision made in the indemnity case within 30 (thirty) days from the date of receipt of the decision.

## 8. Consequences of non-fulfillment of obligations by the Policyholder and/or the Insured.

8.1. If any action or inaction of the Policyholder and/or the Insured has been or will be the reason for misleading the Insurer, the insurance contract will be recognized as invalid from the date of its conclusion, except in case if the law "On Insurance Contract" prohibits it in the event that the deception was committed as a result of minor negligence. The Insurer shall not reimburse the paid insurance premium.

8.2. The Insurer, at its discretion, may refuse to pay the insurance indemnity or reduce the indemnity payment by 50 (fifty) % if the Policyholder and/or the Insured has not fulfilled or partially fulfilled any of the requirements specified in the insurance contract, as well as if the Policyholder and/or the Insured has violated the requirements of any regulatory act valid in the Republic of Latvia, which are applicable to the specific insurance event. The exception is if such non-fulfillment of the requirements of the insurance contract that occurred as a result of minor carelessness – in such a case, the Insurer acts under provisions of the Law "On Insurance Contract".

8.3. In the event that the Policyholder or the Insured, as a result of their action or inaction, has negatively affected the Insurer's exercise of any rights, the Insurer has the right to reduce the insurance indemnity by 50 (fifty) % or to refuse payment of the insurance indemnity in full.

8.4. The Insurer does not pay the insurance indemnity if the occurrence of the insured risk was caused by the malicious intent or gross negligence of the Policyholder, the Insured, the beneficiary. The Insurer shall not reimburse the paid insurance premium.

## 9. Obligations and rights of the Insurer

9.1. Obligations of the Insurer:

9.1.1. In the case of concluding an insurance contract, to issue to the Policyholder a set of documents that are an integral part of the contract – insurance policy, insurance policy annexes, descriptions of insurance programs.

9.1.2. In accordance with the concluded insurance contract, upon the occurrence of an insured event, to pay the insurance indemnity to the Insured or the beneficiary, in accordance with the insurance contract.

9.1.3. To ensure availability of relevant critical illness insurance regulations on the Insurer's website [www.compensa.lv](http://www.compensa.lv).

9.2. Rights of the Insurer:

9.2.1. To require each natural person to fill out a health statement individually, before preparing an insurance offer, and to determine additional medical examinations at the medical institution indicated by the Insurer in order to assess the risk and determine insurance premiums.

9.2.2. To make sure of the truth of the submitted information, the occurrence of an insurance event and the validity of the payment of insurance indemnity, by reviewing the medical documentation that is at the disposal of medical institutions and medical persons, and/or in case of uncertainty, to contact an independent certified medical expert selected by the Insurer to check the validity of the Insured's health condition and/or occurrence of the insured event.

9.2.3. Before making a decision in the indemnity case, to request the submission of documents confirming the occurrence of an insured event.

9.2.4. To refuse to pay out or reduce the insurance indemnity under procedure established in these regulations and the laws and regulations of the Republic of Latvia.

9.2.5. To process the data of the Policyholder, the Insured and the beneficiary, including sensitive data. Data processing is carried out in accordance with the Law on protection of personal data. The Insurer ensures safe storage of personal data.

9.2.6. To send the decision made in the insurance indemnity case electronically to the Insured, using the contacts specified by the Insured.

## 10. Procedure for payment of insurance indemnity

10.1. The Policyholder and/or the Insured, beneficiary or an heir shall submit a written application to the Insurer regarding the occurrence of the insured risk.

10.2. The Insurer evaluates all received documentation within 30 (thirty) days and makes a decision whether the occurrence of the insured risk is an insured event:

10.2.1. if an insured event is established and the parties have agreed on the amount of insurance indemnity, then:

10.2.1.1. The Insurer makes a decision on the payment of the insurance Indemnity;

10.2.1.2. The insurer pays the insurance indemnity within 5 (five) working days after the decision is made;

10.2.1.3. if the parties mutually agree on it, then the procedure for payment of insurance indemnity can be drawn up in writing, with both parties drawing up and signing a loss settlement protocol.

10.2.2. if an insured event is established, but the parties have not agreed on the amount of the insurance indemnity:

10.2.2.1. The Insurer has the right to request additional documents for determining the amount of insurance compensation;

10.2.2.2. The Insurer has the right to individually decide and invite a medical expert to determine the amount of insurance indemnity. The conclusion of the medical expert will be binding on both the Policyholder and the Insured;

10.2.2.3. after evaluating the medical expert's opinion, the Insurer makes a decision on the amount of insurance indemnity and other controversial issues;

10.2.2.4. The insurer pays the insurance compensation within 5 (five) working days after receiving the signed loss settlement protocol.

10.2.3. if no insured event is established:

10.2.3.1. then the Insurer shall make a decision regarding the refusal to pay the insurance indemnity;

10.2.3.2. the Insurer shall notify the Insured, the Insured's heir or beneficiary of the adopted decision within 5 (five) working days after the adoption of the decision.

10.3. The Insurer pays insurance indemnity to the Insured, the Insured's heir or beneficiary only for such an insured event, which is proven by relevant documents.

10.4. During the insurance period, only 1 (one) insurance indemnity is paid to the Insured.

10.5. In the event that a split payment is applied to the insurance premium for the Policyholder – a natural person, the Insurer has the right to deduct the difference between the paid and the full insurance premium from the insurance indemnity to be paid.

10.6. In case that, due to objective reasons, the Insurer is unable to meet the predetermined deadline, then the deadline is extended to six months, informing the Indemnity recipient about it.

## 11. Disagreements settlement procedure and confidentiality

11.1. Any disagreements will be resolved through negotiations.

11.2. If disagreements have arisen on the basis that some issue is not regulated in the insurance regulations, then the parties will apply the laws of the Republic of Latvia, including the Law "On Insurance Contract" and "Law on Protection of Consumer Rights" to resolve this issue.

11.3. If the parties fail to resolve their disagreements through negotiations, the case will be referred to the court of the Republic of Latvia in accordance with the laws of the Republic of Latvia.

11.4. The division of the insurance contract into clauses, subsections and their names does not affect the legal interpretation of the text.

11.5. Unless the law stipulates otherwise, the Insurer, the Insured and the Policyholder undertake not to disclose to third parties, without written consent, information that has become known during the period of the insurance contract or after its termination. Confidentiality shall remain in effect for an unlimited period of time regardless of the validity of this contract. Information that is publicly available and has not become so by violating the law or contractual obligations shall not be considered confidential information.

## 12. General exceptions

12.1. The Insurer's responsibility to pay insurance indemnity for the insured event does not arise in the event that the losses occurred as a result of exceptions provided for in the regulatory acts of the Republic of Latvia or in the insurance contract.

12.2. The Insurer does not pay the insurance indemnity if:

12.2.1. the conditions and instructions specified in the insurance regulations and the program have not been followed;

12.2.2. the critical illness specified in the insurance program has not been diagnosed in accordance with the established criteria;

12.2.3. The insured has misled the Insurer by providing false information about his state of health;

12.2.4. the cause of the illness is:

12.2.4.1. the result of the use of alcohol or any narcotic or other toxic substances;

12.2.4.2. Intentional self-inflicted injuries, suicide or attempted suicide by the Insured;

12.2.4.3. illegal behavior of the Insured, serving a sentence in a prison;

12.2.4.4. the use of medicines and similar preparations or the Insured's participation in drug trials;

12.2.4.5. human immunodeficiency virus (HIV), except if acquired through blood transfusion, or acquired immunodeficiency syndrome (AIDS) and any of their derivatives or other diseases after infection with HIV;

12.2.4.6. mental or mental disorder resulting in paralysis, convulsions, epilepsy or other spasmodic fits;

12.2.4.7. the result of a long-term chronic illness;

12.2.4.8. the illness/stage diagnosed in the insurance program is specified as an exception (not an insured event).

12.2.5. there are general exceptions:

12.2.5.1. terrorism – acts of terrorism or their result, regardless of any other causes that, by chance or otherwise, have contributed to losses, damages or expenses; in the context of this provision, terrorism means violence or dangerous activity that threatens human life, tangible or intangible property or infrastructure, with the intention of influencing any government or keeping society or any part of it under the power of fear;

12.2.5.2. in the event of war, military invasion, civil war, insurrection, revolution, sedition, military or other usurpation of power;

12.2.5.3. global natural disasters and powers of nature.

12.2.6. in the case of an individual insurance contract, a case of critical illness occurs during the waiting period after the date of entry into force of the insurance contract;

12.2.7. during the term of the group contract, an additional Insured is added and a case of critical illness occurs during the waiting period;

12.2.8. The insured dies during the survival period, after diagnosis of a critical illness;

12.2.9. the instructions given by the doctor are not followed;

12.2.10. The case of critical illness of the insured child occurs as a result of intentional or unintentional actions caused by parents, guardians or the Insured, beneficiary specified in the policy;

12.2.11. The Insured has received medical advice and/or treatment, or has known about the diagnosed critical illness before the start date of the insurance period.

## 13. Critical illness program

13.1. The insurance program consists of the insured risks included in the insurance program – critical illnesses, which are diagnosed in medical institutions registered in the Register of health care institutions, companies, practices and certification of the Republic of Latvia and/or in the Commercial Register of the Register of Enterprises of the Republic of Latvia.

## 14. Documents required for payment of insurance indemnity

14.1. In order to evaluate and establish whether an insured event has occurred, the indemnity beneficiary must submit:

- 14.1.1. Insurer's application of the prescribed form for the occurrence of the insured risk [www.compensa.lv](http://www.compensa.lv);
- 14.1.2. a copy of a passport or other identity document;
- 14.1.3. documents on the occurrence of the specific insured risk specified in the program descriptions for the corresponding risk;
- 14.1.4. documents that confirm and prove the first initial positive diagnosis in the Insured's life, and the final positive diagnosis of one of the critical illnesses, confirmed by the doctor specified in the program descriptions for the diagnosed illness;
- 14.1.5. A copy of the insured's medical history and a written conclusion issued by the medical examination commission, which indicates the exact diagnosis and the date of the final diagnosis;
- 14.1.6. A copy of the insured's death certificate (in case of the Insured's death);
- 14.1.7. decision of a sworn notary or court on the distribution of inheritance rights (in case of death of the insured);
- 14.1.8. certificate of hospitalization, which indicates the exact diagnosis and duration of hospitalization;
- 14.1.9. at the request of the Insurer, additional documents proving the occurrence of the insured event;
- 14.1.10. conclusion of a medical expert, at the request of the Insurer;
- 14.1.11. an autopsy of the deceased, at the Insurer's request (payment of expenses is covered by the Insurer).

## 15. Terms used in the regulations

- 15.1. **Object of insurance** – person's life or health.
- 15.2. **Amount of insurance** – the amount of money specified in the insurance contract, which is paid out in accordance with the insured risk upon occurrence of an insured event, during the insurance period.
- 15.3. **Insurance premium** – the payment for insurance specified in the insurance contract.
- 15.4. **Application for insurance** – a document of the form and content determined by the Insurer, which the Policyholder and/or the Insured fills out and submits to the Insurer in order to inform about the object of insurance, its condition, as well as other facts and circumstances.
- 15.5. **Insurance offer** – an offer prepared by the Insurer before the conclusion of the insurance contract in order to inform the Policyholder about the terms of the insurance contract and/or changes in them.
- 15.6. **Insured risk** – an event which is independent of the Insured's will and which is likely to occur in the future, as specified in the insurance contract. The insurance contract is valid only for the insured risks specified in the relevant insurance policy.
- 15.7. **Insured event** – a sudden and unpredictable event causally related to the insured risk, independent of the will of the Policyholder or the

Insured, upon the occurrence of which the payment of the insurance indemnity is foreseen in accordance with the provisions of the insurance contract.

15.8. **The date of the insured event** – when the Insured is diagnosed with the first, positive diagnosis of the illness, which, after additional examination during the survival period, is confirmed as a positive, final diagnosis by the relevant documents required for each insurance case, mentioned in the insurance regulations.

15.9. **Initial diagnosis of illness** – a positive diagnosis of critical illness for the insured risk which requires confirmation of the final diagnosis.

15.10. **Final diagnosis of the illness** – confirmation of the initial diagnosis, which has been proven by laboratory and instrumental examinations, in accordance with the established conditions for ascertaining the insured risk.

15.11. **Survival period** – a period of 30 (thirty) days, starting from the date of the insured event, during which the insured must be alive. If the Insured dies during the survival period, then the insurance indemnity is not paid.

15.12. **Waiting period** – the first 90 (ninety) days, starting from the date of entry into force of the insurance contract, when the insurance indemnity is not paid, if during this time period the Insured received a positive initial or final diagnosis of one of the critical illnesses. The said waiting period condition is not valid if the insurance contract is extended to the next insurance period without interruption, and the conditions of the insurance contract are not changed.

15.13. **Insurance indemnity** – the insurance amount to be paid for the insured event according to the insurance contract. In case of a diagnosed critical illness, the insurance indemnity shall be paid only once during the insurance period, and after the insurance indemnity has been paid, the insurance contract for the specific insured shall be terminated.

15.14. **Indemnity recipient** – in the event of the occurrence of the insured risk, the recipient is the insured, but in the event of death, the recipient is the beneficiary or the insured's heirs, following the procedures for the distribution of inheritance established by the laws and regulations of the Republic of Latvia, if the beneficiary is not specified in the insurance policy.

15.15. **Beneficiary** – a person who has the right to receive insurance compensation in the event of the Insured's death in accordance with the terms of the insurance contract and in accordance with the procedures established in the laws and regulations of the Republic of Latvia for such cases, provided that the insured's death occurred after the survival period.

15.16. **Provider for the child** – parents or guardians to whom the Insured child is dependent in accordance with the requirements of the laws and regulations of the Republic of Latvia.

15.17. **Expert doctor** – the doctor who determines the final diagnosis of the illness for the Insured.

## Attention!

**Health insurance** is intended to pay the insured persons their unexpected expenses while receiving medical services. The Insurer pays the insurance compensation according to the insurance program specified in the insurance policy, not exceeding the insurance amount and/or the insurance limit specified in the insurance policy.

**Critical illness insurance** is a type of personal insurance that provides for a one-time payment of the insurance amount stipulated in the insurance contract to the insured person in cases where, during the insurance contract period, the insured person is diagnosed with one of the critical illnesses included in the insurance contract and the waiting period stipulated by the insurance contract has passed, so that the insured person can use the insurance indemnity paid for the treatment of the critical illness or for daily expenses.

**Accident insurance** provides for the payment of indemnity if the insured person gets an injury or physical damage to the body as a result of exposure to external circumstances that he did not foresee in advance. The amount of indemnity is determined according to the risks included in the policy and indemnity calculation tables.

**Life insurance** is a type of insurance – life insurance with possible savings, when by making regular payments, it is possible to save for the financial security of your future, while providing material protection for your family in the event of a person's death.

Insured risks of critical illness

# A Program

## Alzheimer's disease

– causes irreversible symptoms.

An accurate diagnosis of Alzheimer's disease must be confirmed by a neurologist, psychiatrist or geriatrician.

There must be a permanent clinical loss of the ability to perform all of the following:

- to remember;
- to think, to reason;
- perceive, understand, express and implement ideas.

**An insured event is not:**

- other types of dementia.

## Parkinson's disease

*A slowly progressive disease of the brain, causing irreversible symptoms*

An accurate diagnosis of Parkinson's disease must be confirmed by a neurologist.

There must be persistent clinical impairment of motor function and associated tremors, muscle rigidity, and orthostatic instability.

**An insured event is not:**

- other Parkinson's syndromes.

## Poliomyelitis

– or polio, is an acute infectious disease caused by enteroviruses that damage the nervous system, especially the gray matter of the spinal cord; causes irreversible symptoms

Poliomyelitis is an acute viral infectious disease in a paralytic form.

There must also be laboratory tests confirming that poliovirus has been identified as the causative agent.

**An insured event is not:**

- meningeal and non-paralytic form of poliomyelitis;
- if vaccination has not been carried out according to the vaccination calendar.

## Loss of speech ability

*Irreversible, permanent and total loss of the ability to speak as a result of injury or illness and first diagnosed during the term of the insurance contract.*

The loss of speech ability must be continuous for at least 6 (six) months. The diagnosis must be confirmed by a consultant – ENT specialist.

**An insured event is not:**

- loss of speech ability as a result of mental disorders.

## Cancer

*Except in less advanced cases*

Any malignant tumor positively diagnosed by histological confirmation and characterized by uncontrolled growth and spread of malignant cells in tissues.

The diagnosis must be confirmed by an oncologist, and the diagnosis must be supported by a certain histological analysis.

The term "malignant tumor" includes leukemia, sarcoma, and lymphoma, excluding cutaneous lymphoma (lymphoma of the skin only).

**An insured event is not:**

- all cancers that are histologically classified as any of the following:
  - precancerous stage;
  - the first stage of cancer;
  - non-invasive;
  - cancer in situ;
  - a cancer that has either borderline malignancy or
  - low malignant potential.
- all prostate tumors unless they are histologically classified as having a Gleason scale score greater than 6 or advanced to at least clinical TNM classification in T2N0M0;
- malignant melanoma, unless histologically classified as having invaded beyond the epidermis (outer skin layer);
- any other skin cancers (including skin lymphomas) unless histologically classified as having invaded lymph nodes or spread to distant organs.

## Crohn's disease

*Chronic non-specific autoimmune and recurrent intestinal disease*

Crohn's disease can damage every part of the intestinal tract – ulcers form in the intestines, which cause great inflammation and swelling. Crohn's disease can affect both the colon and the small intestine, or both, or the entire digestive tract can be affected.

The diagnosis must be made by a gastroenterologist – a diagnosis of low-grade prostate cancer in cases where the cancer is localized and Crohn's disease, which has been treated with bowel surgery, has not spread outside the prostate gland.

Crohn's disease sometimes requires a bowel resection (surgery to remove part of the bowel).

Crohn's disease – surgically treated. The exact diagnosis, with the formation of fistulas and the diagnosis of intestinal narrowing, must be confirmed by a gastroenterologist.

There must also have been two or more resections of intestinal segments in each case. There must also be evidence of persistent inflammation with symptoms that persist despite optimal therapy with dietary restrictions, medication, and surgical intervention.

## Hepatitis C

*Acute or chronic viral infection*

The diagnosis of chronic hepatitis C should be confirmed using recombinant immunoblot analysis (RIBA). At least two HCV RNA tests must be performed within 4–6 months in order to make a final diagnosis of the presence of the virus in the blood.

**An insured event is not:**

- hepatitis caused by alcohol or medication.

## Aplastic anemia

*with irreversible bone marrow failure*

Aplastic anemia must be diagnosed by a hematologist. There should be persistent bone marrow failure with anemia, neutropenia, and thrombocytopenia.

## Coma

– causes irreversible symptoms

Coma is the final state of brain function – unconsciousness without any response to external irritants or internal needs, which:

- requires the use of a life support system for at least 96 hours; and
- leads to irreversible neurological deficit with persistent clinical symptoms.

According to the Glasgow Coma Scale (GCS), the depth of coma is determined by scoring three parameters – eye reaction (E), verbal (voice) reaction (V) and motor (movement) reaction (M).

To evaluate the depth of coma according to the Glasgow scale, add up all the indicators: E + M + V

Interpretation of the Glasgow scale:

- ☐ ≤ 8 coma;
- ☐ 9–12 medium damage;
- ☐ ≥ 13 – mild traumatic injury.

**An insured event is not:**

- secondary coma due to alcohol or drug use;
- if the total sum of the parameters evaluated according to the Glasgow scale is **≥ 9**.

Insured risks of critical illness

## B Program

### Lyme disease

– an infection caused by bacteria that enter the human body through the bite of an infected tick

The tick bite must have been detected during the insurance period, and the tick must have been removed in a medical facility. The insured must submit the results of two serological tests confirming the presence of infection (*Borrelia burgdorferi*) in the blood, as well as the conclusion of a consultant - infectious disease specialist - confirming the disorders caused by the disease at least 3 (three) months after the date of diagnosis.

**An insured event is not:**

- illness in the first stage, when **Lyme borreliosis - antibody indicators IgM, IgG are:**

IgG	IgM
Neg	Neg
Neg or gray area	Pos

### HIV infection

Acquired as a result of a blood transfusion, physical abuse or an accident at work

Infection with human immunodeficiency virus caused by:

- blood transfusions performed during medical treatment;
- physical assault; or
- an accident in the course of performing work duties;

after the policy start date if all of the following conditions are met:

- the accident must be reported to the relevant authorities and investigated in accordance with established procedures;
- if the HIV infection is acquired as a result of physical violence or an accident during work while performing normal work duties, the accident report must be supplemented with a negative HIV antibody test performed within 5 days after the accident;
- have another HIV test made within the next 12 months confirming the presence of HIV or antibodies to the virus;
- the incident causing the infection must have occurred in the European Union.

**An insured event is not:**

- HIV infection acquired in any other way, including through sexual activity or drug use.

### Bacterial meningitis

– an infectious disease causes irreversible symptoms

Bacterial meningitis - meningococcal type B infection of the brain and its covering.

Diagnosed with bacterial meningitis causing persistent neurological deficit with persistent clinical symptoms. The illness must be diagnosed with laboratory tests of the spinal fluid.

**An insured event is not:**

- all other types of meningitis except those caused by bacterial infection;
- if vaccination has not been carried out according to the vaccination calendar.

### Wilson's disease

– causes irreversible symptoms

Wilson's disease is genetic - it causes excessive accumulation of copper in the liver and brain, as well as in the kidneys, cornea and other organs, resulting in hepatitis, psychiatric or neurological symptoms. The illness must be diagnosed with laboratory tests.

### Liver failure

– is the last stage of various liver diseases, when the liver does not perform one or more of its functions

Liver failure leads to all of the listed symptoms:

- ascites;
- liver encephalopathy;
- yellow atrophy or dystrophy of the liver;

The most important enzymes in the detection of liver damage or pathology that are tested in the tests are GGT, AST, ALT and ANR.

AST value should be from lower than normal to 4–5 times higher than ANR. AST activity is higher than ALT. GGT is 5–10 times more compared to ANR.

**An insured event is not:**

- secondary liver disease resulting from alcohol or drug use.

### Chronic renal failure

Consequences of chronic kidney disease requiring dialysis

Chronic kidney disease (CKD) is a decline in kidney function up to their complete exhaustion. CKD is based on disturbances in the physiological processes of the kidneys, which is the end stage of kidney diseases, as a result of which regular dialysis is required.

Clinically, CKD manifests when less than 30 % of the nephrons are functional, while the terminal stage occurs when less than 10 % of the nephrons are functional.

Stages of CKD (main indicator - glomerular filtration rate - GFR):

- Full compensation - GFR decreases to around 50–70 ml/min. (N - 105–125 ml/min.). Healthy nephrons work with overload and hypertrophy;
- Compensated retention - GFR decreases to 25–30 ml/min. The amount of creatinine and urea in the blood increases;
- Decompensated delay - GFR is less than 20–25 ml/min. Clinical symptoms of uremia appear;
- Terminal stage - GFR is only 5–10 ml/min. The amount of urine decreases. All symptoms of uremia are clearly expressed.

**An insured event is not:**

- full compensation and compensated delay stages.

### Organ transplantation

The patient undergoes a bone marrow or complete heart, kidney, lung, pancreas, liver or liver lobe transplant.

**An insured event is not:**

- transplantation of any other organs, parts of organs, tissues or cells;
- organ donors;
- auto-transplantation;
- syngeneic transplantation;
- NON-syngeneic transplantation.

### Deafness

Irreversible, permanent and total hearing loss in both ears resulting from injury or illness and first diagnosed during the term of the insurance contract.

Deafness must be continuous for at least 6 (six) months. The diagnosis must be confirmed by a consultant - ENT specialist.

Insured risks of critical illness

## C Program

### Paralysis (extremities)

*Complete and irreversible*

Complete and irreversible loss of muscle function in all or any one limb after injury or disease. The diagnosis must be confirmed by a neurologist and documented for at least 3 (three) months.

**An insured event is not:**

- Guillain-Barre syndrome

### A stroke

*– causes symptoms that last at least 24 hours*

Death of brain tissue due to insufficient blood supply or intracranial hemorrhage leading to neurological deficit with persistent clinical symptoms lasting at least 24 hours.

The diagnosis must be confirmed by a neurologist and proven by all the typical clinical symptoms mentioned below, as well as by evidence from imaging studies.

Symptoms covered include numbness, hyperesthesia (increased sensitivity), paralysis, localized weakness, dysarthria (difficulty speaking), aphasia (inability to speak), dysphagia (difficulty swallowing), visual disturbances, difficulty walking, lack of coordination, tremors, convulsions, lethargy, coma.

**An insured event is not:**

- Transient ischemic attack, micro stroke
- Brain damage from trauma or infection.
- Recurrent stroke during the Insured's lifetime.

### Type 1 diabetes

*Constant insulin injections are required*

Type 1 insulin-dependent diabetes that requires constant insulin injections and has lasted for at least 12 months.

The diagnosis must be confirmed by an endocrinologist and substantiated by laboratory tests.

**An insured event is not:**

- gestational or pregnancy diabetes;
- Type 2 diabetes (including type 2 diabetes treated with insulin);
- latent autoimmune adult diabetes.

### Myocardial infarction (heart attack)

*Specific severity*

Death of the heart muscle due to insufficient blood supply resulting in all of the following symptoms of an acute myocardial infarction:

- New characteristic electrocardiographic changes.
- A characteristic increase in biochemical cardiac specific markers such as troponin or enzymes.

The diagnosis must be confirmed by a cardiologist and the symptoms must accurately diagnose an acute myocardial infarction.

**An insured event is not:**

- other acute coronary syndromes – angina pectoris or any other heart disease;
- a history of typical chest pains, as there are tests that can be used to prove that a heart attack has occurred;
- “silent” myocardial infarction.

### Primary pulmonary hypertension

*A disease that affects the lungs and heart*

Diagnosis of primary pulmonary hypertension – there must be clinical cardiac disorders resulting in permanent loss of ability to perform physical activities. Heart deficiency that results in severe limitation of physical activity, where exertion less than normal activity results in fatigue, palpitations, shortness of breath, or chest pain.

Pulmonary hypertension is classified into 5 groups according to the mechanism of pathogenesis:

1. group – pulmonary arterial hypertension (PAH)
2. group – pulmonary hypertension in connection with pathology of the left side of the heart;
3. group – pulmonary hypertension related to lung diseases;
4. group – pulmonary hypertension related to thromboembolism;
5. group – pulmonary hypertension related to various reasons

**An insured event is not:**

- pulmonary hypertension, which is classified under group 3, 4 or 5 according to the mechanism of pathogenesis

### Blindness

*Permanent and irreversible loss of vision in both eyes*

Permanent and irreversible loss of vision to the extent that, even when vision is tested using visual aids, the visual measurement is 6/60 or less on the Snellen chart in the better-seeing eye.

The duration of vision loss must be consecutive for at least 6 months.

**An insured event is not:**

- temporary blindness.

### Multiple sclerosis

*Multiple sclerosis is an autoimmune chronic disease that affects the brain and spinal cord.*

Multiple sclerosis is a disease of the central nervous system that destroys the myelin of nerve fibers in the brain and spinal cord. The diagnosis must be confirmed by a neurologist. There must be clinical motor or sensory impairments caused by multiple sclerosis. The disease must be demonstrated by typical symptoms of demyelination, motor and sensory dysfunction demonstrated in at least two different central nervous system sites, as well as by typical magnetic resonance imaging.

In order for the diagnosis to be confirmed, the insured must either have a neurological pathology that has existed continuously for at least 6 (six) months or there must be at least two clinically documented episodes with an interval of at least one month, or there must be at least one clinically documented episode together with characteristic signs in spinal fluid examinations, as well as typical brain lesions in magnetic resonance imaging.

### Burns

*Third and fourth degree burns*

Burns that cause full-thickness skin damage to subcutaneous tissue and/or muscle and affect at least 20 % of the body surface area.

**An insured event is not:**

- burns caused by self-inflicted injury;
- for first or second degree burns..