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

Valid from 01 07 2022

ERGO

Simple because it matters.

ERGO Life Insurance SE

Special Conditions of Cancer and Other Critical Illness Insurance of Children No 028-05

(these conditions shall apply along with the Universal Life Insurance Rules No 028)

1. Object of insurance

1.1. The object of insurance shall be property interests if the Insured develops cancer or another critical illness insured under the Insurance Agreement conditions and corresponding to the list of insured critical illnesses and the criteria for recognizing it as an Insured Event (Annex 1 to these conditions).

2. Insured persons

2.1. The person specified in the Insurance Certificate who is 2 to 17 years old at the time of conclusion of the Insurance Agreement and who shall be subject to insurance coverage for the period of time specified in the Insurance Agreement, but no longer than until he turns 18.

3. Insured events

3.1. When the Insured is diagnosed with an illness referred to in the list of insured critical illnesses for the first time during the validity period of insurance coverage or undergoes a surgery, where the diagnosis has been confirmed by medical documents and meets the description of the illness and the criteria for recognition as an insured event as set out in the Insurance Agreement and Annex 1 to these conditions, except as provided for in Article 4 hereof.

3.2. An event shall only be recognised an insured event if all the statements made by the Insured (or by the Policyholder on his behalf) in the health questionnaire provided by the Insurer were true before the moment of entry into force of the Insurance Agreement, or if the circumstances referred to in the statements were already manifested after the entry into force of insurance coverage.

4. Non-insured events

4.1. Non-insured events when no Insurance Benefit shall be paid include cases when an illness has been diagnosed:

4.1.1. within the first 3 months from the date of entry into force of insurance coverage in respect of the Insured, also before the commencement of insurance coverage or when the insurance coverage is suspended, as well as 3 months following the resumption of insurance coverage, when coverage has been suspended. **Exception**: the 3-month timeframe shall not apply if:

- agreed in writing in the Insurance Agreement;
- the Insured has previously been insured against the illness (to the same extent) with the same insurance company, and the insurance coverage has continued uninterruptedly;
- blindness, paralysis and/or loss of limbs, deafness, coma, severe head injury has been diagnosed as a consequence of an accident and occurred during the insurance coverage period.

4.1.2. cases that do not meet the definition of critical illness and the criteria for recognition as an insured event provided in Annex 1 hereto;

4.1.3. cases related to hostilities (whether or not a war has been declared), exposure to nuclear energy and radioactive radiation (excluding the effects of radiotherapy);

4.1.4. events caused by the Insured as a result of being under the influence of alcohol, drugs or toxic, psychotropic or other psychoactive substances used for the purpose of intoxication, or of potent medicinal products that were not prescribed by a doctor, if this has a causal link to the diagnosed illness;

4.1.5. events suffered while the Insured was committing or preparing to commit a criminal offence, or from any other act contrary to the law;

4.1.6. events caused by deliberate self-harm or attempted suicide;

4.1.7. events related to engagement of the Insured in professional and/or extreme sports/leisure-time. If the Insured has notified of engagement in such a sport at the time of conclusion or during the validity period of the Insurance Agreement, and the Insurer has assessed and assumed this risk, the specific agreement between the Insurer and the policyholder regarding the risk assumed shall be indicated in the Insurance Agreement;

4.1.8. in respect of a person who is infected with HIV or AIDS;

4.1.9. in respect of a person who has a congenital defect;

4.1.10. cases when the Insured has already been diagnosed with a tumour of any kind, leukaemia, lymphoma, bleeding, painful, discoloured or disfigured moles or skin lesions, colorectal polyposis, inflammatory bowel disease (Crohn's disease or ulcerative colitis), polycystic kidney disease, benign breast tumours, asbestosis, hepatitis in any form (except hepatitis A), cirrhosis of the liver before the conclusion of the Insurance Agreement, also if the Insured has already been consulted for the diagnosis of the above-mentioned disorders before the date of conclusion of the Insurance Agreement. If the Insured has been consulted, and an illness has not been diagnosed, or if the Insured has gone into remission and has recovered, and has provided written information (medical report and test data) to the Insurer thereon before the date of conclusion of the Insurance Agreement, and the Insurer has concluded an Insurance Agreement knowing all the detailed information thereon, then this clause shall not apply to cancers diagnosed after the conclusion of the Insurance Agreement;

4.1.11. a critical illness was the cause of the death of the Insured occurring within 30 days of the diagnosis of a critical illness (not applicable in case of cancer).

5. Insurance options

5.1. The Insured shall be insured against 14 critical illness listed in Annex 1 hereto.

6. Sum insured and insurance benefits

6.1. The Insured's Sum Insured for cancer and critical illness insurance shall be indicated in the Insurance Certificate and can be variable.

6.2. Having recognized the Insured person's critical illness to be an insured event, the Sum Insured of the critical illness insurance of that person shall be paid, and, in case of cancer, a part of the Sum Insured depending on the diagnosed illness the criteria of which is listed in Annex 1 hereto may also be paid:

10% of the Sum Insured	20% of the Sum Insured	100% of the Sum Insured
Invasive skin cancer	**Non-invasive/early-stage cancer** Melanoma *in situ* Primary carcinoma *in situ* Primary prostate cancer Papillary or follicular thyroid cancer	**Invasive cancer** Advanced melanoma

6.3. If a person has already been paid a part of the Sum Insured in accordance with conditions of clause 6.2 hereof, it shall not be deducted from the 100 % of the Sum Insured payable for critical illnesses.

6.4. Having paid a benefit of 100% of the Sum Insured for a critical illness, the cancer and other critical illness insurance in respect of the Insured shall terminate.

6.5. If the Sum Insured has been increased, and the Insured contracts a critical illness within the first 3 months from the date of increase of the Sum Insured, the Sum Insured equal to the Sum Insured of the Insured applicable 3 months ago shall be paid. This clause shall not apply if the Insured is diagnosed with blindness, paralysis and/or loss of limbs, deafness, coma, or a severe head injury as a result of an accident suffered during the validity period of the Insurance Agreement.

6.6. Upon the death of the Insured, insurance coverage under the Insurance Agreement for that person shall cease in full.

7. Procedure of reporting insured events

7.1. In case of a critical illness of the Insured, the following shall be submitted to the Insurer:

7.1.1. a report on contracting a critical illness in the form prescribed by the Insurer;

7.1.2. documents from health care institutions confirming the diagnosis of the illness, the medical history, a description of the examinations performed and the treatment prescribed, as well as the surgeries performed;

7.1.3. any other documents requested by the Insurer which are relevant for determining circumstances of the Insured Event.

7.2. Costs related to obtaining the documents listed in clause 7.1 above in support of the Insured Event shall be borne by the person claiming an Insurance Benefit.

7.3. The beneficiary/the Insured or the policyholder shall notify the Insurer in writing of the critical illness within 30 days from the date when the critical illness was diagnosed.

8. Procedure of payment of insurance benefits

8.1. The Insurer shall pay an Insurance Benefit in the event of a critical illness to the Insured, unless the Insurance Agreement establishes otherwise.

8.2. If the Insured is deceased on the date the event is recognized as an insured event, an Insurance Benefit shall be paid to heirs of the Insured.

9. Procedure of amending insurance conditions

9.1. In light of developments in medical science or changes in incidence rates, as well as changes in legal regulation, the Insurer shall have the right to change definitions of critical illnesses and/or the criteria for diagnosing them. The Insurer may make unilateral amendments provided that they do not violate rights or interests of the customer, and by warning the Policyholder thereof in writing at least 30 days before the scheduled date of amendment of the insurance conditions.

9.2. The Policyholder shall have the right to terminate the Insurance Agreement or to cancel the selected insurance coverage before the date of entry into force of amendments to the rules, if it finds amendments unacceptable.

9.3. The Insurer shall have the right to amend the Special Conditions of Cancer and Critical Illness Insurance of Adults for insurance agreements concluded for a period of 1 year, by notifying the Policyholder thereof at least 30 days before the date of automatic extension of the Insurance Agreement.

General Manager
Bogdan Benczak

ERGO

Simple because it matters.

ERGO Life Insurance SE

Annex No 1 to Special Conditions of Cancer and Other Critical Illness Insurance of Children No 028-05

List of Critical Illnesses Insured and Criteria for Recognizing Insured Events

1. Cancer – invasive cancer, invasive skin cancer, non-invasive/early-stage cancer.
It shall be confirmed by a medical oncologist, haematologist or pathologist and supported by medical documentation, i.e. a histological examination shall be performed diagnosing malignant process, and meet the criteria set out in clauses 1.1 and 1.2 hereof.

1.1. Non-invasive/early-stage cancer
It is a cancer with a histologically confirmed diagnosis, characterised by malignant cell growth at the original tumour site, which does not affect the base membrane and has not spread to other tissues. In this case, 20 % of the Sum Insured shall be paid.
Such cancer includes:
- all primary carcinomas in situ according to the current AJCC classification adopted by the American Joint Committee on Cancer;
- melanoma in situ, excluding other forms of skin cancer;
- primary prostate cancer stage T1aN0M0, T1bN0M0 or T2aN0M0 – only when treated with radical prostatectomy;
- papillary or follicular thyroid cancer stage T1 (including T1aN0M0 and T1bN0M0).

The following shall not be considered non-invasive/early-stage cancer:
- benign tumour, dysplasia or precancerous disease;
- any skin cancer other than pre-invasive melanoma in situ.

1.2. Invasive cancer
Invasive skin cancer (except melanoma *in situ*) means basal cell carcinoma of the skin, squamous cell carcinoma and dermatofibrosarcoma. In this case, 10 % of the Sum Insured shall be paid.
Invasive cancer is cancer characterised by uncontrolled growth and spread of malignant cells into tissues, blood organs and the lymphatic system, including malignant lymphoma, malignant bone marrow disorders, leukaemia, malignant advanced melanoma, Hodgkin's disease and myelodysplastic syndrome. In this case, 100 % of the Sum Insured shall be paid.

The following shall not be considered invasive cancer:
- Benign tumour, dysplasia or precancerous disease;
- Basal cell and squamous cell carcinoma of the skin and dermatofibrosarcoma;
- Carcinoma in situ;
- Non-invasive malignant cancer;
- Prostate cancer – in stage lower than T2bN0M0;
- Papillary or follicular thyroid cancer – in stage lower than T2N0M0;
- True polycythemia and primary thrombocythemia, monoclonal gammopathy of undetermined origin.

2. A benign brain tumour – a non-malignant tumour located in the cerebral part of the skull, meninges or the cranial nerves. The tumour shall be treated with at least one of the following therapies:
- complete or partial surgical removal;
- stereotactic radiosurgery;
- external beam radiotherapy.

If none of the treatments can be used for medical reasons, the tumour shall cause a permanent neurological deficit which persist for at least 3 months after the diagnosis. It shall be diagnosed by a neurologist or neurosurgeon and confirmed by imaging tests.

An Insurance Benefit shall not be paid having diagnosed:
- any cyst, granuloma, hamartoma or malformation of the cerebral arteries or veins;
- pituitary tumours;
- congenital tumours.

3. Transplantation of internal organs, tissues and bone marrow – a transplantation surgery of one or more organs performed on the Insured, when the Insured is the recipient of the following:
- a heart;
- a kidney (kidneys);
- liver (including a part of liver or transplantation of liver of a living donor);
- lungs (including transplantation of a lobe of a living donor or transplantation of one lung);
- bone marrow (transplantation of allogeneic hematopoietic stem cells performed after complete removal of bone marrow);
- small intestine;
- pancreas;
- a part or the entire face, arm, hand or leg (composite tissue allotransplantation).

A transplantation shall be vital and confirmed by a specialist of a respective field.

An Insurance Benefit shall not be paid in the following cases:
- transplantation of organs, body parts or tissues other than those listed above;
- transplantation of stem cells other than those listed above;
- transplantation for congenital defects or abnormalities.

4. Chronic renal failure – an irreversible terminal insufficiency of the function of both kidneys requiring a regular dialysis. The need for dialyses shall be confirmed by a nephrologist and renal function tests.

An Insurance Benefit shall not be paid for:
- acute reversible renal failure treated by temporary renal dialysis;
- renal failure due to congenital kidney and/or congenital urinary tract anomalies;
- renal failure due to impaired renal perfusion in the perinatal phase.

5. Paralysis of the extremities – a complete and irreversible loss of muscle function of any 2 extremities due to a trauma or an illness.
Persistent nature of the illness shall be confirmed by a neurologist, clinical data and diagnostic tests, and shall persist for more than 3 months.

An Insurance Benefit shall not be paid in the following cases:
- paralysis of the extremities caused by self-harm or psychological disorders;
- Guillain-Barre syndrome;
- paralysis due to congenital defects or abnormalities.

6. Blindness – an irreversible loss of vision of both eyes due to an illness or trauma. An irreversible condition confirmed by an ophthalmologist that cannot be treated with refractive correction, medication or surgery.
Loss of vision shall be proven when visual acuity of the better seeing eye is 3/60 or less (0,05 or less on a decimal scale) as measured after correction, or when the field of vision of the better seeing eye is less than 10° in diameter after correction.

An Insurance Benefit shall not be paid:
- for a congenital or inherited loss of vision, including due to infection during pregnancy.

7. Deafness – irreversible deafness in both ears due to an illness or trauma.
Deafness shall be confirmed by an otorhinolaryngologist with a hearing threshold of at least 90 db in the better-hearing ear after tonal threshold audiometry in all frequency ranges.

An Insurance Benefit shall not be paid:
- for a congenital or inherited deafness, including due to infection during pregnancy.

8. Coma – a loss of consciousness without responding to external stimuli or internal demands, when:
- the condition lasts for at least 96 hours and is scored 8 or less on the Glasgow Coma Scale,
- requires the use of a life support system, and
- a permanent neurological deficit[1] that persists for at least 30 days from the onset of coma.

The diagnosis shall be confirmed by a neurologist.

An Insurance Benefit shall not be paid in the following cases:
- coma has been artificially induced by medical means or medication (for medically justified reasons);
- coma has been caused by the use of alcohol or drugs, psychotropic or other psychoactive substances without a doctor's prescription;
- injury resulting from exploitation or abuse of a child by a parent, legal guardian or their spouse/cohabitant;
- coma due to complications of childbirth or congenital defects.

9. Acute viral encephalitis – a diagnosis causing a permanent neurological deficit[1] that persists for at least 3 months from the diagnosis, or complete loss or cessation of motor, cognitive and language development for 12 months in children under 6 years of age.
The diagnosis shall be confirmed by a neurologist and substantiated with typical clinical symptoms and cerebrospinal fluid tests or the results of a brain biopsy.

An Insurance Benefit shall not be paid in the following cases:
- encephalitis caused by bacterial or protozoal infections;
- myalgic or paraneoplastic encephalomyelitis.

10. Severe head injury – an injury that causes severe and permanent damage to the brain.
The suffered person is unable to perform at least 3 out of 6 daily tasks on his own (washing, dressing/undressing, eating, personal hygiene, moving around indoors, getting in and out of bed) for at least 3 months continuously, and there is no sign of improvement.
The diagnosis shall be confirmed by a neurologist or neurosurgeon, substantiated with the results of functional independence and imaging tests (CT scan, MRI).

An Insurance Benefit shall not be paid in the following cases:
- use of alcohol or drugs, psychotropic or other psychoactive substances without a doctor's prescription;
- injury resulting from child abuse or exploitation by a parent, legal guardian or their spouse/ cohabitant.

11. Loss of limbs – the loss of two or more limbs above the wrist or ankle joint as a result of an accident or medically necessary amputation. The diagnosis shall be confirmed by a surgeon or orthopaedic traumatologist.

12. Bacterial meningitis – the diagnosis that causes:
- a permanent neurological deficit[1] that persists for at least 3 months after diagnosing it; or
- in children under the age of 6 years, complete loss or cessation of motor, cognitive and speech skills for 12 months development.

The diagnosis shall be confirmed by a neurologist or an infectologist and be based on the results of a bacteriological examination when growth of pathogenic bacteria is detected in a cerebrospinal fluid sample.

An Insurance Benefit shall not be paid in the following cases:
- aseptic, viral, parasitic or non-infectious meningitis.

13. Severe asthma exacerbation – the diagnosis for which the Insured has been treated in a hospital at least twice in the last 12 months. The condition shall be confirmed by a pulmonary index score of at least 12 or an equivalent value of alternative scores.
The diagnosis shall be confirmed by a pulmonologist and be based on typical clinical signs and laboratory test results.

An Insurance Benefit shall not be paid in the following cases:
- asthma due to gastroesophageal reflux disease (GERD);
- drug-induced asthma;
- asthma as a result of a respiratory infection.

14. Insulin-dependent diabetes mellitus (type I) – a diagnosis characterised by the inability of the pancreas to produce enough insulin, with the need for lifelong use of exogenous insulin.
The diagnosis shall be confirmed by an endocrinologist and supported by typical clinical features and laboratory test results. The conducted laboratory tests shall demonstrate at least one of the following results:
- pancreatic autoantibodies;
- insulin and C-peptide levels consistent with a diagnosis of type 1 diabetes mellitus.

An Insurance Benefit shall not be paid in the following cases:
- when the Insured suffers from diseases of the exocrine system (e.g. cystic fibrosis, hereditary haemochromatosis or chronic pancreatitis);
- endocrine disorders of glucose regulation (e.g. Cushing's syndrome);
- drug-induced diabetes;
- type II diabetes mellitus.

[1] Neurological deficit
Symptoms of neurological impairment as determined by clinical examination. Symptoms include numbness, hyperaesthesia (hypersensitivity), paralysis, local weakness, dysarthria (impaired speech), aphasia (inability to speak), dysphagia (difficulty swallowing), visual impairment, difficult walking, incoordination, tremor, convulsions, lethargy, dementia, delirium and coma.

An Insurance Benefit shall not be paid in the following cases:
- Abnormalities visible on CT or MRI scans or other neuro-visual examinations which are not obviously related to clinical symptoms;
- neurological signs occurring without pathological symptoms, e.g. sudden reflexes without other symptoms;
- symptoms of psychological or psychiatric origin.