Gjensidige

Health insurance terms and conditions No 067

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Health insurance terms and conditions No 067

APPROVED BY:
ADB Gjensidige
By a resolution of the Board meeting 24 October 2024
The Terms shall be valid from 1 November 2024

1. Terms and definitions

If any differences arise between the terms used in these Health Terms and Conditions and the General Insurance Terms and Conditions, the terms contained in these Health Insurance Terms and Conditions shall apply. Any terms not defined in these Health Insurance Terms and Conditions shall be construed in the manner they are defined in the General Insurance Terms and Conditions.

1.1. **"You"** or the **"Insured Person"** means the natural person specified in the insurance policy whose property interests are covered by the Health Insurance Contract.
1.2. **"Outpatient surgery service"** means an elective curative healthcare service, the provision which may include the application of local or regional anaesthesia, administered by the doctor performing the operation or procedure, followed by post-operative (post-procedural) care and the possibility to provide healthcare services without removing the patient from his/her normal social environment.
1.3. **"Diagnostics"** means medical advice, diagnostic tests and procedures to diagnose, investigate or monitor a disease.
1.4. **"Day surgery service"** means a scheduled personal healthcare service, during which a therapeutic and/or diagnostic interventional procedure when the Insured Person stays in an day-care ward of the surgery unit up to 24 hours.
1.5. **"Day-care inpatient service"** means a scheduled therapeutic and/or diagnostic personal health care activities, during which the patient is ensured up to 8 hours of care.
1.6. **"Policyholder"** means the person who has applied to Us for the conclusion of an insurance contract, or whom We have proposed to conclude an insurance contract with Us.
1.7. **"We"** or the **"Insurer"** means ADB Gjensidige.
1.8. **"Treatment"** means medical advice, diagnostic tests, diagnostic and therapeutic procedures to treat a disease.
1.9. **"Long-term care"** means permanent, long-lasting care for elderly people, people with disabilities, or chronically ill people, or for people who have suffered from acute illnesses and their consequences, including services at home, in a nursing home, in a medical centre, or in a social assistance institution.
1.10. **"Medical supplies"** means bandages, plasters, syringes, and drip systems.
1.11. **"Medical device"** means an instrument that helps to diagnose, treat, monitor a person's disease and detect, treat or compensate for a person's injury or disability.
1.12. **"Non-traditional (alternative) medicine"** means the diagnosis, treatment or prevention of health disorders using medicine methods not approved or regulated in the Republic of Lithuania, such as: acupuncture, ozone therapy, medicinal leech therapy, bioresonance diagnostics, phytotherapy, colonic hydrotherapy, osteopathy, homeopathy, reflexology, aromatherapy, endobiogeny, detoxication, etc.
1.13. **"Partner"** means an institution, company, organisation that has entered into a cooperation agreement with Us and where the Insurance Card can be used to pay for services provided and/or goods sold. The Partner is not Our representative.
1.14. **"Health disorder"** means an acute illness or injury diagnosed by a doctor for which you have expressed complaints and which requires diagnosis or treatment, or a diagnosed chronic illness for which a doctor has prescribed periodic follow-up.
1.15. **"Trauma"** means sudden and unexpected damage to the integrity of body tissues at a specific time and at a specific place due to physical, chemical, thermal environmental effects and resulting dysfunction of body parts and/or organs. Impairment of health due to degenerative changes is not considered an injury.

1.16. **"Insurance card"** means a digital or plastic card issued by the Insurer confirming that insurance cover has been provided to the Insured Person under the insurance contract. The Insurance Card may be used to pay for services provided (goods sold) by the Partner.
1.17. **"Outpatient treatment"** means services (consultations, tests, and day surgery services) provided to the Insured Person in a personal health care institution where the Insured Person spends up to 24 hours.
1.18. **"Inpatient treatment"** means services provided to the Insured Person when he/she spends at a health care institution more than 24 hours. The first day (day of admittance) and the last day (day of discharge) at the inpatient treatment institution shall be counted as one day (bed day).
1.19. **"Pharmacy"** means a legal entity or a unit thereof established in the Republic of Lithuania, or a unit of a foreign legal entity or other organisation established in the Republic of Lithuania, licensed to carry out pharmaceutical activities, including distance selling.
1.20. **"Dietary supplement"** means a food product included in the list of dietary supplements notified by the State Food and Veterinary Service.
1.21. **"Orthopaedic equipment"** means splint systems, prosthetic systems for the locomotor system, canes, crutches, inserts, post-operative shoes, elastic bandages, belts, ligaments, corsets, compression stockings and tights.
1.22. **"Doctor"** means a person holding a licence for the practice of medicine and authorised by law to carry out personal health care activities: to determine a person's state of health, diagnose and treat diseases.
1.23. **"Medicines"** means medicinal products registered in the Register of Medicinal Products of the Republic of Lithuania or of the European Community, having an Anatomical Therapeutic Chemical (ATC) classification code and purchased at a Pharmacy.
1.24. **"Referral"** means a medical document, which contains the date of issue, period of validity, patient's details, diagnosis, history and course of the disease, purpose of the referral, signed by the Doctor who refers the Insured Person for consultations by other specialist doctors, performance of examinations, revision of the treatment, or hospital treatment, and is valid for 180 calendar days from the date of issue to the date of the provision of the prescribed service.
1.25. **"Medically justified"** means Health Care Services justified in the medical documentation as necessary by a competent doctor to the Insured Person based on his/her complaints.

2. Insurance object and insurance territory

2.1. "Insurance object" means Your proprietary interests related to insured events provided for in the insurance risks chosen by the Policyholder and specified in the insurance policy and assumed by Us.
2.2. In all cases, the insurance object relates to:
2.2.1. personal health care services provided or goods purchased because of a medical disorder that needs to be diagnosed or treated;
2.2.2. services provided or goods purchased for disease prevention or health promotion purposes.
2.3. Voluntary health insurance is a supplementary insurance under which We assume the obligation to reimburse You for the costs that are not covered by the budget of the Compulsory Health Insurance Fund (hereinafter referred to as the "CHIF").
2.4. "Insurance territory" means the Insurer's obligation to pay the insurance benefit in the event of an insured event for health care services and/or goods provided and purchased in the territory of the Republic of Lithuania and in institutions that are registered with the State Enterprise Centre of Registers.

3. Insurance risks

3.1. All or some of the listed classes of property risks may be insured on the basis of these Regulations and under the conditions specified in the insurance policy:
3.1.1. "Outpatient treatment" (Chapter 4);
3.1.2. "Inpatient treatment" (Chapter 5);
3.1.3. "Prenatal care and childbirth" (Chapter 6);
3.1.4. "Dentistry" (Chapter 7);
3.1.5. "Medicines and medical supplies" (Chapter 8);
3.1.6. "Vitamins and dietary supplements" (Chapter 9);
3.1.7. "Optics" (Chapter 10);
3.1.8. "Prophylaxis" (Chapter 11);

3.1.9. "Medical rehabilitation" (Chapter 12);
3.1.10. "Wellness" (Chapter 13);
3.1.11. "Critical disease insurance" (Chapter 14);
3.1.12. "Insurance of various risks" (Chapter 15);
3.1.13. "Classic insurance of various risks" (Chapter 16).

3.2. **By agreement between Us and the Policyholder, the insurance contract may also cover other insurance risks not provided for in these Regulations. Such an agreement must be clearly expressed and set out in the insurance policy.**

3.3. We only assume liability for insured events in respect of the insurance risks specified in the insurance policy.

3.4. If the risks specified in the insurance policy are aggregated, the descriptions of the aggregated risks listed in Chapters 4 to 16 shall apply.

4. Outpatient treatment

4.1. The purpose of this insurance risk is to protect against potential property losses when services related to outpatient treatment are provided as a result of an insured event.

4.2. Insured events.
An insured event is considered a medical disorder that requires You to medically justified personal health care services specified in Sub-paragraph 4.3.

4.3. In case of an insured event under the risk **"Outpatient treatment"**, We reimburse losses (costs) for:
4.3.1. medical advice, including remote;
4.3.2. diagnostic (laboratory, instrumental) tests prescribed by a doctor;
4.3.3. ambulance services;
4.3.4. nurse services prescribed by a doctor (e.g. medicine administration excluding the price of medical substances, blood draws, wound dressing);
4.3.5. doctor's home visits;
4.3.6. psychotherapeutic treatment provided by a psychiatrist, psychiatrist-psychotherapist or medical psychologist (up to 12 single visits during the period of validity of the insurance contract);
4.3.7. surgical services (including anaesthesia, nursing and medical devices) prescribed by a doctor:
4.3.7.1. out-patient surgery services in accordance with the currently effective list of out-patient surgery services approved by the Ministry of Health of the Republic of Lithuania (hereinafter referred to as the "MOH");
4.3.7.2. day surgery services in accordance with the currently effective list of day surgery services approved by the MOH;
4.3.8. day-care inpatient services prescribed by a doctor according to the currently effective list of day-care inpatient services approved by the MOH.

4.4. The costs for the services specified in Sub-paragraphs 4.3.1–4.3.2, 4.3.4, 4.3.6–4.3.8 shall only be reimbursed if they are provided in a licensed personal health care institution.

4.5. Under the risk **"Outpatient treatment"**, We do not reimburse the following costs:
4.5.1. inpatient personal health care services;
4.5.2. antenatal care and pregnancy-related health conditions, childbirth and postnatal care;
4.5.3. vision correction surgeries;
4.5.4. dental services related to the diagnosis, treatment and prevention of diseases of the teeth, mouth, face and jaws;
4.5.5. diagnosis and treatment of benign skin and subcutaneous lesions, moles, lipomas, warts, acne, papillomas, condylomas, keratomas, molluscs, etc;
4.5.6. consultations, tests, operations and other procedures for the treatment of ligaments, tendons, joints, muscles and foot bones (excluding damage caused by a trauma);
4.5.7. injections of bodily fluids with or without blood elements (PRP (blood plasma, amber, amino acid etc.), hyaluronic acid, botulinum injections; stem cell therapy;
4.5.8. hemodialysis; organ (tissue) transplantation;
4.5.9. medical rehabilitation treatment and services;
4.5.10. cosmetology, plastic and aesthetic procedures and surgeries, aesthetic dermatology services (phototherapy, photodynamic therapy, pulsed light therapy, redermalization, biorevitalization, etc.), removal, diagnostics, treatments and procedures for pigmentation, redness, rosacea (pink), dilated blood vessels, acne, stretch marks, scars; hair removal procedures, laser treatment of nail fungus; diagnosis and treatment of hair loss;

4.5.11. laser gynaecology/urology, shockwave therapy services;
4.5.12. diagnosis and treatment of infertility, inability to conceive, family planning, contraception (including contraceptive procedures) and potency disorders; consultations with a sexologist; artificial insemination; termination of pregnancy in the absence of medical indications;
4.5.13. leg vein treatments (surgeries) whereby the venous disease in accordance with the CEAP classification complies with classes C0-C3; vein or capillary disease treatment – sclerotherapy;
4.5.14. diagnostic tests: allergens; HPV; cancer markers; food intolerances; physical fitness examinations (tests);
4.5.15. for the diagnosis and treatment of the following diseases, disorders and new growths: sexually transmitted diseases (gonorrhoea, syphilis, human papillomavirus, syphilis, chlamydiosis, genital herpes, etc.); AIDS (HIV); addiction diseases;
4.5.16. eyelid surgery (reimbursed only if the surgery is performed after a computerized perimetry test and part of the cost of the surgery is reimbursed by the territorial patients' fund);
4.5.17. diagnosing and treatment of overweight and obesity; development of diet plans;
4.5.18. genetically determined diseases; genetic testing; geneticist's advice and tests prescribed by a geneticist; congenital anomalies and their complications;
4.5.19. if a personal health care institution is contacted in the absence of any specific complaints about the health condition;
4.5.20. in cases where treatment is not related to a health issue;
4.5.21. endoprotheses;
4.5.22. services of non-traditional (alternative) medicine;
4.5.23. any services provided at an institution or by an individual that does not have the licences, permits, certificates, stamps, etc., required for engaging in the respective activity;
4.5.24. psychologist's advice provided other than at a health care institution;
4.5.25. research programme (test packages, etc.) prescribed by a doctor, paid for solely from the prevention risk;
4.5.26. services and goods reimbursed under other risks;
4.5.27. services (goods) specified in Paragraph 18.

5. Inpatient treatment

5.1. The purpose of this insurance risk is to protect against potential property losses in the case of the provision of services or purchase of goods related to in-patient treatment and specified in Sub-paragraphs 5.4.1–5.4.2 as a result of an insured event.
5.2. When concluding an insurance contract, the Policyholder may choose one of the two options for this insurance risk:
5.2.1. "Inpatient treatment in public hospitals";
5.2.2. "Inpatient treatment in public and private hospitals".
5.3. Insured events.
An insured event is considered a health disorder due to which services and goods are required.
5.4. In case of an insured event under the risk "Inpatient treatment", We reimburse losses (costs) for:
5.4.1. a paid ward and diagnostic and treatment services, medical devices, medicines, vitamins and dietary supplements at a public health care institution licensed as a personal health care institution, in case of choosing the option "Inpatient treatment in public hospitals";
5.4.2. a paid ward and diagnostic and treatment services, medical devices, medicines, vitamins and dietary supplements at a public or private health care institution licensed as a personal health care institution, in case of choosing the option "Inpatient treatment in public and private hospitals".
5.5. Under the risk **"Inpatient treatment"**, We do not reimburse the following costs:
5.5.1. antenatal care and pregnancy-related health conditions, childbirth and postnatal care;
5.5.2. vision correction surgeries;
5.5.3. dental services related to the diagnosis, treatment and prevention of diseases of the teeth, mouth, face and jaws;
5.5.4. diagnosis and treatment of benign skin and subcutaneous lesions, moles, lipomas, warts, acne, papillomas, condylomas, keratomas, molluscs, etc;
5.5.5. consultations, tests, operations and other procedures for the treatment of ligaments, tendons, joints, muscles and foot bones (excluding damage caused by a trauma);

5.5.6. injections of bodily fluids with or without blood elements (PRP (blood plasma, amber, amino acid etc.), hyaluronic acid, botulinum injections; stem cell therapy;
5.5.7. hemodialysis; organ (tissue) transplantation;
5.5.8. medical rehabilitation treatment and services;
5.5.9. cosmetology, plastic and aesthetic procedures and surgeries, aesthetic dermatology services (phototherapy, photodynamic therapy, pulsed light therapy, redermalization, biorevitalization, etc.), laser procedures (removal of pigmentation, redness, rosacea (pink), dilated blood vessels, acne, stretch marks, scars, etc.); hair removal procedures, laser treatment of nail fungus; diagnosis and treatment of hair loss;
5.5.10. laser gynaecology/urology, shockwave therapy services;
5.5.11. diagnosis and treatment of infertility, inability to conceive, family planning, contraception (including contraceptive procedures) and potency disorders; consultations with a sexologist; artificial insemination; termination of pregnancy in the absence of medical indications;
5.5.12. leg vein treatments (surgeries) whereby the venous disease in accordance with the CEAP classification complies with classes C0-C3; vein or capillary disease treatment – sclerotherapy;
5.5.13. diagnostic tests: allergens; HPV; cancer markers; food intolerances;
5.5.14. for the diagnosis and treatment of the following diseases, disorders and new growths: sexually transmitted diseases (gonorrhoea, syphilis, human papillomavirus, syphilis, chlamydiosis, genital herpes, etc.); AIDS (HIV); addiction diseases;
5.5.15. eyelid surgery (reimbursed only if the surgery is performed after a computerized perimetry test and part of the cost of the surgery is reimbursed by the territorial patients' fund);
5.5.16. diagnosing and treatment of overweight and obesity; development of diet plans;
5.5.17. genetically determined diseases; genetic testing; geneticist's advice and tests prescribed by a geneticist; congenital anomalies and their complications;
5.5.18. if a personal health care institution is contacted in the absence of any specific complaints about the health condition;
5.5.19. in cases where treatment is not related to a health issue;
5.5.20. endoprotheses;
5.5.21. services of non-traditional (alternative) medicine;
5.5.22. any services provided at an institution or by an individual that does not have the licences, permits, certificates, stamps, etc., required for engaging in the respective activity;
5.5.23. psychologist's advice provided other than at a health care institution;
5.5.24. research programme (test packages, etc.) prescribed by a doctor, paid for solely from the Prophylaxis risk (Chapter 11);
5.5.25. services and goods reimbursed under other risks;
5.5.26. services (goods) referred to in Paragraph 18.

6. Prenatal care and childbirth

6.1. The purpose of this insurance risk is to protect against potential property losses when services related to prenatal care and childbirth are provided as a result of an insured event.
6.2. Insured events.
An insured event is considered pregnancy that causes the need for personal health care services specified in Sub-paragraph 6.3. Costs of the services shall only be reimbursed if the services are provided in a licensed personal health care institution.
6.3. In case of an insured event under the risk **"Prenatal care and childbirth"**, We reimburse losses (costs) for:
6.3.1. family doctor or obstetrician (obstetrician gynaecologist) consultations;
6.3.2. pregnancy-related consultations with other specialist doctors;
6.3.3. diagnostic (laboratory, instrumental) tests prescribed by a family doctor or obstetrician (obstetrician gynaecologist), or other specialist doctors;
6.3.4. genetic testing;
6.3.5. childbirth service, postnatal care, and paid ward during labour.
6.4. Under the risk **"Prenatal care and childbirth"**, We do not reimburse the following costs:
6.4.1. termination of pregnancy in the absence of medical indications, including the treatment of complications following this procedure;
6.4.2. services provided by a dental practitioner;
6.4.3. services (goods) specified in Paragraph 18.

7. Dental

7.1. The purpose of this insurance risk is to protect against potential property losses when services related to the treatment and prevention of diseases of the teeth, mouth, face and jaws are provided as a result of an insured event.

7.2. Insured events.
An insured event is considered a disease of the teeth, mouth, face and jaws, damage resulting from a trauma, and prevention of dental diseases due to which personal health care services specified in Sub-paragraph 7.3 are required. Costs of the services shall only be reimbursed if the services are provided in a licensed dental care (aid) institution or dental practice.

7.3. In case of an insured event under the risk **"Dentistry"**, We reimburse losses (costs) for:
- 7.3.1. oral hygiene treatments;
- 7.3.2. X-ray, tooth filling services, endodontic, periodontic and surgical dental disease treatment services;
- 7.3.3. dental prosthetics, implant and orthodontic treatment services, aesthetic fillings;
- 7.3.4. dental (straightening, myorelaxation) mouth guards.

7.4. Under the risk **"Dentistry"**, We do not reimburse the following costs:
- 7.4.1. aesthetic dentistry services: dental decorations, whitening, coating with silane;
- 7.4.2. sports, whitening, protective and bruxism mouth guards, trainers;
- 7.4.3. dental and oral hygiene products;
- 7.4.4. services (goods) specified in Paragraph 18.

8. Medicines and medical supplies

8.1. The purpose of this insurance risk is to protect against potential property losses when goods related to outpatient treatment are purchased as a result of an insured event.

8.2. Insured events.
An insured event is considered a health disorder due to which goods are required.

8.3. In case of an insured event under the risk **"Medicines and medical supplies"**, We reimburse losses (costs) for medicines and medical supplies (see the term "Medical suplies") prescribed under a doctor's prescription or medical statement and purchased at a Pharmacy or personal health care institution and **Orthopaedic equipment** purchased from orthopaedic technical goods stores;

8.4. If the medicines and/or medical supplies are reimbursed from the funds of the budget of the PSDF, 100% reimbursement on the extra pay shall be provided;

8.5. Under the risk **"Medicines and medical supplies"**, We do not reimburse costs for:
- 8.5.1. any medicines that are not registered in accordance with the procedure prescribed by the Law on Pharmacy of the Republic of Lithuania;
- 8.5.2. goods where it is not possible to separate the prices of services (e.g. the injection service and the price of the medicine);
- 8.5.3. services (goods) specified in Paragraph 18.

9. Vitamins and dietary supplements

9.1. The purpose of this insurance risk is to protect against potential property losses when goods related to the treatment and prevention of diseases are purchased as a result of an insured event.

9.2. Insured events.
An insured event is considered a health disorder of prevention of diseases due to which goods are required.

9.3. In case of an insured event under the risk **"Vitamins and dietary supplements"**, We reimburse losses (costs) for vitamins and notified dietary supplements, non-prescription medicines purchased at a Pharmacy.

9.4. Under the risk **"Vitamins and dietary supplements"**, We do not reimburse costs services/goods specified in Paragraph 18.

10. Optics

10.1. The purpose of this insurance risk is to protect against potential property losses in the case of the provision of services or purchase of goods related to the treatment of eye diseases as a result of an insured event.

10.2. Insured events.
An insured event is considered an eye disease due to which optical goods and services are required. Costs for the items listed in Sub-paragraphs 10.3.2–10.3.3 will only be reimbursed if they are purchased from an optician's or a specialised on-line contact lens shop. Costs of the services specified in Sub-paragraph 10.3.4 shall only be reimbursed if the services are provided in a licensed personal health care institution.

10.3. In case of an insured event under the risk **"Optics"**, We reimburse losses (costs) for:
10.3.1. optometrist services;
10.3.2. corrective lenses prescribed by an ophthalmologist or optometrist, or spectacle frames when purchased together with corrective lenses;
10.3.3. contact lenses prescribed by an ophthalmologist or optometrist;
10.3.4. vision correction surgery prescribed by a doctor.

10.4. Under the risk **"Optics"**, We do not reimburse the following costs:
10.4.1. plano lenses (e.g. sunglasses, computer glasses, driving glasses);
10.4.2. care products and accessories for glasses and contact lenses (e.g. eyeglass cases, cleaners, solvents, wipes);
10.4.3. artificial tears, dietary supplements, medicines;
10.4.4. services (goods) specified in Paragraph 18.

11. Prophylaxis

11.1. The purpose of this insurance risk is to protect against potential property losses when services related to the prevention, early diagnostics, and vaccination of diseases are provided as a result of an insured event.

11.2. When concluding an insurance contract, the Policyholder may choose one of the two options for this insurance risk:
11.2.1. "Prophylaxis";
11.2.2. "Prophylaxis and vaccination".

11.3. Insured events.
An insured event is considered personal health care services to prevent medical disorders or to assess in advance a medical condition, as listed in Sub-paragraphs 11.4–11.5.

11.4. In case of an insured event under the risk "Prophylaxis", We reimburse losses (costs) for services provided at a licensed health care institution: personal health care services according to the currently effective list of preventive health check-ups approved by the MOH (for employees, drivers, etc.) and for personal health care services according to the currently effective preventive programmes approved by the MOH (prevention of cardiovascular diseases, early diagnosis of prostate cancer, etc.); personal health care services under health screening programmes drawn up by personal health care institutions and personal health care services (medical consultations and diagnostic tests) when the insured person had no complaints about his/her health condition, underwent diagnostic tests without a doctor's appointment or at his/her own request.

11.5. In case of an insured event under the option "Prophylaxis and vaccination", We will reimburse losses (costs) for services provided at a licensed health care institution or Pharmacy: the services specified in Sub-paragraph 11.4 and, additionally, for a doctor's consultation on vaccination, the chosen vaccine, and the vaccination service.

11.6. Under the risk **"Prophylaxis"** (any of the options), We do not reimburse the following costs:
11.6.1. inpatient personal health care services;
11.6.2. antenatal care and pregnancy-related health conditions, childbirth and postnatal care;
11.6.3. vision correction surgeries;
11.6.4. dental services related to the diagnosis, treatment and prevention of diseases of the teeth, mouth, face and jaws;
11.6.5. injections of bodily fluids with or without blood elements (PRP, amber, amino acid etc.), hyaluronic acid, botulinum injections; stem cell therapy;
11.6.6. hemodialysis; organ (tissue) transplantation;
11.6.7. medical rehabilitation treatment and services;
11.6.8. cosmetology, plastic and aesthetic procedures and surgeries, aesthetic dermatology services (phototherapy, photodynamic therapy, pulsed light therapy, redermalization, biorevitalization, etc.), laser procedures (removal of pigmentation, redness, rosacea (pink), dilated blood vessels,

acne, stretch marks, scars, etc.); hair removal procedures, laser treatment of nail fungus; diagnosis and treatment of hair loss;

11.6.9. laser gynaecology/urology, shockwave therapy services;

11.6.10. artificial insemination; pregnancy termination in the absence of medical indications;

11.6.11. leg vein treatments (surgeries) whereby the venous disease in accordance with the CEAP classification complies with classes C0-C3; vein or capillary disease treatment – sclerotherapy;

11.6.12. eyelid surgery (reimbursed only if the surgery is performed after a computerized perimetry test and part of the cost of the surgery is reimbursed by the territorial patients' fund);

11.6.13. diagnosis and treatment of overweight and obesity;

11.6.14. endoprotheses;

11.6.15. services of non-traditional (alternative) medicine;

11.6.16. any services provided at an institution or by an individual that does not have the licences, permits, certificates, stamps, etc., required for engaging in the respective activity;

11.6.17. psychologist's advice provided other than at a health care institution;

11.6.18. services (goods) specified in Paragraph 18.

12. Medical rehabilitation

12.1. The purpose of this insurance risk is to protect against potential property losses when services related to rehabilitation treatment are provided as a result of an insured event.

12.2. When concluding an insurance contract, the Policyholder may choose one of the following options for this insurance risk:

12.2.1. "Medical rehabilitation without a doctor's referral";

12.2.2. "Medical rehabilitation with a doctor's referral";

12.2.3. "Medical rehabilitation after inpatient treatment".

12.3. Insured events.
An insured event is considered a health disorder due to which the medical rehabilitation services specified in Sub-paragraph 12.4 are required.

12.4. In case of an insured event under the risk **"Medical rehabilitation"**, We will reimburse losses (costs) for the following services provided at a licensed personal health care institution:

12.4.1. physiotherapy treatments;

12.4.2. kinesiotherapist services and kinesiotherapy treatments;

12.4.3. electrical impulse therapy procedures;

12.4.4. ergotherapy;

12.4.5. mud and water treatments;

12.4.6. curative massages;

12.4.7. halotherapy;

12.4.8. manual therapy.

12.5. In case of selecting the option "Medical rehabilitation with a doctor's referral", costs for the services shall only be reimbursed if there is a doctor's referral (prescription) for the specific rehabilitation services specified in Sub-paragraph 12.4.

12.6. In case of selecting the option "Medical rehabilitation after inpatient treatment", costs for the services shall only be reimbursed if the Insured Person has been treated in hospital for at least 24 hours and there is a doctor's referral (prescription) for the specific rehabilitation services specified in Sub-paragraphs 12.4.1–12.4.8. Medical rehabilitation must be commenced within 3 months of the date of release from the hospital.

12.7. Under the risk **"Medical rehabilitation"** (any of the options), We do not reimburse the services (goods) specified in Paragraph 18 of these Regulations.

13. Wellness

13.1. The purpose of this insurance risk is to protect against potential property losses when services related to the prevention of diseases or strengthening of the body are provided as a result of an insured event.

13.2. Insured events.
The insured event is considered to be the provision of health-promotion services (physical education activities, aquatic treatments, massages) listed in Sub-paragraph 13.3.

13.3. In case of an insured event under the risk **"Wellness"**, We reimburse losses (costs) for the following services provided at licensed personal health care institutions and/or sanatoriums and/or sports clubs and/or swimming pools and/or tennis/squash courts and/or spa centres, gyms or by persons engaged in an individual activity:
13.3.1. sessions in a gym, aerobics, yoga, dance training, tennis, badminton, squash, fitness, callanetics, pilates, swimming and other kinds of sport;
13.3.2. all types of massages, mud and water treatments, physiotherapy, kinesiotherapy;
13.3.3. psychologist consultations;
13.3.4. dietician's consultations and development of diet plans;
13.3.5. physical exercise tests;
13.3.6. homeopath services;
13.3.7. non-traditional medical services.
13.4. Under the risk **"Wellness"**, We do not reimburse the following costs:
13.4.1. services provided at water or winter amusement parks;
13.4.2. cosmetology, aesthetics and beauty treatments;
13.4.3. services (goods) specified in Paragraph 18.

14. Critical disease insurance

14.1. The purpose of this insurance risk is to protect against potential property losses related to the diagnosis and treatment of a critical illness.
14.2. When concluding an insurance contract, the Policyholder may choose one of the two options for this insurance risk:
14.2.1. "Treatment of critical illnesses";
14.2.2. "Lump indemnity in case of a critical disease".
14.3. Insured events.
An insured event is considered a critical illness diagnosed for the first time in life during the period of validity of the insurance contract. The list of critical illnesses and the criteria for the recognition of these illnesses as insured events, which must be met in order for the illness to be recognised as an insured event, are set out in Annex 1 to these Regulations.
14.4. In case of an insured event under the risk **"Critical illness insurance"**, We reimburse losses (costs) for:
14.4.1. in case of choosing the option "Treatment of critical illnesses", we will pay for the following services during the treatment of a critical illness diagnosed by a doctor within the period of validity of this insurance contract: medical consultations, prescribed tests, inpatient treatment, medical rehabilitation, medicines, vitamins, orthopaedic equipment;
14.4.2. in case of choosing the option "Lump indemnity in case of a critical disease", the whole insurance sum is paid out once within the period of validity of the insurance contract if a critical disease is diagnosed during the period of validity of the insurance contract, irrespective of the number of critical illnesses diagnosed.
14.5. Under the risk **"Critical illness insurance"** (any of the options), We do not reimburse the following costs (do not pay out the benefit):
14.5.1. for diagnosed illnesses not listed in the of Critical Illnesses (Annex 1 to the Regulations);
14.5.2. services (goods) specified in Paragraph 18.

15. Insurance of various risks

15.1. The purpose of this insurance risk is to protect against potential property losses in the case of the provision of services or purchase of goods specified in Paragraphs 1–13 and Sub-paragraph 14.4.1.
15.2. Insured events.
An insured event is considered a health disorder of prevention of diseases (body strengthening) due to which goods and services are required.
15.3. In case of an insured event, We reimburse losses (costs) for:
15.3.1. services provided at out-patient and in-patient personal health care institutions;
15.3.2. services provided by dental practices;
15.3.3. goods purchased from pharmacies: medicines and medical supplies, vitamins, dietary supplements, medical devices, hygiene and curative cosmetic products, orthopaedic equipment;

15.3.4. orthopaedic **equipment** purchased from orthopaedic technical goods stores;
15.3.5. services (goods) provided by (purchased from) opticians or specialised online shops selling contact lenses;
15.3.6. services provided in sports clubs, swimming pools, tennis (squash) courts, spa facilities, wellness facilities;
15.3.7. psychologist consultations;
15.3.8. homeopath and non-traditional medical services.
15.4. Under the risk **"Insurance of various risks"**, We do not reimburse the following costs:
15.4.1. medicines and medical supplies, vitamins, dietary supplements, medical devices, hygiene and therapeutic cosmetics purchased other than at a **Pharmacy**;
15.4.2. decorative cosmetics;
15.4.3. cosmetology, plastic procedures and operations and those performed for aesthetic purposes (beauty), aesthetic dermatology services (phototherapy, photodynamic therapy, impulse light therapy, laser aesthetic treatments (pigmentation, rosacea, dilated capillaries, acne, stretch marks, scars, etc.); hair removal treatments;
15.4.4. services (goods) specified in Paragraph 18.

16. Classic insurance of various risks

16.1. The purpose of this insurance risk is to protect against potential property losses in the case of the provision of services or purchase of goods specified in Paragraphs 4–14.4.1.
16.2. Insured events.
An insured event is considered a health disorder of prevention of diseases (body strengthening) due to which goods and services are required.
16.3. In case of an insured event, We reimburse losses (costs) for:)
16.3.1. services provided at out-patient and in-patient personal health care institutions;
16.3.2. services provided by dental practices;
16.3.3. goods purchased from pharmacies: medicines and medical supplies, vitamins, dietary supplements, medical devices, orthopaedic equipment;
16.3.4. **orthopaedic equipment** purchased from orthopaedic technical goods stores;
16.3.5. services (goods) provided by (purchased from) opticians or specialised online shops selling contact lenses;
16.3.6. homeopath and non-traditional medical services, when provided at a licensed medical institution.
16.4. Under the risk **"Classic insurance of various risks"**, We do not reimburse the following costs:
16.4.1. glasses or lenses without dioptres (e.g. sunglasses, computer glasses, driving glasses);
16.4.2. medicines and medical supplies, vitamins, dietary supplements, medical devices purchased other than at a Pharmacy;
16.4.3. care products and accessories for glasses and contact lenses (e.g. eyeglass cases, cleaners, solvents);
16.4.4. services provided at sports clubs, spa centres or other than at health care institutions;
16.4.5. services provided at unlicensed institutions;
16.4.6. teeth whitening, dental and oral hygiene products;
16.4.7. hygiene and cosmetic products;
16.4.8. blood plasma, hyaluronic acid, botulin injections; stem cell therapy, haemodialysis; artificial insemination; organ/tissue transplantation services and/or procedures;
16.4.9. cosmetology, plastic procedures and operations and those performed for aesthetic purposes (beauty), aesthetic dermatology services (phototherapy, photodynamic therapy, impulse light therapy, laser aesthetic treatments (pigmentation, rosacea, dilated capillaries, acne, stretch marks, scars, etc.); hair removal treatments;
16.4.10. services (goods) specified in Paragraph 18.

17. Excluded events

17.1. In case of any insurance risk, health disorders are considered a non-insured events when they arose in the following situations:
17.1.1. attempts of suicide or deliberate self-harm;
17.1.2. intentional acts of the Policyholder or the person;

17.1.3. performance of acts which, under the legal acts of the Republic of Lithuania or the country in which they are performed, are considered a criminal offence or an administrative offence (except for infringements of road traffic rules); as well as those that arose when attempting to deter a person from such acts;
17.1.4. the person is under the influence of alcohol, drugs or other intoxicating substances;
17.1.5. acts of foreign enemies, military action (whether or not martial law has been declared), civil war, coup d'état or usurpation of power, mass disturbances, insurrection, revolution, rebellion, terrorist activities;
17.1.6. participation in hostilities, military operations, mass and civil disturbances, insurrections, riots and strikes;
17.1.7. restrictions imposed by the authorities, strike, riots, mass disturbances, act of terrorism;
17.1.8. kidnapping or holding hostage;
17.1.9. atomic explosions, nuclear power, global catastrophes or natural disasters (earthquake, hurricane, tsunami, etc.); pandemics, ecological disasters, chemical contamination.

17.2. An insurance benefit shall not be paid when:
17.2.1. The Policyholder or the person fails to comply with Our written instructions, evades, refuses to cooperate, fails to assist or obstructs the investigation of the circumstances of the event, misleads Us, provides Us with information or documents that do not correspond to the truth, as well as carries out any other actions aimed at obtaining unjustifiably the insurance benefit or its part, as well as a benefit higher than due.
17.2.2. You have purchased a membership (subscription) for health services during the period of validity of the insurance cover, but the period of validity of the membership (subscription) is longer than that of the insurance cover. In this case, the benefit is reduced in proportion to the period of validity of the insurance cover. In cases where the insurance contract is extended uninterruptedly, services may be reimbursed in proportion to the period of validity of the renewed contract;
17.2.3. At the time of the conclusion of the insurance contract, the Insured Person and the person have provided information that does not correspond to the truth, which would have cause Us to refuse to conclude the insurance contract;
17.2.4. The goods/services were paid for other than by You;
17.2.5. No written notification of the event has been received within 30 calendar days after the expiry of the insurance cover.

18. Non-compensable losses

18.1. We do not reimburse the costs of the following services provided (goods purchased):
18.1.1. services provided (goods purchased) before the insurance cover comes into force or after the period of validity of the insurance cover has expired;
18.1.2. accommodation and/or catering services;
18.1.3. vitamins, dietary supplements or medicines for children;
18.1.4. services provided at water or winter sports or amusement parks;
18.1.5. long-term nursing costs.

18.2. We do not reimburse the cost of the services provided (personal health care services):
18.2.1. if a personal health care institution was contacted in the absence of any specific complaints about the health condition;
18.2.2. provided at an institution or by an individual that does not have the licences, permits, certificates, stamps, etc., required for engaging in the respective activity;
18.2.3. drafting, copying, issuing, sending, formalising of medical documents and certificates, recording of medical examinations on information media;
18.2.4. group buying (discounts), gift vouchers;
18.2.5. delivery, packaging and service charges.

19. Rights and obligations

19.1. The Policyholder's obligations:
19.1.1. to familiarise You of the terms and conditions of the insurance contract;

19.1.2. to inform the Insured Person of the concluded Contract, its amendments and expiry, to properly and comprehensively familiarise him/her with the terms and conditions of the insurance contract applicable to or relating to him/her, including the Insurance Regulations;
19.1.3. to immediately inform about changes to the list of Insured Persons.
19.2. The obligations of the Insurer and You:
19.2.1. To take all available reasonable steps to avoid the insured event.
19.2.2. In the case of an insured event:
19.2.2.1. to take available reasonable steps to reduce the extent of the damage and to follow Our instructions to avoid and/or reduce the extent of the damage;
19.2.2.2. within 30 days of the event, to notify Us of any personal health care, disease prevention (body strengthening) services provided to you or goods purchased that have been paid for, which We reimburse in accordance with the terms and conditions of the insurance contract;
19.2.2.3. to provide Us with complete and correct information about the causes, circumstances and extent of the damage; to provide Us with documents (originals or their copies) evidencing the insured event and other documents related to the event, necessary to: establish the fact of the insured event and the extent of the damage; exercise Our right of recourse against the person responsible for the damage; and enforce Our lawful claims;
19.2.2.4. within 1 (one) year from the event, to keep the documents evidencing the insured event (if their copies have been provided to Us) and to provide them if we request so;
19.2.2.5. to allow Us to review the medical records and provide any data, documents, consents, approvals or other information requested to verify the existence of the insured event. To undergo a health check at a personal health care centre indicated by Us if we request so.
19.3. Our obligations:
19.3.1. upon the conclusion of the insurance contract, to issue an insurance certificate (policy) to the Policyholder and Insurance Cards to each Insured Person;
19.3.2. to provide information about the Insurer, insurance services, dispute resolution procedure and other essential information in accordance with the procedure established by legal acts;
19.3.3. not to disclose any confidential information about the Policyholder or You obtained in the course of the performance of the Contract, except for exceptions provided for in the insurance contract or in the legal acts;
19.3.4. At the Policyholder's request, We may specify in the insurance contract or its annexes what proportion of the insurance premium payable under the insurance contract is allocated to the various insurance risks specified in the insurance contract. However, this break-down is for information only and does not change the insurance premium payment procedure specified in the insurance contract. We do not assume responsibility for the Policyholder's/Insured Person's compliance with their tax obligations, nor responsibility for any adverse tax consequences arising from the Policyholder's/Insured Person's failure to comply with their tax obligations properly.
19.4. Our rights:
19.4.1. to request and receive from the Policyholder the information and documents necessary to assess the insurance risk;
19.4.2. to process the Policyholder's and Your data, including sensitive personal data, in accordance with the law. In addition to the data subjects specified in Paragraph 12 of the General Part of these Regulations, You are also a data subject. We have the right to obtain additional information from public registers, banks and law enforcement authorities for the purposes of examining an application for the conclusion of an insurance contract, determining the amounts of insurance premiums and benefits, recognising an event insurable, and assessing previously occurred events;
19.4.3. to give you binding instructions on how to reduce damage;
19.4.4. to establish and amend the list of Partners and the terms and conditions of cooperation with a Partner, requirements or restrictions on the use of the Insurance Card for payment at the Partners' institutions for all or certain Health Care Services provided to the Insured Persons. In any case, the Partners are not authorised to interpret the terms of the Contract or to perform Our or Your obligations under the insurance contract.

20. Calculation and payment of insurance benefit

20.1. The extent of the damage and the amount of the insurance benefit is determined by Us in accordance with the terms and conditions of the insurance contract and the documents provided to Us.

20.2. The insurance benefit shall be equal to the amount of the costs incurred as a result of the insured event and reimbursable by Us in accordance with the terms and conditions of the Regulations, less the portion of the costs not reimbursable by the insurer as provided for in the policy, or, in the case of the option "Lump indemnity in case of a critical disease", the insurance sum of this option.
20.3. We will calculate the insurance benefit on the basis of the general (these Rules) and individually negotiated (specified in the insurance policy and its annexes) terms and conditions of the insurance contract, including, but not limited to, insured and non-insured events, the price list of the provider's goods and services, if applicable, and on the basis of the documents evidencing the insured event and the damage incurred as a result of it.
20.4. The insurance benefit or the sum of several insurance benefits may not exceed the unused portion of the insured sum of the risk specified in the insurance policy.
20.5. The portion of the costs of the insured risk which is not paid by the Insurer (i.e. which is to be paid by the Insured Person himself/herself) shall in all cases be non-reimbursable and be deducted from the insurance benefit. The part of the costs not reimbursed under a specific insurance risk is not reimbursable under other insurance risks.
20.6. We shall pay the insurance benefit:
  20.6.1. to You, when you have paid for the provided services with your own money;
  20.6.2. to the institution (Partner) when the provided services are paid for under a cooperation agreement with the Partner.
20.7. If the parties disagree on the amount of the benefit calculated by Us, independent experts' reports may apply. If the insurance benefit is paid according to the extent of damage determined in independent experts' conclusions, or when independent experts are contacted with Our prior consent, We will pay the costs of the independent expert examination. In all other cases, these costs are borne by the person who has ordered the independent expert examination.
20.8. The insurance benefit shall only be paid after We are provided with documents evidencing the fact of the insured event and necessary to determine the amount of the insurance benefit. If the insurance benefit is paid to an institution (the Partner), the information and documents necessary to pay out the insurance benefit will be provided to Us by the Partner; however, We have the right, if necessary, to request You or the Partner to provide any additional information, consents, approvals or documents listed in Sub-Paragraphs 20.9–20.11 and necessary to ascertain the fact of the insured event and the extent of the damage.
20.9. When applying for a benefit, you must provide Us with:
  20.9.1. insurance benefit claim;
  20.9.2. consent to the processing of health data;
  20.9.3. an invoice evidencing the purchase of the services and/or goods, stating: the buyer's and seller's details, the name, price and quantity of the service and/or goods purchased;
  20.9.4. documents evidencing payment for the services and/or goods purchased: checkout receipts, cash deposit receipts, cash receipts, bank transfer statements;
  20.9.5. the certificate of individual activity or a business certificate of the person who has provided the services where the services have been provided by a person engaged in such activity.
20.10. When applying for benefits under the risks "Outpatient treatment", "Inpatient treatment", "Dentistry", and "Critical illness insurance", You must provide Us with the documents specified in Sub-paragraph 20.9 above and, in addition, with the medical documents from the institution that provided the personal health care services, including the patient's details (forename, surname, date of birth), the date of referral to the personal health care institution, information about the health disorder, the complaints, the course of the development of the health disorder, the clearly formulated diagnosis, the prescribed examinations, procedures and treatment applied.
20.11. When applying for a benefit under the risks "Medicines and medical supplies" and "Opticians", You must provide Us with the documents specified in Sub-paragraph 20.9 above and, in addition, with prescriptions (electronic prescriptions) for the purchase of out-of-the-counter medicines, medical supplies, optics and other goods reimbursable by Us.
20.12. An application for an insurance benefit can be submitted:
  20.12.1. at the self-service portal gjensidige.lt/savitarna;
  20.12.2. on the website www.gjensidige.lt;
  20.12.3. in the Insurer's app.
20.13. The insurance benefit is paid within 30 days of the date of receipt of all information relevant to establishing the fact of the insured event, its circumstances and consequences, and the amount of the insurance benefit.

21. Cases of reduction of the insurance benefit

21.1. We have the right to reduce the insurance benefit if:
- 21.1.1. The policyholder or You you have failed to comply with the obligations of the Insurer or You as set out in Sub-clauses 19.1–19.2;
- 21.1.2. when concluding the insurance contract, the Policyholder and You have provided information that do not correspond to the truth which has led to an incorrect assessment of the insurance risk;
- 21.1.3. Your treatment started before the insurance cover came into force or continues after the period of validity of the insurance cover expired. In this case, the benefit is reduced in proportion to the period of validity of the insurance cover;
- 21.1.4. You have failed to follow the treatment regimen or medical advice and this has lead to the deterioration of Your health;
- 21.1.5. The insurance benefit is reduced by the amount that has been reimbursed to You by other persons.

22. Validity and expiry of the insurance cover

22.1. The insurance cover is valid in the territory of the Republic of Lithuania. The service provider may be a legal entity (company) registered in the Republic of Lithuania in accordance with the procedure provided for by the legal acts.

22.2. Your insurance cover expires before the expiry date of the insurance contract:
- 22.2.1. in case the insured sums for all the risks covered have been used;
- 22.2.2. in case the Insurer removes You from the list of insured employees. In the case specified in this clause, We have the right to provide the Policyholder with information about the part of the insured sum used by You, without disclosing any further details about the places where the funds were used (for example, the names of the medical institutions) and/or the purpose of the use of the funds (for which services You used the funds to pay for the services);
- 22.2.3. in case of your death;
- 22.2.4. in case of termination of insurance cover in accordance with Sub-paragraph 22.2, We deduct the insurance benefits paid and payable under the insurance contract from the portion of the premium to be refunded to the Policyholder for the unused period of insurance.

23. Protection of personal data

23.1. The Insurer acts as a data controller and processes personal data in accordance with the requirements of the General Data Protection Regulation, the Law on Legal Protection of Personal Data of the Republic of Lithuania and other legal acts regulating the protection of personal data.

23.2. The Insurer shall process personal data in a lawful, fair and transparent manner, for specified, clearly defined and legitimate purposes, in order to be able to conclude the insurance contract and and perform the activities related thereto.

23.3. When providing health insurance services, the Insurer shall process the Insured Person's personal data of special categories (health data) on the basis of the Insured Person's consent. The processing of such personal data is necessary to enable the Insurer to ascertain the existence of the insured event and to determine the amount of the insurance benefit. If the Insured Person does not give consent to the processing of health personal data, the Insurer has the right not to pay the insurance benefit.

23.4. The Insurer may disclose the Insured Person's personal data, including health data, to experts and other persons possessing special knowledge, where this is necessary to establish the fact and consequences of the insured event and the amount of the insurance benefit.

23.5. The Insurer also receives the Insured Person's personal data on the scope, price, time of performance of the services provided to the Insured Person as well as other relevant data in order to be able to pay the service provider directly for the services provided to the Insured Person and to protect the Insured Person's property interests related to the insured events provided for in the insurance risks selected by the Insured Person and specified in the insurance policy.

23.6. Persons whose personal data are processed by the Insurer have the following rights: to know that the Insurer processes his/her data; to have access to the personal data processed by the Insurer; to

request the rectification of his/her incorrect or inaccurate personal data; to request the erasure of his/her personal data processed unlawfully; to request the Insurer to restrict the processing of personal data; to request the Insurer to transfer the personal data processed; to oppose to the processing of his/her personal data; to withdraw the given consent at any time; to express his/her opinion on automated decision-making; to lodge a complaint with a supervisory authority.

23.7. More detailed information on how the Insurer processes personal data is available in the General Terms and Conditions of Insurance and on the Insurer's website www.gjensidige.lt published at Principles for the Processing of Personal Data.

Annex No 1 list of critical Illnesses:

A critical Illness is recognised as an insured event when the illness has been diagnosed during the period of validity of the insurance contract by a specialist in the relevant medical field or a case conference of doctors, and complies with the criteria for diagnosing a critical Illness and the prerequisite conditions listed below against the relevant illness.
In the case of critical illnesses insurance risk, uninsured events include a critical illness diagnosed within the first 2 months of the period of validity of the insurance cover, with the exception of uninterruptedly renewed insurance contracts, where the previously valid insurance contract included the critical illness insurance risk at the time of renewal of the insurance contract.

1. Myocardial infarction
This refers to the part of the heart muscle that has been permanently damaged and necrotized due to impaired blood flow in the coronary arteries. The disease must meet at least three of the following criteria:
- prolonged pain in the chest area, typical of infarction;
- new electrocardiogram changes typical of myocardial infarction;
- increased troponin levels.
- 3 months after myocardial infarction, left ventricular ejection fraction less than 50%.

2. Coronary artery bypass surgery
This refers to a type of open-heart surgery performed to correct narrowed or occluded coronary arteries by using a graft, which may be sourced from the superficial leg vein, internal mammary artery, or another suitable artery. The insurance benefit is only paid in case the angiography proves that surgery is necessary.
An insurance benefit shall not be paid for:
- balloon angioplasty of the coronary arteries and other catheterisation-based techniques;
- laser treatments.

3. Stroke
This refers to cerebrovascular disorders, which include the infarction of cerebral tissue, cerebral hemorrhage, subarachnoid hemorrhage, cerebral embolism, and cerebral thrombosis, all of which can lead to permanent neurological deficits. The disease must meet all of the following criteria:
- a long-term neurological impairment confirmed by a neurologist no earlier than 6 weeks after the event;
- MRI or CT scans show new changes that are characteristic of stroke.

An insurance benefit shall not be paid for:
- transient ischemic attacks;
- brain damage due to an accident, infection, vasculitis or inflammatory diseases;
- ischemic vestibular disorders.

4. Cancer
Cancer is a malignant tumour characterised by the uncontrolled growth and spread of malignant cells to intact tissues. The diagnosis must be based on histological evidence of malignancy and confirmed by an oncologist, haematologist or pathologist.
The term "cancer" also covers leukaemias and lymphomas.
An insurance benefit shall not be paid for:
- any tumours in someone infected with HIV (human immunodeficiency virus);
- localised non-invasive tumours with only early malignant changes (carcinoma in situ), pre-cancerous diseases;
- hyperkeratosis, basal cell and squamous cell skin cancer, melanomas thinner than 1.5 mm according to the Breslow classification or less than Clark's Level III, except in cases with evidence of the occurrence of metastases;

- prostate cancer histologically defined as T1 according to the TNM classification, or similar prostate cancer according to another classification; T1N0M subepithelial thyroid microcarcinoma less than 1 cm in diameter; papillary bladder carcinomas; chronic lymphocytic leukaemia below RAI Stage 3.

5. Renal failure
This refers to the total loss of kidney function due to chronic and persistent impairment affecting both kidneys. The insurance benefit is paid if a kidney transplant or regular dialysis is necessary.
An insurance benefit shall not be paid for:
- acute renal failure;
- failure or removal of one kidney when the other kidney is functioning normally.

6. Internal organ transplantation
Heart, lung, liver and bone marrow transplant surgery when You are the recipient. The insurance benefit may also be paid when you are on the official waiting list for surgery (there are vital indications and no contraindications).
Insurance benefit is not paid:
- to organ donors;
- for stem cell transplantation.

7. Coma
A state of the loss of consciousness lasting at least 96 hours. The disease must meet all of the following criteria:
- no reaction to any external stimuli for at least 96 hours;
- life functions supporting machines are essential to sustain life;
- brain damage causing neurological impairment, which must be assessed no earlier than 30 days after the onset of coma.

An insurance benefit shall not be paid for:
- coma directly caused by alcohol or drug abuse.

8. Limb function loss (paralysis)/loss of limbs
Total and irreversible loss of at least 2 limbs or the loss of function of at least 2 limbs as a result of injury or disease.
The loss of a limb is considered to be the loss of a limb or its function above the knee or elbow joint for a period of at least 6 months.

9. Blindness
Blindness means complete, permanent, irreversible loss of vision in both eyes due to an injury or disease that cannot be restored by medical measures or procedures. The diagnosis must be clinically substantiated by an ophthalmologist. In some cases, blindness may be temporary, in which case the insurance benefit is paid if total blindness in both eyes persists for 6 months after the diagnosis.

10. Third-degree burns
Third-degree burns (affecting all layers of the skin) covering at least 20% of the body surface area.

11. Aorta surgery
This refers to open surgery on the thoracic or abdominal sections of the aorta, during which the portion of the aorta damaged by a disease is removed and replaced with a prosthesis.
An insurance benefit shall not be paid for:
- aortic branch surgeries;
- traumatic injury of the aorta;
- minimally invasive or intra-arterial surgeries.

12. Heart valve replacement or function restoration
This refers to the replacement of one or more heart valves (aortic, mitral, pulmonary, or tricuspid) with a prosthesis, or the restoration of valve function during open-heart surgery due to conditions such as stenosis, insufficiency, or a combination of these factors. Pathology of the heart valve must be evidenced by such examination techniques as imaging (echocardiography, etc.) or angiography.
An insurance benefit shall not be paid when:
- heart valve function is restored by closed surgical intervention.

13. Hearing loss
Total and irreversible loss of hearing in both ears due to disease or accident. The diagnosis must be evidenced by audiometric and threshold sound tests performed and confirmed by an ear, nose and throat (ENT) specialist. "Total loss" refers to the loss of hearing of at least 90 decibels across all frequencies.

14. Speech loss
This refers to the total loss of the ability to speak due to traumatic injury or disease. The benefit is also paid in cases of loss of speech due to surgical and medical treatment of a disease. The diagnosis must be confirmed by an otolaryngologist. In some cases, the loss of speech may be temporary, in which case the insurance benefit is paid if the total loss of speech persists 6 months after establishing the diagnosis.
An insurance benefit shall not be paid for:
- speech impairment due to mental disorders.

15. Benign brain tumour
This refers to brain tumour that meets all the following criteria:
- life-threatening;
- brain damage;
- surgery to remove the tumour has been performed or, if it is inoperable, it has resulted in permanent neurological impairment;
- the tumour has been confirmed by a neurologist or neurosurgeon, and the diagnosis is evidenced by such examination techniques as MRI, CT scan or other reliable imaging techniques.

An insurance benefit shall not be paid for:
- cysts;
- granulomas;
- vascular anomalies;
- haematomas;
- pituitary or spinal tumours.

16. Fulminant hepatitis
This refers to partial or expanded necrosis of the liver caused by a hepatitis virus, which leads to acute liver failure. The disease must meet all of the following criteria:
- rapid decrease in liver size;
- necrosis of entire liver lobes whereby only a deteriorated network system remains;
- rapid worsening of liver function tests;
- worsening jaundice;
- hepatic encephalopathy.

An insurance benefit shall not be paid for:
- liver damage caused by alcohol or drug abuse.

17. Encephalitis
This refers to a severe inflammation of the brain (cerebral hemispheres, brainstem, or cerebellum) caused by a viral infection and leading to permanent neurological impairment. The diagnosis must be confirmed by a neurologist, and at least 6 weeks of permanent neurological impairment must be documented.
An insurance benefit shall not be paid for:
- brain damage caused by alcohol or drug abuse;
- encephalitis caused by HIV infection.

18. Bacterial meningitis
This refers to a bacterial infection that causes severe inflammation of the meninges surrounding the brain and spinal cord, leading to irreversible permanent neurological impairment. The disease must meet all of the following criteria:
- a bacterial infection found in the cerebrospinal fluid by performing a lumbar puncture;
- a neurological disorder, confirmed by a neurologist, persisting at least 6 weeks.

An insurance benefit shall not be paid for:
- bacterial meningitis in the presence of HIV infection.

19. Alzheimer's disease
This refers to a neurodegenerative disorder characterised by progressive impairment of cognitive function, changes in behaviour, etc.

The disease must meet all of the following criteria:
- the disease has been diagnosed in the Insured Person before he/she reaches the age of 60;
- the disease has been confirmed by standard neuropsychological and neuroimaging tests (e.g. CT scans, MRIs);
- a slowly progressive loss of intellectual capacity, manifested by impaired memory and cognitive functions (sequencing, organisation, generalisation and planning), with marked impairment of mental and social functions, has been diagnosed;
- personality changes and persistent cognitive decline have been determined;
- undiagnosed disorders of consciousness;
- the insured person needs continuous 24-hour care;
- the diagnosis must be established and objectively confirmed by a neurologist.

No benefit is paid if other forms of dementia due to brain, systemic or psychiatric diseases are diagnosed.

20. Parkinson's disease

The initial diagnosis of Parkinson's disease must be established and confirmed by a neurologist.
The disease must meet all of the following criteria:
- the disease has been diagnosed in the Insured Person before he/she reaches the age of 60;
- at least two of the following clinical signs have been diagnosed:
- muscle stiffness (rigidity);
- tremor;
- bradykinesia (pathologically slowed movements, sluggishness of physical and mental response);
- complete inability to independently perform at least 3 of the 6 everyday activities listed below for a continuous period of at least 3 months:
- washing – being able to wash in a bath or shower (including getting in and out of the bath or shower) or to wash satisfactorily by other means;
- dressing and undressing – being able to dress, undress, fasten and unfasten all clothing, braces, artificial limbs or other orthopaedic devices if necessary;
- eating – the ability to independently eat cooked and served food;
- personal hygiene – the ability to fairly take care of personal hygiene by using the toilet or to manage otherwise bowel and urinary functions;
- moving around rooms – the ability to move from room to room on the same floor;
- getting in and out of bed – the ability to get in and out of bed, into and out of a chair or wheelchair.

The disease is considered critical in case of implantation of a cerebral neurostimulator to correct the symptoms of the disease, irrespective of the change in the ability to perform daily activities.
The necessity to implant a neurostimulator must be confirmed by a neurologist or neurosurgeon.
An insurance benefit shall not be paid for:
- secondary parkinsonism (including those caused by drugs or toxins);
- tremor/parkinsonism caused by other diseases or causes;
- essential (intrinsic) tremor.

General insurance conditions

Approved:
ADB "Gjensidige" during the meeting of the Board 29 of April, 2021.
Entered into force on 11 of May, 2021.

1. Definitions

1.1. **Policyholder** - the person who has approached the insurer for the conclusion of an insurance contract or to whom the insurer has proposed to conclude an insurance contract, or who has concluded an insurance contract with the insurer.
1.2. **Insurer** - ADB Gjensidige.
1.3. The lists of distributors of ADB Gjensidige insurance products are published at www.gjensidige.lt and www.lb.lt.
1.4. **Insured event** - an event defined in the insurance contract, upon the occurrence of which the insurer must pay the insurance indemnity.
1.5. **Insurance cover** - the insurer's obligation to pay an insurance indemnity upon the occurrence of an insured event.
1.6. **Insurance premium** - the amount of money specified in the insurance contract, which the policyholder shall pay to the insurer for the insurance cover in accordance with the procedure determined in the insurance contract.
1.7. **Insurance indemnity** - the amount of money that the insurer must pay the policyholder or another person entitled to the insurance indemnity upon occurrence of an insured event, or another indemnity form specified in the insurance contract.
1.8. **Insurance period** - the time period from the beginning to the end of the insurance cover, which does not necessarily coincide with the period of the insurance contract. Unless specified otherwise in the terms and conditions of the insurance contract, the insurance cover is considered to be valid only during the insurance period.
1.9. **The period of the insurance contract** - the period of validity of the insurance contract specified in the insurance policy, applicable under the proper and timely performance of the contractual obligations by the parties.
1.10. **Insurance policy** - the document issued by the insurer confirming the conclusion of the insurance contract.
1.11. **Insurance risk** - the probable danger to the object of insurance.
1.12. **Sum insured** - the amount of money specified in the insurance contract or calculated in accordance with the procedure determined in the insurance contract, which the insurance indemnity cannot exceed, except for the cases specified in the insurance contract.
1.13. **Insurance contract** - the written agreement between the insurer and the policyholder concluded on the basis of the terms and conditions of insurance type. In keeping with the contract, the policyholder shall undertake to pay the insurance premium specified therein. In keeping with the contract, the insurer shall undertake to pay an insurance indemnity upon the occurrence of an insured event. The insurance contract consists of:
- insurance policy and its appendices;
- insurance terms and conditions and (or) other provisions of insurance contract agreed upon in writing between the policyholder and the insurer (individual terms and conditions of the insurance contract);
- application for the conclusion of an insurance contract if one was submitted.

1.14. Insurance terms and conditions - standard terms and conditions of the insurance contract prepared by the insurer and consisting of:
- general insurance conditions;
- conditions of insurance type;

- additional conditions of insurance type. The insurance contract is subject only to the additional conditions of insurance type specified in the insurance policy.

In case of discrepancies between the general insurance conditions and the conditions of insurance type, the conditions of insurance type shall prevail. In case of discrepancies between the additional conditions of insurance type and the general insurance conditions or the conditions of insurance type, the additional conditions of insurance type shall prevail.
The terms and conditions of the insurance are published on the website of the insurer www.gjensidige.lt. Also, its copy shall be presented to the policyholder upon concluding an insurance contract.
If certain cases are not discussed in these Insurance Terms and Conditions, the laws of the Republic of Lithuania shall apply.

1.15. **Insurance value** - the value of the insured property or property risk value.
1.16. **Deductible** - a fixed amount of money or an amount expressed in percentage or otherwise specified in the insurance contract, by which the insurance indemnity to be paid upon occurrence of an insured event is reduced (the policyholder shall contribute this amount to the compensation of losses himself).
1.17. **Unconditional deductible** - an amount of money by which the insurer reduces the indemnity to be paid upon occurrence of any insured event. Unless specified otherwise in the insurance contract, the deductible shall be deemed to be unconditional.
1.18. **Conditional deductible** - the share of the loss expressed in the amount of money that the policyholder shall cover in case the loss incurred does not exceed the amount of deductible. In case the loss exceeds the amount of deductible, the indemnity shall be paid without deducting the deductible.
1.19. **Beneficiary** - the person specified in the insurance contract or the person assigned by the policyholder or, in certain cases specified in the insurance contract, by the insured entitled to receive insurance indemnity.
1.20. **Non-insured event** - an event defined in the insurance contract or by law upon occurrence of which the insurer shall not pay the insurance indemnity.

2. Concluding the insurance contract

2.1. The insurance contract is concluded upon agreement between the insurer and the policyholder.
2.2. If the terms and conditions of insurance type do not specify otherwise, the policyholder is entitled to conclude the insurance contract in regard to the financial interests of himself or of another person specified in the insurance policy. Such person becomes the insured. The terms and conditions of the insurance contract that apply to the policyholder also apply to the insured except for the obligation to pay insurance premium.
2.3. The policyholder shall submit to the insurer a written application for the conclusion of an insurance contract or shall otherwise express his will to conclude it (on internet, by phone, by e-mail, in customer service office).
2.4. The policyholder is responsible for the accuracy of the data provided in the application for the conclusion of the insurance contract.
2.5. The conclusion of the insurance contract is confirmed by the insurance policy issued by the insurer. Until the insurance premium or the first instalment of it is paid, the insurance policy shall be considered as insurance proposal, unless the insurance contract provides for the deferment period of the insurance premium or the first instalment of it.
2.6. The Insurer processes data of the object of insurance when assessing insurance risk. Depending on the object of insurance such data may be obtained from entities such as the Real Property Register of the State Enterprise Centre of Registers, State Enterprise Regitra or the Motor Insurers' Bureau of the Republic of Lithuania. More information is provided in the Principles of Personal Data Processing that can be found on the website of the insurer www.gjensidige.lt.
2.7. A different procedure for conclusion of the insurance contract may be defined by the conditions of insurance type.

3. Validity and amendment of the insurance contract

3.1. The insurance contract is made for the period agreed upon by the parties and specified in the insurance policy.
3.2. The insurance contract comes into effect from 00:00 (Lithuania time) of the day specified in the insurance policy, unless a different time is specified in the insurance contract, but not before the full insurance premium or the first instalment thereof is paid, unless the insurance contract provides for the deferment period of the insurance premium or the first instalment thereof:

3.2.1. If the insurance premium (or the first instalment thereof in case the premium is paid in instalments) is paid prior to the commencement of the insurance contract specified in the insurance contract, the insurance contract comes into effect and the insurance cover applies from the commencement of the insurance contract specified in the insurance contract;

3.2.2. If the insurance premium (or the first instalment thereof in case the premium is paid in instalments) is not paid prior to the commencement of the insurance contract specified in the insurance contract but the payment is delayed less than 30 calendar days, the insurance contract comes into effect but the insurance cover applies from 00:00 of the day following the day of the payment; the period of the insurance contract shall not be prolonged in such case;

3.2.3. If the insurance premium (or the first instalment thereof in case the premium is paid in instalments) is not paid prior to the commencement of the insurance contract specified in the insurance contract and the payment is delayed 30 calendar days or more, the insurance contract does not come into effect, and the insurance cover does not apply, and the late payment of the insurance premium shall be returned to the policyholder;

3.2.4. If the insurance premium (or the first instalment thereof in case the premium is paid in instalments) is paid only partially, the insurance contract does not come into effect and the insurer shall not provide the insurance cover, unless specified otherwise in the written insurance contract.

3.2.5. If the insurance contract provides for the deferment period of the insurance premium or the first instalment thereof, the commencement of the insurance contract is not linked to the payment of the premium and the insurance contract comes into effect and the insurance cover applies from the commencement of the insurance contract specified in the insurance contract. If the policyholder fails to pay the deferred insurance premium (or the first instalment thereof in case the premium is paid in instalments) within the time specified in the contract, standard consequences of non-payment of the insurance premium shall apply as specified in clauses 4.6-4.7 of these General Insurance Conditions.

3.3. If the insurance contract is concluded by means of communication (clause 7.3.2 of these General Insurance Conditions), the commencement of the contract is set at 14 days from the conclusion except for the cases when the policyholder indicates an earlier date. If the policyholder indicates an earlier date for the commencement of the contract, the insurance cover shall be deemed to apply from the date indicated by the policyholder (before the cancellation term applicable to the contracts made by means of communication expires) but not before the full agreed insurance premium or the first instalment thereof is paid.

3.4. The insurance contract may be amended only by a written agreement between the insurer and the policyholder, except for the cases specified therein.

4. Insurance premium and its payment procedure

4.1. The amount of the insurance premium is calculated by the insurer, taking into consideration the information provided by the policyholder, the object of insurance, the sum insured, the insurance risk, other conditions specified in the insurance contract and other relevant information.

4.2. Insurance premiums may be paid by bank transfer, in cash, using electronic banking or the network of insurer's partners. It is possible to pay insurance premiums in cash or by payment card only in some branches indicated by the insurer. The policyholder is responsible for ensuring that the insurance premium he pays reaches the bank account of the insurer on time and that all details identifying the payer and the insurance contract are provided in the payment documents as requested by the insurer.

4.3. The actual date of payment of the insurance premium is the day when the insurance premium is credited to the bank account specified by the insurer or the insurance intermediary authorized by the insurer or paid in cash and meets the requirements of clause 4.2 of these General Insurance Conditions; otherwise it is the day when the insurer identifies the received insurance premium.

4.4. Other persons may pay insurance premiums for the policyholder without acquiring any rights to the insurance contract and the insurance premiums paid.
If the policyholder terminates the insurance contract prior to its termination date or a refundable balance of the insurance premium appears on other basis, it shall be refunded to the policyholder in spite of who has paid the insurance premium or the instalment thereof, except for the special cases specified in the insurance contract or separately agreed upon by the policyholder and the insurer in written.

4.5. If the insurance premium or the instalment thereof is not paid on time, the insurer is entitled to charge interest at the rate of 0.02% of the unpaid amount for every day delayed.

4.6. If the policyholder does not pay the insurance premium or the instalment thereof within the time specified in the insurance contract (except for the cases when commencement of the insurance contract is linked to the payment of the insurance premium or the instalment thereof), the insurer must inform the policyholder about this in written notifying that the insurance contract will be terminated if the policyholder does not pay the insurance premium or the instalment thereof within 30 days from the day when the notification was sent to the policyholder. The procedure for providing information is specified in clause 13 of these General Insurance Conditions.

4.7. In case the insurance premium was paid partially and a refundable balance appears when the contract is terminated due to the failure of payment of the premium, the amounts of money specified in clause 8.3 of these General Insurance Conditions shall be deducted from the refundable balance.

5. Rights and responsibilities of the policyholder and the insurer

5.1. **Rights of the policyholder:**

5.1.1. to get acquainted with the insurance terms and conditions and receive the copy thereof;

5.1.2. in the event of an insured event, to demand that the insurer pay the insurance indemnity in accordance with the procedure established by law and (or) the insurance contract;

5.1.3. to receive information about the investigation of the insured event;

5.1.4. to terminate the insurance contract in accordance with the procedure specified therein;

5.1.5. to demand the amendment of the terms and conditions of the insurance contract or reduction of the insurance premium if the insurance risk decreases, and, if the insurer refuses to amend the terms and conditions of the insurance contract or to reduce the insurance premium, to go to court for the termination or amendment of the insurance contract due to fundamental changes in the circumstances or to terminate the insurance contract in accordance with the procedure specified therein.

5.2. **Responsibilities of the policyholder:**

5.2.1. to submit the written application for the conclusion of an insurance contract and to provide other documents specified therein before concluding the insurance contract. The written application for the conclusion of an insurance contract must be submitted if it is required by the conditions of insurance type.

5.2.2. to provide the insurer with all the information known about circumstances that might have fundamental impact on the probability of occurrence of an insured event or on the extent of probable loss in case of such event (on the insurance risk). Fundamental circumstances about which the policyholder must inform the insurer before concluding the insurance contract:

5.2.2.1. the information provided in the written application for the conclusion of an insurance contract (if such application is required by the terms and conditions of insurance type);

5.2.2.2. the information requested by the insurer in written;

5.2.2.3. the information requested by the insurer when the insurance contract is concluded on internet or by phone;

5.2.2.4. the information about other insurance contracts under which the object of insurance is insured against the same risks;

5.2.2.5. in addition to the circumstances mentioned above, the conditions of insurance type might define other circumstances that might have fundamental impact on risk assessment;

5.2.3. to inform the insured, the beneficiary and (or) the payer about the insurance contract to be concluded and (or) the insurance contract concluded; to acquaint the insured and (or) the beneficiary with the terms and conditions of the insurance contract and their amendments; to ensure that the insured and (or) the beneficiaries do not object to their appointment as the insured and (or) beneficiary throughout the period of the insurance contract. to inform the insured, the beneficiary and (or) the payer that their personal data has been provided to the insurer for the purpose of concluding the insurance contract, and to acquaint them with the ADB Gjensidige policies of processing personal data;

5.2.4. to pay insurance premiums within the terms specified in the insurance contract; when making the payment, to provide in the payment documents all details identifying the payer and the insurance contract as requested by the insurer;

5.2.5. to follow the insurer's instructions in order to reduce the risk and to comply with the security measures specified in the conditions of insurance type, additional conditions or in the insurance contract; also, to follow the insurer's instructions given throughout the period of the insurance contract;

5.2.6. to inform the insurer immediately about the increase in risk or other cases when the circumstances specified in the insurance contract changes fundamentally; the increase in risk and other cases that fundamentally change the circumstances specified in the insurance contract are defined in the conditions of insurance type, additional conditions or in the insurance contract;

5.2.7. upon the occurrence of an insured event or upon the occurrence of circumstances that cause actual risk of the occurrence of an insured event, to register the event on the insurer's website www.gjensidige.lt, on self-service or by phone (1626) and to exercise the responsibilities specified in the conditions of insurance type, additional conditions or in the insurance contract; also, to follow the instructions given by the insurer upon the registration of the event.

5.3. **Rights of the insurer:**

5.3.1. before concluding the insurance contract, the insurer is entitled (but is not obliged) to inspect or to assess the object of insurance and, if necessary, to appoint experts to assess the insurance risk at its own expense. Assessments performed by the insurer, any written report thereof, opinion expressed orally or in written shall be considered only insurance risk assessment and may not be used by the policyholder as the proof that the object of insurance is safe, does not cause danger to the environment, complies with the laws and r egulations, engineering, industry standards or other requirements;

5.3.2. if the interest of the insurance is linked to the health of a natural person, the insurer is entitled to require the policyholder to provide documents confirming the age, health status, profession of the policyholder (the insured) and other circumstances affecting the insurance risk;

5.3.3. to refuse to conclude the insurance contract without indicating the reason;

5.3.4. to demand the amendment of the terms and conditions of the insurance contract or recalculation of the insurance premium if the insurance risk increases or other fundamental circumstances of the insurance contract changes; and, if the policyholder refuses to amend the terms and conditions of the insurance contract or to pay an increased insurance premium, to go to court for the termination or amendment of the insurance contract due to fundamental changes in the circumstances of the contract;

5.3.5. in case the policyholder fails to inform the insurer about the increase in insurance risk or about the fundamental changes in the circumstances of the insurance contract, the insurer is entitled to demand termination of the contract and compensation of losses to the extent that exceeds the premiums received; the cases of the increase in insurance risk are defined in the conditions of insurance type, additional conditions and other documents constituting insurance contract.

5.3.6. to terminate the insurance contract in accordance with the procedure established by law and terms and conditions of insurance;

5.3.7. to apply fee for issuing a duplicate of the insurance policy.

5.4. **Responsibilities of the insurer:**

5.4.1. to pay insurance indemnity only after assuring that the insured event has actually occurred;

5.4.2. to amend conditions of the insurance contract and to recalculate insurance premium if the insurance risk decreases due to fundamental changes in circumstances during the period of the contract;

5.4.3. if the insurance contract is terminated, to refund the insurance premium paid for the remaining period of the insurance contract, except for the cases specified in the terms and conditions of insurance when unused part of the premium is not refunded.

5.5. Additional rights and responsibilities of the parties may be specified in the conditions of insurance type, additional conditions and in the insurance contract.

6. The procedure of paying insurance indemnity

6.1. Insurance indemnities for insured events shall be paid within the limits of insurance cover as agreed upon in the conditions of insurance type.

6.2. The insurance cover shall apply for all insured events occurred within the period of insurance contract. If the insurance contract provides for the application of insurance cover to the insured events that have occurred before the insurance contract has come into effect, such condition shall apply if the parties of the insurance contract were not aware, were not obliged to be aware and could not be aware of the insured event that occurred before the insurance contract came into effect.

6.3. The policyholder, the insured and (or) the injured third party must provide the insurer with all the documents and information on the causes and consequences of the event that may be recognized as insured event necessary to assess the amount of insurance indemnity, as well as all the documents and information confirming certainty of the insured event, persons liable and extent of damage.

6.4. The terms of paying insurance indemnity:

6.4.1. insurance indemnity shall be paid within 30 days from the day when the insurer receives all the documented information relevant and essential to assess the fact of the event, its circumstances, consequences and to calculate the amount of insurance indemnity;

6.4.2. if, as a result of the event that may be recognized as insured event, the policyholder, the insured or the beneficiary is sued in civil action, criminal proceedings are instituted, legal proceedings are initiated against him or her, a pre-trial or other mandatory investigation by a state institution is carried out, the insurer is entitled to defer the payment of insurance indemnity until the end of pre-trial investigation or until the end of other mandatory investigation by a state institution and (or) until the court decision comes into effect or until the suspension or termination of the case;

6.4.3. if the insurance indemnity is not paid, the insurer shall inform the policyholder (the beneficiary or the injured third party) in written about the progress of the investigation of the insured event every 30 days from the day when the notification about the insured event was received, except for the cases when documents or information are missing only from the policyholder (the beneficiary or the injured third party) and the policyholder (the beneficiary or the injured third party) is already informed about the documents or information that must be provided for the investigation of the insured event;

6.4.4. if the event is recognized as insured event, but the policyholder and the insurer do not agree on the amount of the insurance indemnity, and the assessment of the exact extent of damage continues for more than 3 months, upon the request of the policyholder, the insurer must pay the amount equal to the undisputed insurance indemnity.

6.5. The insurance indemnity shall be paid by bank transfer to the current account.

6.6. If the insured is a minor, the insurance indemnity shall be paid:

6.6.1. to his personal bank account, if the minor has it and its number is provided to the insurer;

6.6.2. if the minor is under fourteen years old and does not have a personal bank account, insurance indemnity shall be paid to the bank account of one of his parents or guardians upon receival of a request of one of the parents or guardians and written agreement of the other parent or guardian;

6.6.3. if the minor is between fourteen and eighteen years old and does not have a personal bank account, insurance indemnity shall be paid to the bank account of one of his parents or guardians upon receival of the written agreement of the minor.

6.7. When paying the insurance indemnity to the policyholders who are entitled to claim for a tax refund in accordance with the procedure determined by law in order to restore the object of insurance to the previous condition, the insurer shall reduce the insurance indemnity by the amount corresponding to the possible tax refund. In such case, when calculating insurance indemnity, the amount of tax is deducted first and then the deductible.

6.8. The exemption from paying insurance indemnity:

6.8.1. the insurer shall be exempt from paying the insurance indemnity if the insured event occurred due to the intention of the policyholder, the insured or the beneficiary, except for the cases specified by legal acts;

6.8.2. the insurance indemnity shall not be paid if the claim for payment is based on fraud, i.e. if the policyholder, the persons related to him, the insured or the beneficiary have tried to mislead the insurer by falsifying the facts, providing incorrect data, unlawfully increasing the amount of loss;

6.8.3. legal acts may provide for additional cases for exemption from paying insurance indemnity.

6.9. The insurer is entitled to reduce the insurance indemnity or to refuse to pay it if the policyholder, the insured and the beneficiary, or anyone of them:

6.9.1. do no inform the insurer properly, provide incorrect or incomplete information on the insured event;

6.9.2. do not take measures to prevent occurrence of damage or to reduce its extent;

6.9.3. do not comply with the terms and conditions of the insurance contract or with the reasonable requirements of the insurer related to the reduction of insurance risk;

6.9.4. do not provide the insurer with an opportunity to properly assess the amount and (or) causes of losses;

6.9.5. do not take measures to enable the recovery of compensation for the damage from the person who has caused it, or act in a way that impedes the insurer to exercise the right of this claim (subrogation);

6.10. If, upon occurrence of the insured event, the policyholder fails to provide information on fundamental circumstances due to negligence, the insurer must pay a part of the insurance indemnity that would be paid to the policyholder under proper performance of his obligations in proportion to the ratio between the agreed insurance premium and the insurance premium that would have been calculated knowing the missing information.

6.11. Deduction of insurance premium:

6.11.1. the insurer is entitled (but is not obliged) to deduct from the insurance indemnity an unpaid insurance premium corresponding to any insurance contract concluded if the term of the payment has passed; also, other amounts that have not been paid on time; if no deduction is made, the policyholder remains obliged to pay the determined insurance premiums and other arrears;

6.11.2. if the insurance contract terminates upon the payment of the insurance indemnity, all the unpaid insurance premiums corresponding to this insurance contract shall be deducted from the insurance indemnity.

6.12. If the same object is insured under several insurance contracts with different insurers (double insurance) and the sum insured exceed the insurance value, the insurance indemnity shall be paid in proportion to ratio of the sums insured under all insurance contracts.

6.13. If, after paying the insurance indemnity or part thereof, it turns out that according to the conditions established in the insurance contract the indemnity should not have been paid or should have been lower, upon the written request by the insurer, the policyholder must refund him the insurance indemnity or the amount overpaid within 30 calendar days, except for the cases determined by law. The same obligation applies to the insured or the beneficiary.

6.14. The insurer shall not provide insurance cover and shall not pay insurance indemnity if the provision of insurance cover and payment of insurance indemnity is subject to United Nations, European Union or other international trade, economic or other sanctions, prohibitions, restrictions and other laws and regulations applicable to the insurer.

7. Termination of the insurance contract

7.1. The period of the insurance contract terminates at 24:00 (Lithuania time) of the day indicated in the insurance contract (policy) unless different time is indicated in the insurance contract (policy).
Towards the expiration of the insurance contract, within reasonable time limit, the insurer is entitled to remind the policyholder about the expiration of the insurance contract and to propose to prolong the insurance cover by sending an insurance proposal of the same insurance type for a new period. The insurance proposal shall specify the sums insured, premiums and other conditions applicable. It should also specify how the policyholder can express his will in regard to accepting the proposal. The policyholder who does not wish to receive the reminder about the expiring insurance contract may submit his refusal to the insurer by phone 1626.

7.2. **The insurance contract shall terminate prior to the expiration date:**

7.2.1. if the probability of the insured event or the insurance risk has disappeared due to reasons unrelated to the insured event;

7.2.2. if the insurer pays all indemnities corresponding to the sum insured for the entire period of insurance contract as determined by the insurance contract;

7.2.3. if the object of insurance is completely destroyed (as specified in the conditions of insurance type);

7.2.4. if the policyholder (legal entity) is liquidated and there is no successor of his rights and responsibilities;

7.2.5. if the owner of the insured property changes, unless the parties of the insurance contract and the new property owner agree otherwise in writing or when the policyholder becomes the new owner himself (e.g. the policyholder redeems the property by leasing or otherwise). On the basis specified in this section the insurance contract is terminated the next working day after the policyholder is informed about the corresponding changes;

7.2.6. if the policyholder does not pay insurance premium or the instalment thereof after the notification from the insurer (clause 4.6 of these General Insurance Conditions);

7.2.7. if there are other grounds for termination of the contract or the obligations determined by law or the insurance contract.

7.3. **Termination or withdrawal of the insurance contract at the initiative of the policyholder:**

7.3.1. the policyholder is entitled to terminate the insurance contract for any reason by notifying the insurer in written at least 15 days prior to the desired date of termination;

7.3.2. the policyholder who is a natural person and has concluded insurance contract for purposes that are not related to business, trade, craft, or profession remotely, only by the means of communication (on internet, by phone, by email), or in another way without physically meeting the insurer is entitled to withdraw from such insurance contract within 14 calendar days after concluding the contract, except for:

7.3.2.1. insurance contracts with the period thereof shorter than one month;

7.3.2.2. insurance contracts that, upon the request of the client, have been exercised completely by both parties (i.e. the insurer has provided the insurance cover and the policyholder has paid the insurance premium) before the end of the 14 days term from the date of the conclusion of the insurance contract;

7.3.3. the policyholder is entitled to terminate the insurance contract in other cases and in accordance with the procedure determined by other legal acts, or by the insurance contract.

7.4. **Termination of the insurance contract at the initiative of the insurer:**

7.4.1. if, after concluding the insurance contract, it turns out that the policyholder or the insured has provided the insurer or his representative with the knowingly false information on fundamental circumstances, the insurer is entitled to declare the insurance contract invalid, unless the circumstances concealed disappeared before the occurrence of the insured event or did not affect it;

7.4.2. if the policyholder or the insured have failed to provide information on fundamental circumstances due to negligence, within two months after the revelation of such circumstances the insurer is entitled to propose to the policyholder to amend the insurance contract. If the policyholder refuses to amend the contract or does not respond to the proposal of the insurer within one month, the insurer is entitled to demand termination of the insurance contract;

7.4.3. if the insurer knowing the circumstances, about which the policyholder failed to inform due to negligence, would not have concluded the insurance contract, the insurer is entitled to terminate the insurance contract within two months from the revelation of the fact that the policyholder has failed to provide necessary information due to negligence;

7.4.4. the terms and conditions of insurance type may provide for additional cases when the insurance contract may be terminated at the initiative of the insurer or may expire.

8. Settlement procedure upon termination of the insurance contract

8.1. If the insurance contract is terminated or expires before the end of its period, the insurer is entitled to the part of the premium for the term of validity of the insurance contract.

8.2. If the insurance contract expires or is terminated in accordance with clauses 7.3.2-7.3.3, 7.5.1 of these General Insurance Conditions, the remained part of insurance premium is not refunded to the policyholder.

8.3. If the insurance contract expires or is terminated at the initiative of the policyholder or in accordance with clauses 7.3.4-7.3.7, 5.1.2 or 8.4.2 of these General Insurance Conditions, the insurer shall deduct from the refundable part of the premium the expenses of conclusion and exercise of the contract (20% of the premium for the unused part of insurance period no longer than one year but not less than 14 EUR); if it is impossible to deduct the expenses of conclusion and exercise of the contract from the part of the premium paid by the policyholder (the amount paid is insufficient), such expenses shall be covered by the policyholder. The fees to be paid or refunded are revised not sooner that the next day after the insurer is informed about the circumstances that form the basis for termination or expiration of the insurance contract.

8.4. In case the policyholder withdraws from the insurance contract concluded by means of communication (clause 7.3.2 of these General Insurance Conditions) within 14 days from the conclusion of the insurance contract:

8.4.1. if the insurance cover has not been provided, the full paid insurance premium shall be refunded without deducting administrative costs;

8.4.2. if the insurance cover has been provided, the unused premium is refunded after deducting the part of the premium that corresponds to the period when the insurance cover was valid.

8.5. If the policyholder had not paid all the insurance premiums agreed before the termination or expiration of the insurance contract, upon the termination or expiration of the insurance contract he must pay the part of insurance premium corresponding to the insurance cover provided until the termination or expiration of the insurance contract.

8.6. The refundable insurance premium or the part thereof shall be transferred to the current account indicated by the policyholder within 14 working days from the receival of written request by the policyholder but not before the termination or expiration of the insurance contract.

9. Terms and conditions for the insurance contract longer than one year

9.1. If the period of the insurance contract is longer than one year, at the end of each current insurance year, the insurer is entitled to:
  9.1.1. determine different sums insured, insurance premiums and deductible for the next year (e.g. in order to avoid incomplete insurance, due to inflation, amendments of law or reinsurance conditions, loss history, etc.);
  9.1.2. apply new edition of insurance terms and conditions for the next year.
9.2. The new terms and conditions of the insurance contract shall come into effect from the beginning of the next insurance year only if both of the following conditions are met:
  9.2.1. the insurer has submitted to the policyholder (and, if applicable, to the beneficiary) the written proposal for the amendment of the terms and conditions of the insurance not later than 1 month before the end of the current insurance year, and
  9.2.2. the policyholder and (or) the beneficiary have not notified the insurer in written about the disagreement to the amendment of the terms and conditions of the insurance before the end of the current insurance year.
9.3. If the policyholder and (or) the beneficiary disagree with the amendments of the terms and conditions of the insurance proposed by the insurer and notify the insurer about this in written before the end of the current insurance year, the insurance contract shall terminate at the end of the current insurance year and all the insurance premium paid for the remaining period of the insurance contract shall be refunded to the policyholder without deducting the expenses of the conclusion and exercise of the insurance contract.
9.4. If the insurer does not submit the proposal to amend the terms and conditions of the insurance, the insurance contract remains valid for the next year under the same terms and conditions and the same premium must be paid at the same terms as the previous year.

10. The responsibility of data protection

10.1. The insurer shall protect the information received about the policyholder, the insured or the beneficiary and shall not disclose it to third persons, except for the cases specified by legal acts.
10.2. Information about the policyholder, the insured and the beneficiary may be revealed:
  10.2.1. to courts, law enforcement, supervisory, dispute resolution and other institutions in cases specified by law;
  10.2.2. to reinsurers and to the companies of the insurer's shareholder group;
  10.2.3. to the experts, representatives, consultants and other entities hired by the insurer and providing services to the insurer;
  10.2.4. upon receival of a written request or approval by the policyholder, to the insured or the beneficiary;
  10.2.5. in other cases specified by legal acts.

11. Transfer of rights and responsibilities determined by the insurance contract

11.1. The insurer is entitled to transfer the rights and responsibilities arising from the insurance contract to other insurers in accordance with the procedure determined by law. The insurer must notify about the intention to transfer the rights and responsibilities arising from the insurance contract in accordance with the procedure determined by law.
11.2. The policyholder is not entitled to transfer his rights and responsibilities arising from the insurance contract without written approval of the insurer.

12. Procedure for resolving disputes between the policyholder and the insurer

12.1. Complaints regarding the activities of the insurer or the distributor of insurance products can be submitted to ADB Gjensidige by e-mail info@gjensidige.lt or by post to the insurer's registered office address Žalgirio 90, Vilnius.

12.2. Detailed information on the procedure for submitting complaints and resolving disputes, including complaints regarding the activities of the distributor of insurance products, is published on the insurer's website www.gjensidige.lt.

12.3. Disputes arising from the insurance contract shall be resolved by negotiations. If the parties do not reach an agreement, the dispute shall be resolved out of court at the Bank of Lithuania, Totorių 4, LT-01103 Vilnius (for more information visit www.lb.lt) or in the competent court of the Republic of Lithuania.

12.4. Insurance contracts are subject to the law of the Republic of Lithuania, unless the parties have agreed otherwise in the insurance contract (individual insurance contract or insurance policy).

13. Procedure for providing information to the other party of the contract

13.1. Any notification that must be submitted by one party of the insurance contract (as well as by the insured and the beneficiary) to the other party must be submitted in written.

13.2. Notifications sent to the other party by ordinary mail, by e-mail or by courier to the addresses specified in the insurance contract or submitted on the insurer's self-service website shall be deemed to be presented properly.

13.3. It shall be considered that the proper day of presenting the notifications is:

13.3.1. the next working day after sending the notification by e-mail;

13.3.2. if the notification is sent by post:

a) the notification sent by ordinary mail shall be considered as submitted after a reasonable time from the day it has been sent;

b) the date of the receival of the notification sent by registered mail is indicated on the official stamp of the post office;

c) the date of the receival of the notification sent by courier is considered to be the day of its delivery to the addressee;

13.3.3. the next working day after submitting the notification on the self-service website of the insurer;

13.4. The parties of the insurance contract must inform each other about the changed address or other contact details within 15 days from the day such data has changed. The policyholder may provide the insurer with the information about the changed contact details by telephone (1626), on the self-service website of the insurer, or by other means specified in clause 13.3 of these General Insurance Conditions.

14. Protection of personal data

14.1. The insurer in performance of the contract acts as a controller of the data and processes personal data in accordance with the General Data Protection Regulation (hereinafter referred to as GDPR), the Law on Legal Protection of Personal Data of the Republic of Lithuania and other legal acts that regulate protection of personal data.

14.2. The insurer shall process personal data only for predefined purposes in order to be able to conclude and exercise insurance contract and to exercise actions related to it: to identify the party of the insurance contract, to acquire information about the property insured, to assess and control insurance risk, to prepare insurance proposal and draw insurance contract, to assess the extent of the damage, to administer insured events, as well as operations of insurance premiums and insurance indemnities (including invoicing and debt recovery), to contact the policyholder in regard to the exercise of the contract or to remind about the ending insurance contract.

14.3. The insurer in compliance with the legal acts applicable is entitled to process personal data not only of the policyholder but also of other parties involved. Depending on the specifics of insurance product and particular situation the insurer shall process personal data of the beneficiaries, the insured, the payers and other persons involved in the exercise of the insurance contract.
14.4. As a controller of the data, the insurer is entitled to use services of data administrators that process personal data on behalf of the insurer.
14.5. The insurer shall process personal data only when: it is necessary for the conclusion of the insurance contract and/or for the exercise of the insurance contract that has already been concluded; the insurer must process personal data as he is obligated so by legal acts; approval to process personal data is granted; personal data has to be processed for legal interests of the insurer or a third party.
14.6. Persons whose personal data is processed by the insurer (hereinafter referred to as the data entities) have following rights: to familiarize with the personal data processed by the insurer; to request to correct their data that is incorrect or inaccurate; to delete personal data that is processed illegally; to request the insurer to restrict the processing of the personal data; to request the insurer to transmit the data processed; to object to the processing of personal data; to cancel direct marketing authorizations at any time; to submit a claim to the supervisory authority.
14.7. The insurer shall review the request of the data entity and give a response within one month from the receival of the request. This period may be prolonged by two more months taking into consideration the complexity and number of requests.
14.8. The Insurer has appointed a data protection officer, whose contact e-mail address is dpo@gjensidige.lt.
14.9. Detailed information on how the insurer processes personal data and on procedure for the exercise of the rights of the data entities is provided in the Principles of Personal Data Processing on Insurer's website www.gjensidige.lt.