PERSONAL ACCIDENT INSURANCE

Terms and Conditions No 53.2

PATVIRTINTA
BTA Baltic Insurance Company AAS Management Board decision
No LVB1_0002/02-03-03-2018-188 of 18 December 2018

CONTENT

SPECIAL CONDITIONS

1. WHAT IS WHAT

We or the **Insurer –** AAS BTA Baltic Insurance Company, on behalf of Lithuanian Branch.

You or the **Insured Person** – a natural person indicated in the insurance policy ("the Policy") whose interest shall be covered and in whose favour the insurance is contracted.

Accident – a sudden and unexpected event that happens to You beyond Your control during the Policy period as a result of external forces and causes Your Trauma, Loss of Working Capacity or Death.

Loss of Working Capacity – a 50% or greater loss of working capacity (or disability for persons under 18) established to You as a result of a Trauma (which has been recognized as insured event in accordance with the terms of these Rules), by a competent authority within one year after the Trauma which must be confirmed twice by the competence authority, provided that the second confirmation establishing a 50% or greater loss of working capacity (or disability for persons under 18) takes place at least one year after the first one.

Temporary Loss of Capacity for Work – a period when You are temporarily incapable of performing Your job duties as a result of Trauma (which has been recognized as insured event in accordance with the terms of these Rules) and this is confirmed by medical documents and sick leaves.

Trauma – a bodily injury caused by an Accident and listed in Annex 1 "The table of benefits" (hereinafter referred to as "Annex 1").

Polytrauma (multitrauma) – Traumas due to one accident in which two or more systems of the body are seriously injured.

Repeated Fracture – a bone fracture occurring during an Accident due to changes in the bone structure in the location of an earlier fracture.

Pathological Fracture – a bone fracture occurring due to changes in the bone structure or occurring in bones with pathological changes.

Critical Illness – illness listed in paragraph 24.2, when the first symptoms of the illness are diagnosed and the diagnosis is verified during the Policy period. The onset date is the day of applying to a medical establishment when the first symptoms of the illness were diagnosed and Critical Illness diagnosis was verified ('Final Diagnosis') within 1 month after the first symptoms thereof were recorded.

Disease – illness listed in paragraph 27.2, when the first symptoms of the Disease are diagnosed and the diagnosis is verified during the Policy period. The onset date is the day of applying to a medical establishment when the first symptoms of the Disease were observed and the diagnosis was confirmed after medical examinations performed in relation thereto.

Sports – when you earn income from participation in training and/or competitions of the respective type of sports or engaging in regular training in order to prepare for participation in national or international sports competitions individually or with a team.

Intoxication Clause – Inured Person's accidental death will be also recognised as a risk covered if the Insured Person's blood alcohol concentration exceeds 0.4 mg/ml. However, the cover will not apply irrespectively of whether or not the Intoxication Clause is chosen if at the moment of the event the Insured Person was driving any motor vehicle and his/her blood alcohol content exceeded the statutory limit permitted to drivers of motor vehicles in a country where the event occurs.

Insurance risk increase/decrease – means any change or occurrence of the circumstances provided for in these Regulations, insurance policy and/or other documents submitted to the Insurer that may essentially influence the probability of occurrence of an insured event and potential damage caused by the event. Change in work activities, sports classes or other form of activities in which the Insured engages and which is specified in the insurance policy shall be considered to be increase/decrease of insurance risk.

Renewed contract – means an insurance contract which enters into force on the next day following the day of expiry of the previous contract concluded with the Insurer. A contract shall be considered to be renewed only where the Insured is the same person as in the expired contract and the contract is concluded under the terms and conditions of the same Regulations. Where a new Insured is included in the renewed contract, the terms and conditions of the renewed contract shall not apply to such Insured. Where new insurance variants are chosen in the renewed contract, the terms and conditions of the renewed contract shall not apply to such insurance variants.

Plastic surgery – means a surgery the purpose of which is to eliminate visible face/ body defects remaining as a result of an injury which is recognized to be the insured event in accordance with terms and conditions of these Regulations.

2. RISKS COVERED

2.1. Insurance object **–** property interests relating to your Trauma, Loss of Working Capacity or Death caused by an Accident, as well as relating to Critical Illness and/or Disease specified in the Regulations.

2.2. Sum insured – a sum of money specified in the Policy which is the limit of indemnity payable by Us in benefits. The sum insured shall be agreed by the Insurer and Policyholder on a per risk basis.

2.3. The territory of cover is worldwide (unless the Policy reads otherwise), except for Daily Allowance and Medical Expense risks which are covered in the Republic of Lithuania only.

3. VALIDITY OF COVER IN CASE OF ENGAGING IN SPORTS OR INCREASED RISK ACTIVITIES

3.1. This insurance shall cover individual and organized sports activities other than activities defined as Sports and/or Increased-Risk Activities.

3.2. In case of choosing Sports risk in Your Policy, this insurance shall cover all sports training or competitions, except for activities defined in the Regulations as Increased-Risk Activities.

3.3. In case of choosing Increased-Risk Activities in Your Policy, this insurance shall cover:

- **3.3.1.** alpinism, mountaineering to the height exceeding 2500 m with special mountaineering equipment, speleology, expeditions to mountains, jungles, deserts or other uninhabited places;
- **3.3.2.** driving a motorcycle in free time (including as a passenger), including sea and snow, quads, motor-scooters and go karts;
- **3.3.3.** bicycle sports (bicycle cross-country racing, mountain biking; BMX biking);
- **3.3.4.** water sports (windsurfing, surfboarding, water skiing, scuba diving in the depth of up to 30 m). However, the cover shall not apply to swimming or diving in the depth exceeding 30 metres, also if this sport is practiced in the Arctic Ocean and neighbouring seas);
- **3.3.5.** parachuting;
- **3.3.6.** horse riding, American football, handball, rugby, hockey;

3.3.7. combat and contact sports (boxing, martial arts, wrestling);

3.3.8. gliding, paragliding, air-ballooning or travelling in other light aircraft;

3.3.9. any sports activities related to jumps from height, veer, manoeuvring with or without elements of acrobatics (including parkour, tricking, bungee-jumping).

3.3.10. shall exclude activities that are specified in subparagraph 4.1.13 as non-insured events.

4. EXCLUSIONS

4.1. This Insurance shall not apply and no insurance benefit is payable if Accident arises out of circumstances described in the General Terms and Conditions of the Regulation. In addition, no benefits are payable in the following cases:

4.1.1. You were engaged in activities incurring criminal activity;

4.1.2. You were arrested or Your freedom was restricted as a result of serving a sentence;

4.1.3. You take part in fights (except necessary self-defence when its limits are not overstepped or when the use of physical power is directly related to the performance of official duties, or the fact of You being attacked and/or beaten was established by competent authorities);

4.1.4. You were doing jobs dangerous for Your health or life which require special training and appropriate permits issued by a competent body (commission) without holding such permit (i.e. jobs relating to high-voltage equipment, high-altitude and underground operations, special-purpose machinery, explosives, wells, digging/excavation, etc.);

4.1.5. You were travelling as a passenger in an aircraft which was not intended for passenger transportation;

4.1.6. You committed suicide, attempted suicide or injured Yourself;

4.1.7. You were treated using non-traditional medical methods;

4.1.8. before the event or during it, You were using narcotic, psychotropic, toxic substances or medicinal products with no medical indications and not prescribed by a doctor for specific treatment purposes;

4.1.9. served in an army and participated in military exercises, operations, peacekeeping missions or any military acts;

4.1.10. You voluntarily endangered Your own life, except for trying to save another person's life;

4.1.11. You were driving any motor vehicle (road vehicle, aircraft or watercraft) in a state of alcohol, narcotic or psychotropic intoxication or without a proper driving license for a motor vehicle of a certain category; also, if You were travelling by a motor vehicle being aware that its driver was in a state of alcohol, narcotic or psychotropic intoxication or driving without a proper driving license for a motor vehicle of a certain category using alcohol, narcotic or psychotropic substances. This provision does not apply only in cases when driver's blood alcohol content does not exceed the statutory limit permitted to drivers of motor vehicles in a country where the event occurs and this is confirmed by alcohol tester readings or medical documents;

4.1.12. You were snowboarding or alpine skiing in places other than specially designated alpine skiing tracks;

4.1.13. You were performing acrobatic flights, engaged in bushido, kickboxing, no rules fighting and other similar activities, motor sports, cross-country motorcycle races, participating in competitions or training with sea scooters, snow scooters, quads, unless the Policy stipulates otherwise;

4.1.14. You were engaged in Increased-Risk Sports or Sports unless Increased-Risk Sports or Sports were chosen in Your Policy.

4.2. Coverage under the Regulation is also excluded for Accidents:

4.2.1. occurring during surgeries and/or as consequences thereof;

4.2.2. related to developmental and congenital diseases and/or abnormalities;

4.2.3. where the occurrence of a critical disease or accident was influenced by your health disorders in respect of which competent public authorities had already determined for you the level of loss of ability for work or a level of disability, or a mental disease;

4.2.4. occurring as a result of illnesses (including Critical Illnesses) and/or illness-related seizures (e.g. illnesses causing diabetic seizure, epileptic seizure or other convulsive seizures of the body), mental diseases or injuries, reactive conditions (state of affect) causing coordination disorders or muscle weakness (including but not limited to Parkinson's disease, myopathy, disseminated (multiple) sclerosis);

4.2.5. related to birth-giving, abortion, medical errors;

4.2.6. related to AIDS and other HIV caused diseases;

4.2.7. caused by global disasters, natural calamities, epidemics, etc.

4.3. Events listed as exclusions for individual risks shall not be covered, too.

4.4. We shall have the right to disallow insurance benefit if You fail to seek medical assistance from a medical establishment on time (within 72 hours after the Accident) or fail to report of the event to Us on due time and this precludes Us from verifying the exact circumstances thereof when medical documents do not confirm that the event occurred within the Policy period.

4.5. We have the right, at our expense, to carry out an additional inspection of the Insured's state of health, with the help of medical experts or other specialists, in order to determine the causes of the occurrence which may be recognized as prohibitive or non-prohibitive, and the extent of the damage.

5. HOW TO PROCEED IN CASE OF AN ACCIDENT?

5.1. Upon occurrence of the event insured (risk covered), You, the Policyholder or persons authorised by You must:

5.2. notify Us in writing on an event that may be recognised as the risk covered in 30 calendar days after the event and disclose its circumstances. If You undergo in-patient treatment in a medical establishment, the event insured and its circumstances must be notified within 30 calendar days after the last day of Your hospital stay;

5.3. where the Policy stipulates that the Insured Person is covered only at work or on the way to/from work - produce Us documentary proof of the investigation of the event in accordance with the laws of the Republic of Lithuania regulating investigation of Accidents at work and accidents on the way to/from work, and of the event being recognised as Accident at work or Accident on the way to/from work;

5.4. release doctors from their duty of medical confidentiality and give powers to Our representative to get access to Your medical documents and other documents related to the Accident;

5.5. authorize Us to conduct additional medical examination of the Insured Person in relation to the Accident. We shall delegate Our medical experts or other professionals to do the examination. Costs sustained in connection to the acts mentioned in this paragraph above shall be covered by Us.

TRAUMAS

6. WHAT IS COVERED?

6.1. The risk covered is Your Trauma listed in Annex 1.

7. WHEN DOES THIS INSURANCE NOT APPLY?

7.1. This insurance shall not apply to:

7.1.1. traumas not listed in Annex 1;

7.1.2. injury to a functional unit of the organ system in the area attached by disease before the Trauma or Pathological Fracture;

7.1.3. Repeated Fracture occurred during validity of the same insurance policy;

7.1.4. Repeated injury of soft tissues of the same joint or joint structures (e.g., strain, split, etc.) during validity of the same insurance policy.

7.1.5. for transplant tear;

7.1.6. for implant tear, dislocation, fracture and other damage

7.1.7. Hernias occurring as a result of physical loads/pressure (incl. weight lifting), e.g., abdominal hernia, diaphragmatic hernia, hernia of the intervertebral discs, as well as radiculopathies/neuropathies shall not be qualified as risks covered;

7.1.8. traumas caused by Your cosmetic procedures, surgeries, prosthetic dentistry and treatment of their complications, unless this is related to Trauma suffered during the Policy period;

7.1.9. due to the repeated damage of the functional unit of the same organs system (eg internal organs, genital organs, eyes, etc.), if there are still the consequences of the previous Trauma;

7.1.10. Trauma that are not confirmed by primary medical documentation and / or diagnostic tests during the insurance period of the occurrence.

8. WHAT DO WE PAY FOR AND HOW?

8.1. Insurance benefit shall be calculated in accordance with Annex 1, as a percentage of the sum insured set in the Policy in respect of Trauma risk, subject to the type of injury indicated in the medical documents issued by a medical establishment.

8.2. Insurance benefit shall be paid to the Insured Person unless the insurance contract specifies otherwise.

8.3. The number of benefits payables in respect of Trauma shall not be limited, but the aggregate amount of benefits paid during the Policy period for one or several risks covered shall not exceed the sum insured set in the Policy in respect of Trauma risk.

8.4. The sum of benefits payable for all injuries to one part of the body per risk covered shall not exceed the benefit payable in the case of loss of that part of the body or its function.

8.5. Insurance benefit:

8.5.1. in case of polytrauma shall be paid for the consequences of maximum two most severe traumas by summing up the percentage of appropriate benefits;

8.5.2. insurance benefit in respect of one Trauma shall be paid only under one respective paragraph providing for the most severe injury of the respective section;

8.5.3. benefits for bone fractures, dislocations, syndesmolyses shall be paid only if the mentioned injuries are confirmed by a radiograph examination (computed tomography myelogram (CTM) or magnetic resonance imaging (MRI));

8.5.4. multiple fracture of one bone shall be considered to be one fracture;

8.5.5. insurance benefit for the injuries of one organ suffered as a result of one risk covered shall not exceed the sum fixed for the loss of such organ;

8.5.6. insurance benefits payable for the loss of a part of body/organ function shall be reduced with the benefits paid down for the injuries of such organ;

8.5.7. If insurance benefit is payable for bone fracture and/or dislocation and surgery, no benefit shall be paid for tendon and/or ligament injuries in the same area.

8.5.8. Insurance benefits in Annex 1 in respect of surgeries related to fractures in one bone (original fracture, recurring fracture, dislocation, syndesmolysis or pseudoarthrosis) shall be paid in addition to the benefit payable in relation to the fracture (dislocation, syndemolysis), but maximum for 2 times only. No insurance benefit is payable for the fixator removal after osteosyntesis.

8.5.9. due to bone fractures (fractures), damage to the integrity of the internal bone surfaces, abruption fractures (the opening of the bone fracture with a strong contraction of the muscle at its attachment point), an appendage (bone structures, a branch fall back) is paid only if medical

documents are provided, confirming immobilization of the affected area with gypsum for at least 3 weeks.

8.6. In case of severe injuries omitted in the Table No.1, decision as to the payment of insurance benefit shall be taken by Our medical professional.

8.7. If the Insured Person dies as a result of Accident, insurance benefit for Trauma shall not be paid.

8.8. Upon occurrence of an event that is likely to be recognised as risk covered, the Policyholder, Beneficiary or persons authorised by You must produce Us all documents related to the event (with enclosed translations to the national language) supporting the fact and circumstances of the event as well as the size of insurance benefit, including:

8.8.1. application for benefit;

8.8.2. consent to process personal data;

8.8.3. documents issued by medical establishment describing the fact and date of Trauma, diagnosis, medical examinations and treatment;

8.8.4. documents issued by law enforcement institutions.

LOSS OF CAPACITY FOR WORK

9. WHAT IS COVERED?

9.1. The risk covered is Loss of Working Capacity (or disability in case of persons under 18) established for the Insured Person within one year after the event.

10. WHEN DOES THIS INSURANCE NOT APPLY?

10.1. This insurance shall not apply if:

10.1.1. Loss of Working Capacity (or disability in case of persons under 18) was established for You later than one year after the Accident;

10.1.2. the established Loss of Working Capacity is less than 50% and/or no disability is established for persons under 18;

10.1.3. Loss of Working Capacity (or disability in case of persons under 18) is established as a result of Traumas and/or their consequences suffered/occurring before the Policy period;

10.1.4. Loss of Working Capacity is caused by diseases/illnesses or their complications, including Critical Illnesses or Diseases.

11. WHAT DO WE PAY FOR AND HOW?

11.1. In case of Loss of Working Capacity, We will pay a benefit which is calculated as a percentage of the sum insured set in the Policy in respect of this risk (Loss of Working Capacity):

11.1.1. Insurance benefit is calculated as a percentage of the sum insured in respect of this insurance risk on the basis of the degree of lost working capacity or disability (see paragraph 11.2).

11.1.2. Insurance benefit is payable when the established Loss of Working Capacity is 50% or greater or disability is established for persons under 18 (see paragraph 11.2).

11.1.3. When Loss of Working Capacity at a rate of 50% or greater, or disability for persons under 18 as per paragraph 11.2, is established by the initial commission of a competent state, 10% of the calculated preliminary benefit shall be paid down.

11.1.4. When Loss of Working Capacity at a rate of 50% or greater, or disability for persons under 18 as per paragraph 11.2, is established by the second commission of a competent state, the final benefit shall be calculated in accordance with the established degree of Loss of Working Capacity or disability and the remaining part of the benefit shall be paid down.

11.2. Insurance benefit for persons under 18 is payable in the following procedure:

11.2.1. if severe disability is established – 100% of the sum insured in respect of this insurance risk;

11.2.2. if medium disability is established – 75% of the sum insured in respect of this insurance risk;

11.2.3. if mild disability is established – 50% of the sum insured in respect of this insurance risk.

11.3. If benefits for Trauma were paid in relation to the same risk covered (event insured), these benefits shall be included in the amount of benefit payable for Loss of Working Capacity or disability (for persons under 18).

11.4. Upon occurrence of an event that is likely to be recognised as risk covered, the Policyholder, Beneficiary or persons authorised by You must produce Us all documents related to the event (with enclosed translations to the national language) supporting the fact and circumstances of the event as well as the size of insurance benefit, including:

11.4.1. application for benefit;

11.4.2. consent to process personal data;

11.4.3. a certificate of the initially and repeatedly established degree of Loss of Working Capacity or disability;

11.4.4. documents issued by medical establishment describing the fact and date of Trauma, diagnosis, medical examinations and treatment;

11.4.5. documents issued by law enforcement institutions.

DEATH

12. WHAT IS C OVERED?

12.1. The risk covered is the Insured Person's accidental death within one year after the Accident.

13. WHEN DOES THIS INSURANCE NOT APPLY?

13.1. This insurance shall not apply to:

13.1.1. the Insured Person's death from alcohol poisoning;

13.1.2. the Insured Person's death when the Insured Person was using alcohol before the event or during it. This provision does not apply if any of the conditions below is present:

1) Insured Person's blood alcohol content does not exceed 0.4 ml/mg and this is confirmed by medical documents;

2) The Insured Person contracted for insurance with the Intoxication Clause which is indicated in the Policy;

3) During the event, the Insured Person was in a motor vehicle (road vehicle, watercraft or aircraft) as a passenger, except for the case in paragraph 4.1.11;

13.1.3. the Insured Person's death caused by suicide.

13.1.4. the Insured Person's death caused by diseases or their complications, including Critical Illnesses or Diseases.

14. WHAT DO WE PAY FOR AND HOW?

14.1. In case of occurrence of the risk covered (event insured), insurance benefit shall be equal to the amount indicated in the Policy in respect of this risk. If the Insured Person was paid insurance benefits for Traumas and/or Loss of Working Capacity due to the same event that results in the death of the Insured Person, the benefit payable in respect of death shall be reduced with the amounts paid down in benefits for the same event.

14.2. Insurance benefit shall be paid to:

14.2.1. the persons named as Beneficiary in writing by the Policyholder during the Policy period or while entering into the insurance contract. If the Insured Person and the Policyholders are different persons, written consent of the Insured Person is required when person appointed as Beneficiaries are not the heirs of the Insured Person;

14.2.2. the heirs of the Insured Person in accordance with the laws of the Republic of Lithuania if Beneficiary was not name in the Policy or appointed by the Insured Person during the Policy period.

14.3. Where a court declares the Insured Person dead, insurance benefit shall be payable if Accident is stated as a potential cause of Insured Person's death in the court judgement and the death occurred within the Policy period.

14.4. Upon occurrence of an event that is likely to be recognised as risk covered, the Policyholder or Beneficiary must produce Us all documents related to the event (with enclosed translations to the national language) supporting the fact and circumstances of the event as well as the size of insurance benefit, including:

14.4.1. application for benefit;

14.4.2. consent to process personal data;

14.4.3. a copy of the death certificate of the Insured Person;

14.4.4. documents issued by law enforcement institutions;

14.4.5. inheritance documents.

MEDICAL EXPENSES

15. WHAT IS COVERED?

15.1. The risk covered is expenses incurred by You in the Republic of Lithuania for prescribed medical services that are justified from the medical point of view and measures required for You in relation to treating Your Trauma, listed in Annex 1.

16. WHEN DOES THIS INSURANCE NOT APPLY?

16.1. This insurance does not apply to and no compensation is payable for the following:

16.1.1. medical expenses when Your Trauma is not qualified as risk covered under these Regulations;

16.1.2. health care services and/or treatment provided in medical establishments and medical products bought outside the Republic of Lithuania;

16.1.3. health care services and/or treatment which dates and reasonability cannot be seen from submitted or received medical documentation;

16.1.4. diagnostics and treatment provided using non-traditional (alternative) medicine or other similar methods;

16.1.5. cosmetic, plastic, beauty and other similar procedures;

16.1.6. organ transplantation surgeries, bone marrow transplantations, haemodialysis;

16.1.7. comfort conditions in hospital (stay in a single or double hospital ward);

16.1.8. eyeglasses, contact lenses, products for taking care of them, eyeglass making, artificial lenses, etc.;

16.1.9. medical supplies (such as thermometers, inhalers, testers, warmers, hearing aids, weight scales, blood pressure monitors, blood glucometers, etc.);

16.1.10. food supplements, anabolic steroids, weight-loss drugs, drugs increasing sexual performance, contraceptive devices, hygiene products and cosmetics, drugs and products to treat various addictions, as well as medicinal products not registered in EU countries;

16.1.11. damage to and/or repair of implants;

16.1.12. expenses related to the issue and/or presentation of medical and other documents;

16.1.13. psychiatric and/or psychological services and consultations on medically unjustified grounds.

17. WHAT DO WE PAY FOR AND HOW?

17.1. The sum insured in respect of Medical Expenses shall be indicated in the policy. Insurance benefit payable in respect of one risk covered (event insured) shall not exceed 30% of the limit established for this risk in the policy.

17.2. Within the limits of the sum insured indicated in paragraph 17.1, We shall compensate for expenses suffered in relation to the following:

17.2.1. consultations of specialised medical doctors (traumatologist, surgeon, neurologist, radiologist, dentist, etc.);

17.2.2. surgeries and procedures (suturing, wound dressing, injections, infusions);

17.2.3. diagnostic tests (laboratory testing, functional testing, imaging testing, instrumental testing) necessary to confirm the existence of Trauma and to administer treatment;

17.2.4. purchase or hire of medicines, medical aid and orthopaedic appliances (plasters, materials for dressing, syringes, splints, walking-sticks, crutches, aid for self-service) registered by the State Medicines Control Agency in EU Member States and acquired in pharmacies or in-patient health care establishments;

17.2.5. prescribed rehabilitation that is necessary to recover from trauma's consequences and is justified on medical grounds (physical therapy procedures, individual or group kinesiotherapy sessions, therapeutic massages, consultations of kinesiotherapist, ergotherapist and/or speech therapist). Compensation for rehabilitation expenses shall not exceed 50% of the sum insured for Medical Expenses as per paragraph 17.1 in respect of one risk covered;

17.2.6. treatment of dental injuries, prosthetics, dental implants;

17.3. Upon occurrence of an event that is likely to be recognised as risk covered, You, the Policyholder or persons authorised by You must produce Us all documents related to the event (with enclosed translations into the national language) supporting the fact and circumstances of the event as well as the size of insurance benefit, including:

17.3.1. application for benefit;

17.3.2. consent to process personal data;

17.3.3. medical excerpt showing doctor's prescription for the medicines, medical devices and/or procedures You have purchased;

17.3.4. original financial documents supporting Your expenses (receipts, paid invoices, bank statements, etc.).

DAILY ALLOWANCE

18. WHAT IS COVERED?

18.1. This insurance will cover Your inability to perform job functions set forth in the valid employment contract under which You were working as a result of Trauma listed in Annex 1, provided this is confirmed by a sick leave issued by a medical establishment of the Republic of Lithuania or an equivalent document issued by a competent authority.

18.2. The sick leave or equivalent document issued by a competent authority must be issued is respect of Trauma which is the risk covered and is indicated in Annex 1.

19. WHEN DOES THIS INSURANCE NOT APPLY?

19.1. This insurance does not apply to Your Temporary Incapacity for Work which:

19.1.1. is caused by Trauma not covered hereunder;

19.1.2. lasts for a period shorter than 3 consecutive calendar days;

19.1.3. is caused by Trauma suffered by You during a period when You were not working under employment contract and receiving no official income;

19.1.4. is not supported with a sick leave or an equivalent document issued by a competent authority, or the sick leave or equivalent document is issued by a competent authority outside the Republic of Lithuania.

19.2. The insurance indemnity with respect to the same event shall not be paid during the period in which the insurance indemnity according to the hospital allowance risk is paid.

20. WHAT DO WE PAY FOR AND HOW?

20.1. The sum insured indicated in the Policy in respect of this risk is the limit for the entire Policy period. Insurance benefit is payable in accordance with paragraphs 20.2 - 20.5 below.

20.2. Insurance benefit is payable for each day of Your Temporary Incapacity for Work starting from the first day of Your Temporary Incapacity for Work, provided that Temporary Incapacity for Work lasts for at least 3 consecutive calendar days:

20.2.1. in respect of one risk covered - max. for 30 consecutive days of Temporary Incapacity for Work as a result of one and the same Trauma;

20.2.2. in respect of all risks covered in aggregate during the Policy period - max. for 90 consecutive days of Temporary Incapacity for Work.

20.3. Where your indemnity with respect to injury under Annex No 1 is set at 2% or smaller, the insurance indemnity with respect to the hospital allowance risk shall be paid for not more than 10 (ten) days of temporary incapacity for work.

20.4. If your child of up to 12 (twelve) years of age (inclusive) has suffered an injury which is recognised to be the insured event under the terms and conditions of these Regulations and due to that you have been issued a certificate of incapacity for work, we will disburse to you the insurance indemnity, but for not more than 10 (ten) consecutive days of the temporary incapacity for work. Insurance indemnity shall be paid to one of the parents only if until the fact of injury he/she had been employed and received remuneration. The provision of this paragraph shall apply only if you and your injured child are insured under one insurance policy and the risk of injury has been chosen for both of you.

20.5. Upon occurrence of the event, the Policyholder, You or the Beneficiary You must produce Us all documents related to the event (with enclosed translations to the national language) supporting the fact and circumstances of the event as well as the size of insurance benefit, including:

20.5.1. application for benefit;

20.5.2. a copy of the employment contract (upon Our request);

20.5.3. consent to process personal data;

20.5.4. a list of sick leaves from the Electronic Sick Leave System (EPTS) or an equivalent document issued by a competent institution, specifying the cause and length of incapacity for work. The sick leave for Temporary Incapacity for Work must be issued in the Republic of Lithuania;

HOSPITAL CONFINEMENT ALLOWANCE

21. WHAT IS COVERED?

21.1. This insurance will cover Your treatment in an in-patient health care establishment in relation to Trauma listed in Annex 1 and recognised as risk covered (hereinafter referred to as 'hospitalisation').

22. WHEN DOES THIS INSURANCE NOT APPLY?

22.1. This insurance does not apply to and no compensation is payable for hospitalisation:

22.1.1. as a result of Trauma which is not recognised as risk covered (event insured);

22.1.2. in relation to rehabilitation, recovery and/or sanatorium therapy;

22.1.3. in relation to preventive therapy and care;

22.1.4. uninterruptedly lasting for less than 3 consecutive calendar days.

23. WHAT DO WE PAY FOR AND HOW?

23.1. The sum insured indicated in the Policy in respect of Hospital Confinement Allowance is the limit for the entire Policy period. Insurance benefit is payable in accordance with paragraph 23.2 – 23.3.

23.2. Insurance benefit is payable to the Insured Person for each day of hospitalisation, starting from the first day of hospital stay, provided that hospitalisation lasts for at least 3 consecutive calendar days:

23.2.1. in respect of one risk covered - max. for 30 consecutive days of hospitalisation as a result of one and the same Trauma;

23.2.2. in respect of all risks covered in aggregate during the Policy period - max. for 90 consecutive days of hospitalisation.

23.3. Where due to the insured event specified in subparagraph 21.1 a child of up to 12 (twelve) years of age (inclusive) and one of the insured adults remain in the hospital to nurse the child, insurance indemnity, as specified in subparagraph 23.2 shall be paid both to the child and the adult who stays with the child. The provision of this paragraph shall apply only if both the child and the adult who stays with the child are insured under the same insurance policy against the hospital allowance risk, and the nursing is confirmed by the issued certificate of incapacity for work or any other equivalent document issued by a competent authority.

23.4. Upon occurrence of an event that is likely to be recognised as risk covered, You, the Policyholder or persons authorised by You must produce Us all documents related to the event (with enclosed translations to the national language if so required by the Insurer) supporting the fact and circumstances of the event as well as the size of insurance benefit, including:

23.4.1. application for benefit;

23.4.2. consent to process personal data;

23.4.3. transcripts from medical documents (discharge summary) confirming hospital stay and describing the fact and date of Trauma, diagnosis, medical examinations and treatment;

23.4.4. documents issued by law enforcement institutions.

CRITICAL ILLNESS

24. WHAT IS COVERED?

24.1. The risk covered is Your being stricken with Critical Illness listed in paragraph 22.2 below when the first symptoms of the illness are diagnosed and the diagnosis is verified during the Policy period. The onset date is the day of applying to a medical establishment when the first symptoms of the illness were diagnosed and Critical Illness diagnosis was verified ('Final Diagnosis') within 1 month after the first symptoms thereof were recorded.

24.2. List of Critical Illnesses:

24.2.1. **Myocardial infarction (I21)** – irreversible damage to the heart muscle (necrosis) caused by lack of oxygen due to acute cardiac insufficiency. This diagnosis must be based on all of the following criteria that are consistent with the features of the first myocardial infarction:

1) new electrocardiogram changes, which confirm the acute myocardial infarction, in the presence of inherent complaints;

2) the increase in at least one of enzymes characteristic of infarction are found in blood serum (LD H (lactatdehydrogenase), KFK (creatine kinase), KKM B (MB isoenzyme of creatine kinase), troponine, etc.);

3) diagnosis of the illness with all the listed symptoms must be confirmed in writing by a cardiologist in hospital.

24.2.2. **Stroke (I60–I64)** – brain damage caused by acute cerebrovascular failure. This diagnosis must be based on all of the following criteria:

1) Stroke-specific clinical symptoms persist for more than 3 months after receiving the appropriate treatment.

2) the diagnosis is confirmed by a doctor's neurologist based on clinical symptoms and objective tests (MRI, CT scan or other)

24.2.3. **Aortic aneurysm (I71)** - abnormal enlargement of the vessel (aorta) with the risk of rupturing and causing severe bleeding.

1) The diagnosis must be based on objective examinations (ultrasound examination of the abdomen, aortography, CT scan, MRI, or other).

2) Emergency surgery must be performed or scheduled endovascular stent grafting must be prescribed.

24.2.4. Intracranial aneurysm (I67.1) – unnatural dilation of the blood vessel of brain which can impact surrounding tissues or balloon out and lead to strong bleeding.

1) diagnosis is confirmed by objective tests (computed tomography, magnetic resonance imaging, brain angiography, cerebrospinal fluid testing, etc.).

2) an urgent surgery of brain aneurysm is performed or a planned surgery of brain aneurysm is assigned;

3) insurance indemnity shall not be paid with respect to brain aneurysm producing no symptoms which are only monitored by periodic tests.

24.2.5. Bechterew's disease (M45) – full spinal stiffness resulting from ossification of joints due to chronic inflammation.

1) Diagnosis is confirmed by the rheumatologist.

2) Alterations of spine characteristic of the disease (complete ossification of the spine) are confirmed by X-ray testing.

3) Human tissue antigen HLA B27 Ag is found in blood.

24.2.6. Addison's disease (E27.1; E27.2; E27.4) – adrenal cortex resulting from bilateral disorder of adrenal glands leading to partial or full loss of adrenal hormone function

1) Diagnosis is confirmed by the endocrinologist.

2) The insured has been treated with hormones for 3 months and such treatment is continued;

3) The reduced level of the hormone cortisol and increased level of the adrenocorticotropic hormone (AKT H) is found in blood.

24.2.7. Rheumatoid arthritis (M05) – autoimmune chronic and progressive inflammation multiple joints leading to their deformation.

1) Diagnosis is confirmed by the rheumatologist.

2) The increased level of the rheumatoid factor is found in blood.

3) The changes in joints characteristic of this disease are found by means of objective testing (X-ray, computed tomography, magnetic resonance imaging).

24.2.8. Systemic lupus erythematosus (L93, M32) – chronic autoimmune disease in which the body's immune system mistakenly attacks healthy tissue in many parts of the body.

1) Diagnosis is confirmed by the rheumatologist.

2) Antibodies of native RNP or antibodies of Sm antigen or Lupus cells are found in blood after blood (serological) testing.

24.2.9. Cancer (C00–C96) – uncontrolled reproduction of altered cells, and the ability of these cells to destroy surrounding tissues and spread to other parts of the body (metastases). This diagnosis should be based on a conclusion confirmed by a gynecologist or pathologist regarding the performed histological examination of the malignant tumor. The diagnosis determined on the day of the histological examination is considered to be definitively confirmed.

1) This diagnosis must be justified by a histological opinion on the malignant tumour confirmed by an oncologist or pathologist. The diagnosis is considered as finally confirmed on the date the histological examination diagnosis is determined.

2) The Final Diagnosis of the illness must be confirmed in writing by the opinion of an oncologist.

3) The following illnesses shall not be considered risks covered:

- benign or precancerous stage tumours;
- pre-invasive tumours and in situ tumours (Tis*);

- cervical dysplasia CIN I-III;
- urinary bladder carcinoma in stage TA*;
- all skin tumours;
- all tumours in the presence of HIV or AIDS infection;
- prostate cancer, histologically diagnosed as T1*;

*according to the international TNM classification.

24.2.10. Chronic renal failure (N00–N19) – unconscious loss of both kidney function when a continuous hemodialysis and / or kidney transplant operation is required:

1) an unconscious loss of kidney function is confirmed by a doctor's nephrologist;

2) 6 months of continuous hemodialysis or an Insured person entered the line for a kidney transplant operation or a kidney transplant operation.

24.2.11. Multiple or disseminated sclerosis (G35–G37) – Central nervous system autoimmune disease, in which the nerve fibers disappear (demyelinization).

1) the diagnosis of the illness must be confirmed in writing by a neurologist;

2) the disease-specific changes are determined by MRI;

3) an increase in the IgG index and an oligoclonal band in the cerebrospinal fluid is detected in brain fluid.

24.2.12. AIDS (B20-B24) – immunodeficiency acquired by the human immunodeficiency virus (HIV).

1) the diagnosis of the illness must be confirmed in writing by the professionals from the Lithuanian Centre for Communicable Diseases and AIDS;

2) the result of a HIV test is positive;

3) Blood test reduces CD4 cell count (200 and less).

24.2.13. Blindness (H54.0- H54.4) – complete and irrecoverable vision loss due to an injury or disease.

1) Irrecoverable vision loss is confirmed by ophthalmologist 3 months after diagnosing a disease or injury mos.

2) Vision loss is confirmed by objective testing (skiascopy, refractometry, spectral compensation, etc.).

3) With respect to loss of vision in one eye a half of the specified insurance indemnity shall be paid.

4) With respect to loss of the eye(s) insurance indemnity may be disbursed without waiting for expiry of 3 months.

24.2.14. Cardiac, lung, liver, pancreas transplantation (Y83.0) – transplantation of organs taken from one person to another person for medical treatment purposes (due to a disease or injury).

1) The insured is the recipient of the organ.

2) Performance of transplantation surgery or inclusion of the insured into the official waiting list for such surgery.

24.2.15. Muscular dystrophy (G71) – genetically inherited primary muscular conditions characterised by weakening and wasting (atrophies) of muscles.

1) Disease is confirmed by the geneticist and neurologist.

2) Diagnosis is confirmed by morphological muscle and/or electromyography test and specific muscular enzyme (creatine phosphokinase) tests.

25. WHEN DOES THIS INSURANCE NOT APPLY?

25.1. This insurance does not apply to and no compensation is payable for Critical Illness:

25.1.1. which first symptoms occur or the Final Diagnosis is confirmed within the first 90 days from the entry into force of the insurance contract (except where Critical Illness cover is continued in a renewed policy);

25.1.2. which is caused by alcohol, drugs or other substance abuse;

25.1.3. which does not meet the conditions and criteria for Critical Illnesses in paragraph 23.2;

25.1.4. Critical disease which had already been diagnosed prior to concluding the insurance contract.

25.1.5. Critical disease: Cancer (C00–C96) diagnosed when the insured is HIV infected or has AIDS, except where the insured provides the proof (negative test for HIV) that he/she was not HIV infected on the date of inclusion of the critical disease variant into the insurance contract.

25.1.6. Critical disease: AIDS (B20–B24), if the insured does not provide the proof (negative test for HIV) that he/she was not HIV infected on the date of inclusion of the critical disease variant into the insurance contract.

25.1.7. if the Final Diagnosis is not confirmed during the Policy period and while the Insured Person is alive.

26. WHAT DO WE PAY FOR AND HOW?

26.1. You are eligible to the benefit in the amount of the sum insured indicated in the Policy in respect of Critical Illness only once during the Policy period irrespective of the number of risks covered, provided that the Final Diagnosis was confirmed during the Policy period while the Insured Person was alive.

26.2. Upon occurrence of an event that is likely to be recognised as risk covered, You, the Policyholder, or persons authorised by You must produce Us all documents related to the event (with enclosed translations to the national language) supporting the fact and circumstances of the event, including:

26.2.1. application for benefit;

26.2.2. consent to process personal data;

26.2.3. documents issued by health care establishments containing the confirmed diagnosis of the Critical Illness, anamnesis information, description of medical examinations and treatment that are sufficient to determine whether the diagnosed illness is in compliance with the criteria set out in paragraph 24.2 of the Regulations.

DISEASES

27. WHAT IS COVERED?

27.1. The risk covered is Your Disease listed in paragraph 25.2 below when the first symptoms of the Disease are diagnosed and the diagnosis is verified during the Policy period. The onset date is the day of applying to a medical establishment when the first symptoms of the Disease were observed and the diagnosis was confirmed after medical examinations performed in relation thereto.

27.2. To be a risk covered, the disease must satisfy the following criteria:

27.2.1. **Lyme disease** – infection spread through the bite from a tick infected with Borrelia burgdorferi:

1) the diagnosis of Lyme disease is based on clinical symptoms and opinion of a specialised doctor;

2) presence in the blood of is Borrelia burgdorferi-specific IgG or IgM. The diagnosis is based on serological tests results.

27.2.2. **Tick-borne encephalitis, tick-borne myelitis, tick-borne encephalomyelitis** – infectious disease transmitted by the bite from a tick infected with neurotropic virus:

1) the disease is treated in a hospital;

2) the diagnosis is supported by serologic test results.

27.2.3. **Acute appendicitis** – acute inflammation of the vermiform appendix**:**

1) patient underwent emergency appendectomy.

27.2.4. Tetanus – infectious disease caused by the bacterium Clostridium tetani:

1) the disease is diagnosed and treated in a hospital;

2) the diagnosis is supported by microbiologic testing.

27.2.5. **Diphtheria** – infectious disease caused by the bacteria Corynebacterium diphtheriae and Corynebacterium ulcerans through respiratory tract or saliva.

1) the disease is diagnosed and treated in a hospital;

2) the diagnosis is supported by microbiologic testing.

27.2.6. Meningococcal infection – infectious disease caused by the gram-negative bacterium Neisseria meningitidis through respiratory tract or saliva.

1) the disease is diagnosed and treated in a hospital;

2) a form of purulent meningococcal meningitis, meningoencephalitis, meningococcal sepsis (meningococcemia) or fulminant meningococcal infection is diagnosed;

3) the diagnosis is supported by microbiologic testing.

27.2.7. Gas gangrene – infectious disease (complication of wounds) caused by Clostridium anaerobic bacteria and their spores entering through wounds:

1) disease is diagnosed and treated by way of hospitalisation.

2) diagnosis is confirmed by microbiological testing.

27.2.8. Gastric (duodenal) ulcer perforation (rupture) – complication of a gastric (duodenal) ulcer when the wall of the organ gets perforated at the place of ulcer and the content of stomach (duodenum) effuses to the abdominal cavity causing inflammation of peritoneum (peritonitis):

1) disease is diagnosed and treated by way of hospitalisation.

2) performance of an urgent surgery.

27.2.9. Rabies – viral disease affecting the central nervous system caused by neurotropic Rhabdoviridae family virus which spreads with saliva when an infected animal bite:

1) disease is diagnosed and treated by way of hospitalisation.

2) diagnosis is confirmed by microbiological testing.

27.2.10. Ectopic pregnancy – an acute condition when in which the embryo attaches outside the uterus. An impregnate ovum gets implanted and develops in the uterine tube inside abdominal cavity, in the rudimental uterine horn.

27.2.11. Acute poisoning with toxic mushrooms, food:

1) disease is diagnosed and treated by way of hospitalisation for not less than 3 days.

2) insurance indemnity shall not be paid for poisoning with alcohol.

27.2.12. Trichinosis – is a parasite disease caused by a spiral trichina (*Trichinella spiralis*) which is spread when eating raw or undercooked pork and mead of wild animals.

27.2.13. Disease is diagnosed and treated by way of hospitalization for not less than 3 days. **Botulism –** infectious nervous system disease mainly caused by extremely strong neurotoxin which spreads with food and is produced by *Clostridium botulinum* bacteria.

1) Disease is diagnosed and treated by way of hospitalisation for not less than 3 days.

28. WHEN DOES THIS INSURANCE NOT APPLY?

28.1. This insurance does not apply to and no compensation is payable for Disease:

28.1.1. which occurs within the first 30 days from the entry into force of the insurance contract (except where Disease cover is continued in a renewed policy);

28.1.2. which does not meet the conditions and criteria laid down in paragraph 27.2 of the Regulations;

28.1.3. which diagnosis was not confirmed during the Policy period and when the Insured Person was alive.

29. WHAT DO WE PAY FOR AND HOW?

29.1. You are eligible to the benefit in the amount of the sum insured indicated in the Policy in respect of Disease only once during the Policy period irrespective of the number of risks covered.

29.2. Upon occurrence of an event that is likely to be recognised as risk covered, You, the Policyholder, or persons authorised by You must produce Us all documents related to the event (with enclosed translations to the national language) supporting the fact and circumstances of the event, including:

29.2.1. application for benefit;

29.2.2. consent to process personal data;

29.2.3. documents issued by health care establishments containing the confirmed diagnosis of the Disease, anamnesis information, description of medical examinations and treatment that are sufficient to determine whether the diagnosed disease is in compliance with the criteria set out in paragraph 27.2 of the Regulations;

29.2.4. other documents requested by Us in relation to the risk covered.

EXPENSES FOR STUDIES

30. WHAT IS COVERED?

30.1. The insured event shall be the insured's death caused by injury and recognized to be the insured event in accordance with terms and conditions of these Regulations. When the risk of expenses for studies is chosen, we will pay the insurance indemnity for studies of the insured's biological children and/or adopted children in a higher education, provided that the following conditions are met:

30.1.1. On the date of the insured's death, the insured's children are younger than 24 years of age and before the event a valid agreement on the first level studies had been concluded with a higher education establishment.

30.1.2. Studies at a higher education establishment are paid.

31. WHEN DOES THIS INSURANCE NOT APPLY?

31.1. The following events shall be considered to be non-insured events:

31.1.1. You have not chosen the insurance risk of death;

31.1.2. The insured's death is not recognized to be the insured event in accordance with terms and conditions of these Regulations;

31.1.3. On the date of the insured's death, the insured's children are older than 24 years of age and/or have not studied in a higher education establishment and/or they did not have to additionally pay for studies.

32. WHAT DO WE PAY FOR AND HOW?

32.1. The sum insured for this insurance risk is specified in the insurance policy for the entire period of insurance, and insurance indemnity shall be paid in the manned indicated in subparagraph 32.2.

32.2. Insurance indemnity shall be paid according to the compensation principle: this means that at the end of each academic year we will pay insurance indemnity for the past one year of studies according to the documents submitted by you confirming incurred expenses; however, without exceeding a half of the sum insured provided for this risk under the insurance policy and without exceeding the total sum insured provided for this risk.

32.3. If you have several children eligible to insurance indemnity, the indemnity to them shall be paid pro rata from the sum insured specified for this risk under the insurance policy.

32.4. Payment of insurance indemnity shall terminate when all sum insured specified under the insurance policy is used or when your children reach the age of 25 years.

32.5. Upon occurrence of an event that is likely to be recognised as risk covered, You, the Policyholder, or persons authorised by You must produce Us all documents related to the event (with enclosed translations to the national language) supporting the fact and circumstances of the event, including:

32.5.1. application for benefit;

32.5.2. consent to process personal data;

32.5.3. a copy of the death certificate of the Insured Person;

32.5.4. a copy of the agreement with a higher educational institution;

32.5.5. a payment order confirming the account from higher education establishment for the last year;

32.5.6. statement issued by a higher educational institution confirming that the child studies in that higher educational institution and has completed a respective academic year;

32.5.7. payment order approved by the bank confirming the payment of the tuition fee for the finished academic year;

32.5.8. the abovementioned documents shall be submitted annually during the entire study period upon completion of an academic year.

EXPENSES FOR A TUTOR

33. WHAT IS COVERED?

33.1. The insured event shall be an injury of the insured between 6 and 18 years of age (inclusive), who studies in a basic and/or secondary education establishment (hereinafter – pupil and school) recognized to be the insured event in accordance with terms and conditions of these Regulations. When the risk of expenses for a tutor is chosen, we will pay the insurance indemnity over the period of 6 months from the date of the injury, provided that the following conditions are met:

33.1.1. the pupil is 6 and 18 years of age (inclusive);

33.1.2. the insurance risk of injuries is chosen for the pupil under the insurance policy;

33.1.3. the pupil has suffered the injury which recognized to be the insured event in accordance with terms and conditions of these Regulations;

33.1.4. due to consequences of the injury the pupil is unable to attend school for more than 3 weeks;

33.1.5. the parents or guardians hire a private tutor for the child (hereinafter – tutor) so that he/she can learn at home.

34. WHEN DOES THIS INSURANCE NOT APPLY?

34.1. The following events shall be considered to be non-insured events:

34.1.1. the insurance risk of injuries has not been chosen;

34.1.2. the insured's injury is not recognized to be the insured event in accordance with terms and conditions of these Regulations;

34.1.3. a tutor was hired less than 3 weeks after the date of the injury;

34.1.4. documents confirming the fact of expenses for a tutor have not been furnished to us.

35. WHAT DO WE PAY FOR AND HOW?

35.1. The sum insured for this insurance risk is specified in the insurance policy for the entire period of insurance, and insurance indemnity shall be paid in the manned indicated in subparagraph 35.2.

35.2. Insurance indemnity shall be paid according to the compensation principle: this means that we will indemnify for the costs according to the submitted acquisition documents; however, without exceeding the sum insured provided for this risk:

35.2.1. If, due to the injury, the pupil is unable to attend school for more than 3 weeks and this is confirmed by a medical certificate, we will pay for up to 10 classes with the tutor, without exceeding the sum insured provided for under the insurance policy;

35.2.2. If, due to the injury, the pupil is unable to attend school for more than 2 months and this is confirmed by a medical certificate, we will pay for up to 40 classes with the tutor, without exceeding the sum insured provided for under the insurance policy.

35.3. Upon occurrence of an event that is likely to be recognised as risk covered, You, the Policyholder, or persons authorised by You must produce Us all documents related to the event (with enclosed translations to the national language) supporting the fact and circumstances of the event, including:

35.3.1. application for benefit;

35.3.2. consent to process personal data;

35.3.3. application, indicating the tutor's contact details, the subject taught, the price and number of classes;

35.3.4. a document confirming the absence from school during the period when the Child has not attended school classes.

EXPENSES FOR CHILDREN

36. WHAT IS COVERED?

36.1. The insured event shall be the injury of the insured of up to 16 years of age (inclusive) recognized to be the insured event in accordance with terms and conditions of these Regulations. When the risk of expenses for children is chosen, we will pay an additional insurance indemnity during the period of 6 months from the date of the injury provided that all of the following conditions are met:

36.1.1. the injured insured is a child of up to 16 years of age (inclusive);

36.1.2. the insurance risk of injuries is chosen under the insurance policy for the insured pupil;

36.1.3. the insured child suffered the injury for which the insurance indemnity is paid according to the terms and conditions of the Regulations;

36.1.4. the parents or adoptive parents purchased fruit, confectionery, tickets to the cinema or any other event suitable for the child according to his development and age and will confirm this to us by acquisition documents.

37. WHEN DOES THIS INSURANCE NOT APPLY?

37.1. The following events shall be considered to be non-insured events:

37.1.1. the insurance risk of injuries has not been chosen;

37.1.2. the insured's injury is not recognized to be the insured event in accordance with terms and conditions of these Regulations;

37.1.3. fruit, confectionery, tickets to the cinema or any other event were purchased later than within 6 months of the date of occurrence of the accident;

37.1.4. documentary evidence of the fact of acquisition has not been provided to us.

38. WHAT DO WE PAY FOR AND HOW?

38.1. The sum insured for this insurance risk is specified in the insurance policy for the entire period of insurance, and insurance indemnity shall be paid in the manned indicated in subparagraph 38.2.

38.2. Insurance indemnity Insurance indemnity shall be paid according to the compensation principle: this means that we will indemnify for the costs of purchase of fruit, confectionery, tickets to the cinema or any other event suitable for the child according to his development and age according to the submitted acquisition documents; however, without exceeding the sum insured provided for this risk.

38.3. Upon occurrence of an event that is likely to be recognised as risk covered, You, the Policyholder, or persons authorised by You must produce Us all documents related to the event (with enclosed translations to the national language) supporting the fact and circumstances of the event, including:

38.3.1. application for benefit;

38.3.2. consent to process personal data;

38.3.3. original financial documents supporting Your expenses (receipts, paid invoices, bank statements, etc.);

38.3.4. documents issued by medical establishment describing the fact and date of Trauma, diagnosis, medical examinations and treatment.

PLASTIC SURGERIES

39. WHAT IS COVERED?

39.1. The insured event shall be your plastic surgery performed no later than within one year of the end of validity of the insurance contract due to consequences of the injury specified in Annex No 1.

40. WHEN DOES THIS INSURANCE NOT APPLY?

40.1. The following plastic surgery shall be considered to be a non-insured event:

40.1.1. due to consequences of the injury which is not recognized to be the insured event;

40.1.2. due to an injury when you are not insured against the risk of injuries and such risk is not specified in your insurance policy;

40.1.3. due to injuries occurring before the beginning of the term of validity of the insurance contract.

41. WHAT DO WE PAY FOR AND HOW?

41.1. If your plastic surgery is recognized to be the insured even, the insurance indemnity confirmed by financial records will be disbursed, without exceeding the sum insured provided for this risk under the insurance policy.

41.2. Insurance indemnity for the performed plastic surgery may be disbursed with respect to one or several events; however, without exceeding the sum insured.

41.3. Insurance indemnity for the performed plastic surgery shall be disbursed when the plastic surgery is performed no later than within one year of the end of validity of the insurance contract.

41.4. Upon occurrence of an event that is likely to be recognised as risk covered, You, the Policyholder, or persons authorised by You must produce Us all documents related to the event (with enclosed translations to the national language) supporting the fact and circumstances of the event, including:

41.4.1. application for benefit;

41.4.2. consent to process personal data;

41.4.3. original financial documents supporting Your expenses (receipts, paid invoices, bank statements, etc.);

41.4.4. documents issued by medical establishment describing the fact and date of Trauma, diagnosis, medical examinations and treatment.

PSYCHOLOGICAL ASSISTANCE

42. WHAT IS COVERED?

42.1. Psychological assistance provided due to reasons specified in subparagraphs 42.1.1. – 42.1.4 within 6 months after the occurrence of events listed in subparagraphs 42.1.1. – 42.1.4, as a result of events occurring during validity of the insurance contract in which the insurance variant of psychological assistance was chosen shall be considered to be the insured event:

42.1.1. due to death of your family members (parents, siblings, children, spouse);

42.1.2. physical violence (including rape, sexual harassment) against you (the circumstances of violence, including the date of the incident, must be confirmed by the institution investigating the circumstances of the event);

42.1.3. due to loss of capacity for work/disability established for you as a result of injury which would be recognized to be the insured event in accordance with terms and conditions of these Regulations;

42.1.4. due to a Critical disease contracted by you, provided that the Critical disease risk for you is specified in the insurance policy and the Critical disease is recognized to be the insured event.

43. WHEN DOES THIS INSURANCE NOT APPLY?

43.1. The provision of the following psychological assistance shall be considered to be a non-insured event:

43.1.1. due to injuries occurring before the beginning of the term of the insurance contract;

43.1.2. the reason for which the psychological assistance was sought does not correspond to the reasons specified in the list of insured events indicated in subparagraph 42.1;

43.1.3. psychological assistance was provided to you by persons or institutions not authorized to engage in such activity;

43.1.4. you applied for law enforcement bodies later than within 24 hours following the assault, suffered physical violence, rape or sexual harassment;

43.1.5. psychological assistance was provided to you regarding events occurring during validity of the contract in which the insurance variants of injuries, loss of capacity for work, critical disease and psychological assistance were not chosen.

44. WHAT DO WE PAY FOR AND HOW?

44.1. When psychological assistance provided to you is recognized to be the insured event, a part of the sum insured confirmed by financial records will be disbursed to you without exceeding the sum insured provided for this risk.

44.2. Insurance indemnity for psychological assistance shall be disbursed for 10 visits regarding one event.

44.3. Upon occurrence of an event that is likely to be recognised as risk covered, You, the Policyholder, or persons authorised by You must produce Us all documents related to the event (with enclosed translations to the national language) supporting the fact and circumstances of the event, including:

44.3.1. application for benefit;

44.3.2. consent to process personal data;

44.3.3. original financial documents supporting Your expenses (receipts, paid invoices, bank statements, etc.);

44.3.4. documents issued by medical establishment describing the fact and date of Trauma, diagnosis, medical examinations and treatment.

44.3.5. in the case of death of a family member, a copy of the death certificate and a document certifying the kinship;

44.3.6. if the event was investigated by the police, a statement from the police.

ASSISTANCE

45. WHAT IS COVERED?

45.1. The insured event shall be the costs supported by financial records related to burying and/or cremation of the insured.

45.2. The event must be recognized to be the insured event under death insurance risk.

46. WHEN DOES THIS INSURANCE NOT APPLY?

46.1. Insurance indemnity shall not be disbursed if:

46.1.1. the insured has not chosen the death risk and this risk is not indicated with regard to the insured under the insurance policy;

46.1.2. the event is recognized to be non-insured event under death insurance risk;

46.1.3. incurred losses are not supported by respective financial records;

46.1.4. the costs related to burial lunch, accommodation, grave maintenance.

47. WHAT DO WE PAY FOR AND HOW?

47.1. In the case of the insured event:

47.1.1. when the insured dies as a result of an accident, we will indemnify the following costs for the persons who organize funeral in the Republic of Lithuania and incur related costs and who submit the documents referred to in subparagraph 47.2, without exceeding the sum insured provided for this risk under the insurance policy:

1) purchase of the coffin;
2) transport of the body;
3) cremation and/or burying services.

47.2. Upon occurrence of an event that is likely to be recognised as risk covered, You, the Policyholder, or persons authorised by You must produce Us all documents related to the event (with enclosed translations to the national language) supporting the fact and circumstances of the event, including:

47.2.1. application for benefit;
47.2.2. consent to process personal data;
47.2.3. a copy of the death certificate of the Insured Person;
47.2.4. documents issued by law enforcement institutions.
47.2.5. original financial documents supporting Your expenses (receipts, paid invoices, bank statements, etc.) indicated in subparagraph 47.1.1.

48. MISCELLANEOUS

48.1. You or the Policyholder are required to notify Us in writing of any increase in risk within 5 calendar days after getting aware of such increase.

48.2. In case of risk increase during the Policy period, We have the right to insist on amendment of the terms and conditions of the insurance contract (Policy) or increase of the insurance premium.

48.3. If You or the Policyholder fail to notify Us about the increase in insurance risk in accordance with subparagraph 48.1. above, We have the right to claim termination of the contract and compensation for loss to the extent it is not covered by the earned premiums.

48.4. Premium or any part thereof that is mature under the Policy on the date of risk covered (event insured) shall be deducted from the calculated insurance benefit unless the insurance contract sets forth otherwise.

48.5. Having paid insurance benefit, We shall acquire, in accordance with paragraphs 17.2; 41.1; 44.1 ir 47.1 the right of claim (subrogation) within the limits of the benefit paid against the person(s) responsible for damage caused to You.

48.6. The Regulations apply to all insurance contracts (policies) signed after 01.01.2019 unless otherwise agreed by the parties upon entering into the insurance contract.

Annex No. 1. INSURANCE BENEFIT CALCULATION TABLE

No.	Trauma	Payable benefit (% of the sum insured)
Central and peripheral nervous system		
1	**Cranial bone fractures:**	
	a) fracture of external lamina of the cranial vault bones, depressed fracture;	2
	b)fracture of cranial vault;	10
	c)fracture of skull base.	15
Notes: *1. Only one of the paragraphs above is applicable in respect of the same trauma.* *2. Multiple fractures of base or cranial fornix bones shall be considered as one fracture.* *3. If any of the injuries above necessitated opening of the skull cavity (trepanation, craniotomy) or bone reposition (corrective surgery), additional benefit equals to 5% of the sum insured shall be paid.*		
2	**Intracranial traumatic hematomas treated on an in-patient basis and confirmed by computed tomography myelogram (CTM) or magnetic resonance imaging (MRI):**	
	a) subarachnoid hematoma;	10
	b) epidural hematoma	15
	c) subdural or/and intracerebral hematoma.	20
Notes: *1. Only one of the paragraphs above is applicable in respect of the same trauma.* *2. If any of the injuries above necessitated opening of the skull cavity (trepanation, craniotomy) or bone reposition (corrective surgery), additional benefit equal to 5% of the sum insured shall be paid.*		
3	**Cerebral injuries:**	
	a) cerebral commotion, concussion treated on an outpatient basis for at least 10 days or on an in-patient basis for at least 3 days;	1
	b) cerebral commotion, concussion or commotion syndrome involving continuous treatment for at least 4 days of in-patient treatment;	3
	c) cerebral contusion or contusion syndrome, compression diagnosed on the basis of CT or MR imaging;	10
	d) distortion of brain structure: brain protrusion through an opening in the skull caused by trauma (prolapsus, fuxus, protrusio, fungus cerebri, etc.).	50
Notes: *1. Sections 2 and 3 do not apply together. Only one of them is applicable (whether Section 2 or Section 3).* *2. Only one of the paragraphs above is applicable in respect of the same trauma.*		
4	**Damages to the central NS conditioned by traumas, acute accidental poisoning, consequences of mechanical asphyxia diagnosed 6 months after the trauma or later:**	
	a) arachnoiditis, arachnoencephalitis or encephalopathy of a traumatic (toxic) origin (encephalopathy in persons under 40 only);	10
	b) traumatic epilepsy, traumatic hydrocephaly, medium mental damage, monoparesis, fragment of a foreign body in the skull or brain (not applied in case of foreign bodies remaining after brain surgeries), post-traumatic parkinsonism (post-traumatic parkinsonism in persons under 40 only);	15

	c) loss of two or more extremities (hemiparesis, paraparesis);	30
	d) paralysis of one extremity (monoplegia);	40
	e) paralysis of one side of the body (hemiplegia); paralysis of the lower extremities (paraplegia);	50
	f) dementia; paraplegia with expressive function impairment in pelvic organs (urination or bowel movement);	70
	g) paralysis of the upper and lower extremities (tetraplegia), decortication (brain death).	100

Notes:

1. *If any of the traumas in Section 4 results in impaired vision and/or hearing and this is confirmed during in-patient treatment, additional insurance benefit shall be paid in accordance with relevant paragraphs of the Table.*
2. *Additional benefit shall be added to insurance benefits payable under Sections 1 to 3, if the consequences described in Section 4 have been supported by medical documents.*
3. *Insurance benefit in respect of one trauma is payable only under one paragraph in Section 4.*
4. *Sections 4 and 5 do not apply together in respect of the same trauma. Where any of the paragraphs in these Sections providing for a higher rate of benefit is applied, the sum payable shall be reduced with the benefits paid down under Section 4 or 5.*

5	**Injury of any part of spinal cord and nerve endings caused by:**	
	a) concussion, commotion treated on an in-patient basis for at least 5 days;	5
	b) contusion, compression, hematomyelia confirmed by CTM or MRI analyses in in-patient treatment establishment.	10

Notes:

1. *Sections 5 and 4 do not apply together in respect of the same trauma. Where any of the paragraphs in these Sections providing for a higher rate of benefit is applied, the sum payable shall be reduced with the benefits paid down under Section 5 or 4.*
2. *If any of the injuries above necessitated surgery, additional benefit equal to 5% of the sum insured shall be paid once.*

6	**Cervical, brachial and/or lumbar nerve network injury resulting in a surgery:**	
	a) traumatic plexitis (inflammation of plexus) with functional impairment;	10
	b) partial rupture of neural network;	20
	c) complete rupture of neural network.	40
7	**Neural injuries caused by:**	
	a) hand and/or radius injuries (excl. injuries of finger nerves);	3
	b) injury in the area of forearm, wrist, shin, tarsus;	10
	c) traumatic injury in the area of humerus, elbow, thigh and/or knee joints.	15

Notes:

1. *In case of multiple nerve injuries in one extremity, insurance benefit shall be paid for one injury only.*
2. *Traumatic injuries to peripheral nerves are deemed to include nerve commotion, contusion, compression, strain, rupture, and/or neurectomy.*
3. *No insurance benefit shall be paid for nerve injuries in fingers.*
4. *In case of peripheral nerve injuries in several extremities, injuries in each of them shall be assessed separately.*
5. *Where peripheral nerves and/or nerve plexus are injured due to a closed nerve trauma, insurance benefit shall only be paid if the signs of the nerve injury are persistent for a period exceeding 6 months after the trauma and are confirmed by objective testing methods.*
6. *Where injuries in Section 7 required surgical treatment (nerve sewing, nerve plastics, plexus re-innervation, etc.), insurance benefit shall be increased by 5% of the sum insured irrespective of the number of operations.*

7. Insurance benefit for traumatic plexitis is payable if it is persistent for a minimum period of 3 months after the trauma.		
8	**Post-traumatic inflammatory complications:**	
	a) skull (bone) osteomyelitis (osteitis);	15
	b) brain abscess, purulent meningitis.	20
Notes: *1. Insurance benefit under Section 8 is payable in addition to benefits payable under Section 1 to 3.* 2. *No additional benefit is payable for surgeries related to the injuries in this Section.*		
9	**Peripheral (cerebral) nerve injuries**	*10*
Notes: *1. Insurance benefit shall be paid on a one-off basis irrespective of the number of injured nerves and irrespective of whether the injury is unilateral or bilateral. If insurance benefit is payable under paragraphs (b) or (c) in Section 1, Section 9 shall not apply.* *2. Insurance benefit is payable if the clinical picture of nerve injury is persistent for 6 months in case of conservative (non-surgical) treatment.* *3. Insurance benefit shall be paid without any delay if a traumatic cranial nerve injury required reconstructive surgery.*		
Visual organs		
10	**Paralysis of accommodation of one eye.**	10
11	**Unilateral hemianopsia.**	10
12	**Monolateral narrowing of vision field.**	7
13	**Unilateral pulsating exophthalmus.**	15
14	**Unilateral dysfunction of lacrimal duct: narrow stricture or complete stenosis.**	5
15	**2nd degree burn and spreading eyeball wound, 3rd degree burn, discharge of blood within the eye, keratitis, iris scarring without causing vision impairments, iris erosion, penetrating wound of eyeball.**	5
Note: *1. No insurance benefit is payable for eye contusion or foreign bodies under Section 15. Where such trauma result in vision impairment, section 17 shall apply.*		
16	**Orbital fracture.**	5
17	**Unilateral vision impairment (unaided), diagnosed within 3-12 months after the date of trauma by means of comparing vision acuity before the trauma and thereafter (see Table No. 1)**	

Table No. 1. Insurance benefit in case of traumatic vision impairment

Vision acuity		Payable benefit (of the sum insured)	Vision acuity		Payable benefit (of the sum insured)
Before trauma	Post-traumatic	%	Before trauma	Post-traumatic	%
1.0	0.7 0.6 0.5 0.4 0.3 0.2 0.1 < 0.1 0.0	1 3 5 10 15 20 30 40 45	0.9	0.6 0.5 0.4 0.3 0.2 0.1 < 0.1 0.0	1 3 5 10 20 30 40 45
0.8	0.5 0.4 0.3 0.2 0.1 < 0.1 0.0	1 5 10 20 30 40 45	0.7	0.5 0.4 0.3 0.2 0.1 < 0.1 0.0	1 5 10 15 20 30 35
0.6	0.4 0.3 0.2 0.1 < 0.1 0.0	1 3 10 15 20 25	0.5	0.3 0.2 0.1 < 0.01 0.0	1 5 10 15 20
0.4	0.2 0.1 < 0.1 0.0	3 5 10 20	0.3	0.1 < 0.1 0.0	3 10 20
0.2	0.1 < 0.1 0.0	3 5 10	0.1	< 0.1 0.0	5 20
< 0.1	0.0	10	-------	-------	---------

Notes:

1. *Where retinal detachment results in impaired vision acuity, this should be based on the sighs of injury caused by a fresh eye trauma.*
2. *When visual acuity is impaired in both eyes as a result of trauma, each eye shall be examined separately. The percentages for both eyes shall be added and multiplied by a rate of 1.3.*
3. *If health care institutions have no records about vision acuity before the trauma, the vision acuity shall be considered to be – 1.0, but no better than the vision acuity of the non-injured eye.*
4. *If an intraocular lens is implanted after the injury or aided lens is applied, insurance benefit payable shall be fixed on the basis of the vision acuity before implantation or application of the lens.*
5. *Vision acuity shall be measured at least 3 months, but not later than 12 months, after the injury.*

Hearing apparatus		
18	**Traumatic rupture of unilateral ear drum.**	1
19	**Total hearing loss: unilateral**	15
20	**Total hearing loss: bilateral**	60
21	**Consequences of auricle injuries, unilateral (injury, burn, chilblain):**	
	a) scars on the anterior surface of the auricle exceeding 2 sq. cm, provided that they are present upon medical examination taken at least 1 month after trauma; traumatic deformation of the auricle as a result of the scars; loss of less than 1/3 of the auricle;	1
	b) loss of 1/3 - 1/2 of the auricle;	3
	c) loss of the auricle or more than a half of it.	5
Notes:		
1. *The consequences of injury in Sections 19 and 20 shall be measured at least 9 months after the injury.*		
Respiratory system		
22	**Dislocation of nasal cartilage, fracture of nasal and/or forehead bones.**	3
Note:		
1. No benefit shall be paid to indemnify for nasal bones or nasal septum surgery.		
23	**Fractures in the anterior walls of sinuses: sinus frontalis, sinus ethmoidalis or sinus mixillaris, sinus Haighmori**	5
Note:		
1. In case of multiple facial bone fractures, percentages of insurance benefits due shall be summed up, but the total amount of benefit payable shall not exceed 15%.		
24	**Lung injuries, contusion, subcutaneous emphysema, hemothorax (bleeding from the lung), pneumothorax (presence of air in the pleural cavity), traumatic pneumonia (lung inflammation), exudative pleuritis (inflammation of the pleura with effusion), foreign body in the chest cavity:**	
	a) unilateral impairment;	4
	b) bilateral impairment.	8
Notes:		
1. Insurance benefit shall be paid, if the conditions above have been caused by a direct trauma of chest or thoracic organs. Where the conditions above have been caused by other reasons (e.g., cold, surgeries unrelated to thoracic traumas or complications), insurance benefit shall not be paid.		
2. Insurance benefit shall be paid out, if acute pneumonia is caused by accidental acute chemical intoxication with substances irritating the respiratory tract and/or pneumotoxins.		
25	**Lung injuries resulting in:**	
	a) removal of 1 - 2 segments of the lung;	20
	b) removal of up to 1/2 of the lung;	30
	c) removal of 1/2 of the lung or complete removal of the lung	40
26	**Fracture of sternum.**	5
27	**Fracture of ribs:**	
	a) 1-2 ribs;	3
	b) 3-5 ribs;	5
	c) 6 and more ribs	10
Notes:		
	1. Fractures of costal cartilages or rib dislocations shall be considered rib fractures as well;	
	2. Where the submitted medical certificate shows rib-bone fractures, but the number thereof is not indicated, insurance benefit shall be paid out in accordance with paragraph (a) of this Section.	

28	**Lung injuries resulting in lung dysfunction persistent at least 9 months after the date of trauma.**	20
29	**Laryngeal injuries, trochaic fractures, fractures in the chin area, post-traumatic tracheostomy, bronchoscopy, post-traumatic thoracotomy.**	5
30	**Post-traumatic functioning tracheostomic tube causing breathing impairment, dysphonia or aphonia, and these consequences remain present for a period exceeding 9 months.**	20
	Cardiovascular system	
31	**Injuries of heart, pericardia or primary arteries without causing cardiovascular insufficiency.**	10

Notes: *Great primary arteries include: aorta, pulmonary artery, innominate artery, carotid arteries (roots), internal jugular vein, superior and inferior vena cava, portal vein as well as primary arterial roots ensuring blood circulation in the internals.*

Where injuries to the great arteries involved surgery to restore blood flow, insurance benefit shall be increased by 5% of the sum insured (payable only once under Sections 31, 32 or 33).

32	**Injuries of heart, pericardia or primary arteries causing cardiovascular insufficiency, which is found present at least 3 months after the date of trauma and is originally diagnosed within a year after the trauma (confirmed by a medical certificate or cardiologist conclusion):**	
	a) 1st degree cardiovascular insufficiency;	10
	b) 2nd or 2nd/3rd degree cardiovascular insufficiency;	30
	c) 3rd degree cardiovascular insufficiency.	50
33	**Injuries of great peripheral vessels without causing vascular insufficiency:**	
	a) injuries of both blood vessels at the level of ankle or wrist;	3
	b) injuries of both blood vessels at the level of forearm or lower leg;	5
	c) injuries of both blood vessels at the level of upper arm or thigh.	10

Notes:

1. *Great peripheral vessels include: subclavian artery, axillary artery, brachial artery, ulnar artery, radial artery, femoral arteries at hip and thigh level, popliteal and tibial arteries, subclavian, axillary, femoral and popliteal veins.*
2. *Injuries to blood vessels in the lower third level of forearm and lower leg shall be considered injuries at the level of ankle and wrist respectively.*

Alimentary system, facial bones		
34	**Jaw fractures:**	
	a) fractures of jaw, cheek and lingual bones;	5
	b) dislocation of lower and upper jaw.	3

Notes:

1. *In case of jaw fracture, insurance benefit shall be paid only once irrespective of whether the fracture is unilateral or bilateral.*
2. *Fracture of the alveolar process of the mandible shall not be considered a jaw fracture.*
3. *Where a fracture in the alveolar process results in the loss of teeth, insurance benefit shall not be paid in respect of fractures.*
4. *In case of ordinary mandibular dislocation, insurance benefit shall only be paid if this is a complication of trauma suffered during the period of insurance (i.e., original dislocation was caused by a trauma during the period of insurance) and diagnosed within a period of one year after the trauma. Benefits shall not be paid for recurrent ordinary dislocations.*
5. *Where fracture of the jaw or cheek bones necessitates facial bone surgery, 3% of the sum insured shall be paid in addition on a one-off basis (irrespective of the number of surgeries).*

35	**Jaw injuries that cause:**	
	a) partial loss of the jaw;	20
	b) total loss of the jaw.	40
Note: 1. *The loss of alveolar processes shall not be considered as the loss of a part of the jaw.*		
36	**Tongue injuries resulting in:**	
	a) the loss of the tongue tip or tongue up to the distal third region;	10
	b) the loss of the tongue in the middle third of the tongue;	30
	c) the loss of the tongue in the proximal third (rood) region or loss of the entire tongue.	60
37	**Traumatic injury of teeth (non-parodontal, non-carious, non-filled teeth): splitting of at least ¼ of the tooth, fracture of tooth or its root, partial tooth dislocation, including tooth displacement into the alveolar bone:** a) ½-1 tooth; b) 2-3 teeth; c) 4-6 teeth; d) 7-9 teeth; e) 10 and more teeth.	 2 5 8 10 12
Notes:		
1. *In case of total or partial traumatic loss of milk teeth in children under 5, insurance benefit shall be paid in accordance with the general regulations. Insurance benefits shall not be paid for loss of milk teeth in children above 5, irrespective of reasons.*		
2. *Loss of a tooth crown or entire tooth is understood to be the loss of tooth which is not re-implantable or is removed as a result of injury within a period of 1 year after the trauma.* 3. *Insurance benefit shall not be paid if detachable denture is broken or damaged as a result of trauma.*		
38	**Esophageal injuries causing:**	
	a) narrowing of esophagus, which obstructs swallowing of liquid or soft food;	20
	b) esophageal obstruction, but not earlier than 6 after the trauma, resulting in permanent gastrostomy (external opening of the stomach through the abdominal wall).	80
39	**Damage to the alimentary organs caused by severe intoxication, except for deliberate acts (including alcoholic intoxication), resulting in:**	
	a) gastric, intestinal and rectal cicatricial stricture (deformations);	20
	b) adhesions after abdominal surgeries, functioning pancreatic fistula;	30
	c) intestinal fistula (ileostomy – creation of an opening from the ileum to the outside, enterostomy – creation of an opening from the small intestine to the outside), entrevaginal, rectovaginal fistula;	50
	d) colostomy (creation of artificial anus).	80
Notes: 1. *If one trauma results in several consequences mentioned in Section 39, insurance benefit is payable under the paragraph providing for the most severe consequences.* 2. *Insurance benefit under 39(b) is payable on a one-off basis irrespective of the number of surgeries.*		
40	**Ulcer in the abdominal wall, diaphragm or at the scar site of abdominal surgery (which is required because of trauma).**	10
41	**Hepatic injuries from traumas, severe intoxication resulting in:**	
	a) liver closing or removal of gallbladder;	15
	b) liver closing and removal of gallbladder;	20

	c) removal of a part of the liver;	25
	d) removal of a part of the liver and gallbladder.	30
42	**Splenic injuries resulting in:**	
	a) splenic rupture;	5
	b) removal of the spleen.	20
43	**Gastric, pancreatic, intestinal and/or peritoneal injuries resulting in the removal of:**	
	a) 1/3 of the stomach, 1/3 of the bowels;	25
	b) 1/2 of the stomach, 1/3 of the pancreas and 1/2 of the bowels;	35
	c) 2/3 of the stomach, 2/3 of the pancreas and 2/3 of the bowels;	60
	d) stomach, 2/3 of the pancreas and 2/3 of the bowels;	80
	e) total bowels, stomach and a part of the pancreas.	100
44	**Traumatic injuries of the abdominal organs resulting in:**	
	a) laparocentesis;	2
	b) laparoscopy, diagnostic laparotomy (when injuries of the abdominal organs are suspected);	7
	c) laparotomy (in case of injury of the abdominal organs);	10
45	**Hernia occurring at the post-operative site on the abdominal wall or diaphragm (if surgery was required because of trauma), irrespective of whether the hernia was operated or not.**	5
Notes: *1. Where insurance benefit is paid under paragraphs 42-44, no benefit shall be granted under paragraph 45.* 2. *Where the event requires several interventions, insurance benefit shall be paid only for the most complicated one, except for relaparotomy.* 3. *Insurance benefit shall not be paid for hernias (umbilical hernia, linea alba hernia, pelvic hernia, inguinal hernia) developed as a result of physical tension (including lifting heavy weights).*		
Urinary and genital systems		
46	**Traumatic injuries of kidney causing:**	
	a) removal of a part of the kidney/unilateral nephrectomy;	30
	b) bilateral nephrectomy.	60
47	**Post-traumatic impairment of the urinary system:**	
	a) renal insufficiency;	30
	b) urethral blockage.	40
48	**Injuries of urinary organs resulting in puncture (trocaric) or surgical cystostomy, cystotomy, single hemodialysis.**	10
49	**Traumatic injury of the genital system causing:**	
	a) unilateral removal of ovary, Fallopian tube, in women under 40, bilateral removal of ovary, Fallopian tube, in women above 40, unilateral removal of testicle, partial penectomy;	15
	b) bilateral removal of ovary. Fallopian tube in women under 40, bilateral removal of testicle or total penectomy;	30
	c) hysterectomy in women under 40;	40
	d) from 40 to 50;	30
	e) above 50.	15
Post-traumatic scars		
50	**Injuries to soft tissues in the area of the face, front or side surface area of the neck or in the under-jaw area after healing of which there are:**	

	a) linear scar up to 3 cm in length,	1
	b) linear scar measuring 3.1 cm to 5 cm in length,	3
	c) linear scar measuring 5.1 cm to 8 cm in length or 2 cm^2 to 5 cm^2 in area;	5
	d) linear scar of more than 8.1 cm in length or exceeding the area of 5.1 cm^2;	10
	e) pigment spot up to 2 cm^2 persistent after burns due to direct contact with hot liquids, devices and/or chemicals;	2
	f) pigment spot measuring < 2.1 cm^2 persistent after burns due to direct contact with hot liquids, devices and/or chemicals	5
	g) disfigurement of one side of the face: persistent massive, contrasting spots of face-unnatural colour, disfiguring scars, facial disfigurement (major changes on both sides of the face with no (or substantially no) undamaged areas);	20
	h) disfigurement of the entire face: persistent deformations of the facial soft tissues, massive, contrasting spots of face-unnatural colour, disfiguring scars.	30
51	**Soft-tissue injuries in the hairy part of the head, trunk and/or extremities after healing of which there are:**	
	a) linear scar measuring 2 cm to 5 cm (for children up to 6 years of age inclusive from 1 up to 2 cm in length);	1
	b) linear scar measuring 5.1 cm (for children up to 6 years of age inclusive from 2.1 up to 5 cm in length) or 2 cm^2 in the area;	3
	c) linear scar of more than 10 cm in length (for children up to 6 years of age inclusive more than 5.1 cm in length) or exceeding the area of 5 cm^2.	5
52	**Soft-tissue injuries in the trunk and/or extremities resulting in pigment spots measuring:**	
	a) I – II A degree of burns - a pigmental stain from 2% of the body surface area or a scent up to 1% of the body surface area;	2
	b) II A – II B degree of burns - a pigmental stain from 2% of the body surface area or a scent from 1% of the body surface area;	4
	c) II B degree and deeper burns - a pigmental stain from 2% of the body surface area or a scent from 2% of the body surface area.	6
Note: *If the insurance benefit is paid in accordance with Article 52 a); (b) or (c), and the insured has been treated in a hospital for more than 2 days as a result of the injury, 2% from the Sum Insured is paid additionally.*		
53	**Burn diseases (burn shock, burn intoxication, anuria, burn intoxication, acute burn toxemia, burn septicotoxemia), traumatic post-hemorrhagic anaphylactic shock, fat embolism, if diagnosed during in-patient treatment.**	10
54	**Open or closed injuries to soft tissues with the following resultant consequences: muscular hernia, post-traumatic periostitis (inflammation of the membrane enveloping a bone), non-resolved hematoma (of 5 cm^2 in diameter at least), also, muscular rupture, loss of tendon integrity (except for the tendons in toes and fingers and shoulder joint):**	
	a) presence of one of the consequences above;	3
	b) presence of two or more of the consequences above.	5
Notes: *1. Scar is a skin compound that is injured, cut, burned, is formed after the deeper skin layers (dermis), formed by the connective tissue and blood vessels. Insurance coverage for scars is payable only if the wound has*		

been arranged in a health facility. At the insurer's request, you must submit a photo of a scar / pigment spots.

2. *We do not pay benefits for scratches or other irregularities that prevented the sewing or sticking of fabrics.*
3. *Pigmented spots and scars after burnt of tissues are measured at the end of healing and after trauma for at least 1 month.*
4. *Palmar surface (including palm and digits II-V together) of the insured person's hand is deemed to correspond to 1% of the surface of the body. This area is measured in square centimetres by multiplying the length of hand (measured from the radiocarpal joint to the top of the distal (third) phalanx of the third digit) and the width of hand (measured along the head of MTC II-V.*
5. *Insurance benefit shall not be paid for scars and/or loss of soft tissues as a result of open fractures, surgeries or amputations.*
6. *For the purpose of calculating insurance benefit payable under a relevant section in Annex 1 in respect of scars resulting from one event insured, scar measurements shall be summed up.*
7. *In case of multiple muscle and/or tendon injuries in one extremity as a result of one event insured, insurance benefit payable in respect of injuries to individual muscles and tendons shall not be summed up.*
8. *In case of multiple injuries to ligaments in one joint as a result of one event insured, insurance benefit payable in respect of injuries to individual ligaments shall not be summed up.*

Spine		
55	**Fracture of cervical, thoracic or lumbar vertebrae or their arches (confirmed by an X-ray):**	
	a) 1-2 vertebrae;	10
	b) 3 and more vertebrae.	15
56	**Fracture of processes of cervical, thoracic or lumbar vertebrae, vertebral subluxation or dislocation (confirmed by an X-ray):**	
	a) 1-2 vertebrae;	5
	b) 3 and more vertebrae.	8
Notes: *1. Insurance benefits shall not be paid for recurrent subluxations.*		
57	**Spinal ligament sprain or partial rupture treated for at least 14 days.**	3
58	**Sacrum fracture**	5
59	**Coccyx fracture (broken tailbone)**	3
Notes: *1. Where one trauma results in several injuries of the same vertebra (fracture of the vertebra or its processes, vertebral ligamentous injuries), insurance benefit shall be paid for the most severe injury only.*		
Arm		
60	**Fracture of the scapula.**	5
61	**Fracture of the clavicle.**	5
62	**Partial or total rupture of scapulo-clavicular ligaments.**	10
63	**Rupture of sternoclavicular ligaments.**	10
Shoulder joint		
64	**Injuries of the shoulder joint:**	
	a) rupture of ligaments or tendons, joint lesion rupture, dislocation of the clavicle, dislocation of the humerus in the shoulder area, when treatment lasts for a period of 14 days or longer;	3
	b) factures of the articular surface of the scapula, head of the humerus, anatomical neck and/or the greater tubercle.	10
65	**Damages to the shoulder joints caused by ankylosis (at least 3 months after the trauma).**	10

Notes:

1. *Where trauma in the area of the shoulder joint necessitated surgery, additional 2% of the sum insured shall be paid. No additional benefit shall be paid for a graft.*
2. *No insurance benefit is payable for repeated (regular) dislocations.*
3. *Recurring dislocations shall not be regarded as risks covered and no benefits shall be paid in respect of them, if the initial dislocation occurred prior to entering into the insurance contract.*
4. *Dislocations caused by physical loads (e.g., lifting heavy weights) shall not be recognised as risks covered and no benefits shall be paid in respect of them.*
5. *Dislocation shall be recognised as risk covered only if repaired in a medical establishment.*
6. *Insurance benefit for all injuries to one arm shall not exceed 80 % of the sum insured under the Policy.*

Humerus		
66	**Humeral factures at any part of the humeral shaft, incl. fracture of the surgical neck.**	10

Note:

1. *Where humeral fracture required surgery, additional 5% of the sum insured shall be paid once. However, if additional benefit is payable in respect of surgery of the shoulder or elbow joint, no additional benefit shall be payable under this note. Correction of soft tissues is not considered as being a surgery.*

67	**False joint (nonunion, pseudoarthrosis) persistent at least 9 months after the trauma, if this is confirmed by a medical certificate.**	30
68	**Traumatic amputation of the arm or severe injury resulting in the arm amputation within one year after the trauma:**	
	a) Amputation of the arm, including other shoulder bones (scapula, clavicle or any part thereof);	80
	b) Transhumeral amputation or amputation at the shoulder joint;	75
	c) Amputation of the arm which was the only arm prior to the trauma.	100
Elbow joint		
69	**Injuries in the elbow joint area:**	
	a) elbow joint injuries (total rupture of ligaments, rupture of the articular capsule) with immobilization, when treatment lasts for a period of 14 days or longer;	5
	b) unilateral fracture of humeral epicondyle, split of the radial head (edge), fracture of the coronoid process, dislocation of one bone, olecranon fracture;	5
	c) vertebral humerus fracture, bilateral fracture of humeral epicondyle, fracture of the radial neck, isolated dislocation of the radial head;	10
	d) articular fracture in the humerus (with or without dislocation), dislocation of the forearm bones (with or without articular fractures), articular fracture of the forearm bones (with or without dislocation);	15
	e) articular fracture in the humerus with articular fractures in two forearm bones (with or without dislocations).	20

Note:

1. *Only one paragraph of Section 69 shall apply in respect of one trauma. In case of trauma involving various injuries, the paragraph meeting the most severe injury shall apply.*

70	**Consequences of injuries to the elbow joint present at least 9 months after the trauma and this is confirmed by a medical certificate:**	
	a) impairment in the articular functions (limited motion (rigidity), contracture);	5
	b) joint stiffening (ankylosis), pseudoarthrosis confirmed by X-ray.	20

Note:

1. *Where trauma in the elbow joint required surgery, additional 5% of the sum insured shall be paid once. In case of elbow joint stiffening (ankylosis) being accompanied by shoulder joint stiffening, 40 % of the sum*

insured shall be payable under Section 70(b).		
Forearm		
71	**Forearm shaft fractures confirmed by X-ray:**	
	a) single bone (without relocation);	5
	b) single bone (with relocation);	7
	c) 2 bones, fracture of one or two bones with dislocation of another bone.	10
Note: *1. Where forearm fracture required surgery, additional 5% of the sum insured shall be paid once. However, if additional benefit is payable in respect of surgery of the elbow joint, no additional benefit shall be payable under this note.*		
72	**Loss of arm above the wrist joint or post-traumatic amputation of the forearm as a result of severe injury.**	65
73	**Nonunion of the forearm bones (false joints) present at least 9 months after the trauma:**	
	a) single bone	5
	b) both bones	10
Radial bone and wrist joint		
74	**Traumatic loss of muscular, ligamentous or tendonous integrity (sprains, partial rupture, rupture), dislocation of the wrist joint resulting in:**	
	a) treatment and/or incapacity for work for at least 7 days;	1
	b) treatment involving plaster bandage or other special fixed immobilisation for 14 or more days;	2
	c) treatment requiring reconstructive surgery.	5
75	**Unilateral epiphysiolysis, fractures of bone processes, including *processus styloideus radii* or *ulnae*, fracture of the ulnar head, distal or lower ulna.**	
	a) single bone;	5
	b) both bones.	7
76	**Fracture of the radial bone only or fracture of both bones in a typical place with dislocation or subluxation of the ulnar head, unilateral or bilateral epiphysiolysis.**	10
77	**Consequences of injuries in the wrist joint area, present at least 9 months after the date of trauma:**	
	a) impairment in the articular function (limited motion (stiffening), contracture);	5
	b) joint stiffening (ankylosis) confirmed by X-ray.	15
Hand and metacarpal bone		
78	**Unilateral fracture or dislocation of the carpal and/or metacarpal bones, loss of muscular, ligamentous or tendonous integrity:**	
	a) fracture or dislocation of one bone;	3
	b) fracture or dislocation of two bones, excluding scaphoid bone (os scaphoideum);	5
	c) fracture or dislocation of three or more bones, fracture or dislocation of the scaphoid bone;	10
	d) carpal dislocation;	15
	e) traumatic loss of muscular, ligamentous or tendonous integrity in the hand (sprains, partial rupture, rupture), nerve injury resulting in treatment requiring plaster bandage or other special fixed immobilisation for 14 or more days.	2
Note:		

1. Only one paragraph of Section 78 shall apply in respect of one trauma.		
79	**Consequences of carpal injuries:**	
	a) nonunion of one or several bones, excl. phalanges (false joint, pseudoarthrosis), present at least 9 months after the date of trauma and confirmed by a medical certificate;	10
	b) loss of all hand digits (fingers), transcarpal or transmetacarpal amputation of hand;	65
	c) amputation of the only hand.	100
First digit (thumb)		
80	**Digit injuries:**	
	a) loss of nail plate (nail), ligamentous rupture, injury to the articular capsule ligaments;	1
	b) bone fracture, tendon injuries.	3
81	**Digit injuries with resultant rigidity in:**	
	a) one joint;	5
	b) two joints.	10
82	**Traumatic amputation or severe injury resulting in digit amputation:**	
	a) loss of the entire nail phalanx;	5
	b) at the level of the second and third phalanges (loss of the digit).	10
Hand digits (excl. the first digit)		
83	**Digit fracture, tendon injuries, rupture of the articular capsule ligaments**	1
84	**Post-traumatic digit amputation or injuries resulting in the digit amputation:**	
	a) loss of all nail phalanx;	3
	b) loss of the middle phalanx (loss of 2 phalanges);	5
	c) loss of the basic phalanx (loss of the digit).	10
85	**Loss of all hand digits (fingers) as a result of trauma or injuries.**	50

Notes:

1. *Benefit percentage shall be summed up taking into account the injuries of each finger. However, insurance benefit payable for all injuries of digits in one hand shall not exceed 50% of the sum insured.*
2. *Insurance benefit payable for all consequences of the injuries in one digit shall not exceed the benefit fixed in case of digit amputation.*
3. *Insurance benefit for multiple fractures in one digit shall equal to the benefit payable for one fracture.*

Pelvic bone fractures		
86	**Fractures of the pelvic bones (os pubis, os coxae, os ischii):**	
	a) single bone fracture, fragmentation of the edge of the hip-socket;	5
	b) single symphysis rupture; double-sided fracture of one bone, fracture of two bones, acetabular fracture;	10
	c) multiple symphysis rupture, fracture of three or more bones, acetabular fracture with central femoral dislocation.	15

Note:

1. Where fracture of the pelvic bones or rupture of the cartilaginous symphysis required surgery, additional 5% of the sum insured shall be paid once irrespective of the number of surgeries.

Leg		
Hip joint		
87	**Injuries in the hip joint area:**	
	a) Injuries to the hip joint ligament integrity (sprains, partial rupture or rupture, Acetabular articular lip rupture), when uninterrupted treatment lasts for a period of 14 days or more;	3
	b) trochanteric fractures of the femur (*trochanter minor et major*), intratrochanteric and supratrochanteric fractures of the femur;	10
	c) fractures of the femoral head or neck, femoral dislocation.	15

88	**Consequences of injuries in the hip joint area, present at least 9 months after the date of trauma and confirmed by a medical certificate:**	
	a) joint stiffening (ankylosis) confirmed by X-ray;	15
	b) nonunion of the femoral neck (false, joint, pseudoarthrosis);	20
	c) resection of the femoral head, acetabulum (hip-socket), endoprosthesis (intra-articular prosthesis) after trauma.	35

Notes:

1. *Where trauma in the area of the hip joint required surgery, additional 5% of the sum insured shall be paid once. Correction of soft tissues is not considered as being a surgery.*
2. *Where several consequences of one trauma are provided for under several paragraphs, insurance benefit due is determined on the basis of the paragraph providing for the most severe consequences of the trauma.*
3. *Insurance benefit payable for all consequences of the injuries in one leg shall not exceed 60% of the sum insured.*
4. *Joint stiffening must be confirmed by a traumatologist, including the assessment and description of the mobility amplitude of the injured joint in degrees.*

Femur		
89	**Femoral fracture**	
	a) diaphyseal, close;	7
	b) diaphyseal, open;	10
	c) distal;	5
	d) articular.	10

Note:

1. Where femoral fracture required surgery, additional 5% of the sum insured shall be paid once. However, if additional benefit is payable in respect of surgery of the hip or knee joint, no additional benefit shall be payable under this note. Correction of soft tissues is not considered as being a surgery.

90	**Traumatic leg amputation or severe leg injury resulting in leg amputation within a period of one year after the trauma:**	
	a) one leg;	70
	b) the only leg.	100
91	**Malunion of a femur fracture (assessed at least 9 months after the trauma), nonunion (false joint, pseudoarthrosis).**	30
92	**Unilateral or multiple impairment in the functions of the leg joint(s) (limited motion, contracture).**	5
Knee joint		
93.	**Injuries in the knee joint region:**	
	a) loss of ligamentous integrity in the knee joint (sprains, partial rupture, rupture) when treatment and/or incapacity for work last for 10 or more days; hemarthrosis (based on puncture); patellar dislocation (rupture of patellar ligaments);	1
	b) loss of ligamentous integrity (sprains, partial rupture, rupture), when treatment involved plaster bandage or other special fixed immobilisation for 14 or more days;	2
	c) surgery or MRI evidenced meniscal tear or partial tear in the knee;	5
	d) patellar fracture; fracture of the proximal part of the shinbone (articular fracture of the lateral and medial condyle).	7

Notes:

1. When reconstruction of the integrity of the knee joints has been performed, one additional

	payment of 3% of the sum insured, irrespective of the number of operations, is paid. *2. When insurance benefits shall be paid in accordance with paragraph 93 (d), an additional fee for the operation shall not be charged.* *3. Traumatic tears of both menisci in one knee shall be regarded as one meniscal tear and insurance benefit shall be paid for one meniscal tear.* 4. *Insurance benefits under Section 93 in respect of Trauma suffered during original Policy period shall be calculated in accordance with the rate (percentages) indicated in this Table. However, insurance benefit shall not exceed 1 MSL. This limitation does not apply to Traumas suffered during the renewed Policy period.* *5. If knee joint degenerative changes are detected, in accordance with Section 8.1 of the Rules only 50 % of the amount of the insurance benefit can be calculated.*	
94	**Knee joint injuries resulting in:**	
	a) knee joint blocking due to soft tissue injury;	10
	b) joint instability (as a result of bone surface resections in the knee joint).	20
Shin		
95	**Fracture of the shinbone shaft:**	
	a) fibula;	5
	b) tibia.	10
96	**Amputation after trauma or severe injury resulting in tibial amputation at any level.**	60
97	**Unilateral or bilateral shinbone fracture with resultant formation of a false joint (malunion of the fracture), present at least 9 months after the trauma:**	
	a) fibula;	5
	b) tibia.	10
98	**Shin amputation after trauma or severe injury resulting in shin amputation within a year after the date of trauma.**	60
	Tarsus joint	
99	**Injuries in the tarsus joint area:**	
	a) loss of ligamentous integrity (sprain, partial rupture, rupture), when treatment and/or incapacity for work last for 7 or more days;	1
	b) loss of ligamentous integrity (sprains, partial rupture, rupture), when treatment involved plaster bandage or other special fixed immobilisation for 14 or more days;	2
	c) unilateral ankle fracture, fracture of the posterior edge of the tibia, rupture of the distal tibiofibular syndesmosis (syndesmolysis);	5
	d) bilateral ankle fracture, unilateral ankle fracture with fracture of the posterior edge of the fibula, rupture of the distal tibiofibular syndesmosis (syndesmolysis) with foot subluxation;	10
	e) bilateral ankle fracture with fracture of the posterior edge of the fibula, unilateral or bilateral ankle fracture with foot subluxation, total foot dislocation with (or without) syndesmolysis;	15
	f) bilateral ankle fracture with fracture of the posterior edge of the fibula, foot subluxation (dislocation) and syndesmolysis.	20
100	**Consequences of injuries in the tarsus joint area, present at least 9 months after the date of trauma and confirmed by a medical certificate:**	
	a) joint stiffening (ankylosis) confirmed by X-ray.	15
101	**Tarsal amputation after trauma or severe injury resulting in the leg amputation at tarsus joint area (exarticulation).**	50

102	**Total loss of the integrity of the Achilles tendon** in case of at least 14 days of uninterrupted conservative (non-surgical) treatment.	5
	Note: *When the Achilles tendon has been operated, then an additional 3% of the Insured sum is paid.*	
103	**Foot**	
	Traumatic loss of muscular, ligamentous or tendonous integrity (sprains, partial rupture, rupture) in a foot, nerve injury resulting in:	
	a) treatment and/or incapacity for work last for 7 or more days;	1
	b) treatment involving plaster bandage or other special fixed immobilisation for 14 or more days;	2
	c) reconstructive surgery;	3
	d) fracture or dislocation of one or two bones (excl. calcaneum or talus);	5
	e) calcaneal fracture, talar fracture, fracture or dislocation of three or more bones;	10
	f) talar dislocation, subtalar dislocation, dislocations of the transverse tarsal joint (*articulatio tarsi transversa*, Chopart's joint) or tarsometatarsal articulation (*articulatio tarsometatarseae*, Lisfranc joint).	15
104	**Consequences of foot injuries:**	
	a) foot deformation caused by the consequence of the event insured – bone fracture with relocation;	5
	b) nonunion of one or two metatarsal bones or false joint;	5
	c) nonunion of three, four or five metatarsal bones or false joint;	10
	d) calceneal or talar nonunion (pseudoarthrosis), aseptic necrosis of the talus.	15
105	**Foot amputation:**	
	a) foot amputation at the level of the metatarsophalangeal joint;	25
	b) transmetatarsal amputation;	35
	c) amputation in the sphenoid-tarsal joint area.	45
	Toes	
106	**Unilateral injuries of toe(s):**	
	a) loss of ligamentous integrity in a toe (sprains, partial rupture, rupture), loss of nail plate (nail) of the first digit (thumb);	1
	b) fracture of one or two toes (except for the thumb);	2
	c) fracture of dislocation of the first toe;	5
	d) fracture or dislocation of three or more toes (excl. the first toe), irrespective of the number of broken or dislocated phalanges), tendon injuries in three, four or five toes.	8
107	**Unilateral toe amputation after trauma or severe injury resulting in toe amputation within a year after the date of trauma:**	
	a) first toe (hallux, big toe):	
	i. loss of the entire nail phalanx;	5
	ii. proximal (basic, first) phalanx amputation or amputation at the metatarsophalangeal joint level (loss of the toe);	10
	b) II-V toes:	
	i. phalangeal amputation in one or two toes;	5
	ii. amputation of three or four toe together with the metatarsal bone or a part of it;	10
	iii. amputation of all fingers with or without a subcutaneous part.	25
Notes: *No additional benefit shall be paid for toe surgeries*		

108	**Consequences of other risks covered:**	
	Consequences of various traumatic injuries (this paragraph shall not apply in case of traumas of hand and foot digits):	
	a) taking an osseous autotransplant;	5
	b) post-traumatic osteomyelitis, hematogenic osteomyelitis.	10
109	**Traumatic, hemorrhagic (anaemic, related to blood loss), anaphylactic shock (hypersensitivity to some substances), fat embolism syndrome.**	5
110	**Risks covered resulting in insure person's in-patient treatment for more than 2 days (unless insurance benefit is payable under other paragraphs of the table): traumatic asphyxia, acute (chemical) intoxication, electrical injuries (power discharge from electricity systems, equipment or atmosphere), snakebite, animal bites and/or stings, etc. requiring in-patient treatment for:**	
	a) 3-7 days;	3
	b) 8-15 days;	7
	c) >16 days.	10