COMPENSA
VIENNA INSURANCE GROUP

HEALTH INSURANCE RULES No. 010

Effective from 1 August 2021

CONCEPTS

1. CONCEPTS

1.1. The concepts starting with a capital letter, used in the insurance contract as well as in the notices of the parties, other related documents shall have the meaning defined below and shall be respectively interpreted, unless the context expressly requires otherwise or unless clearly stated otherwise.

1.1.1. **An ambulatory Surgery Service** means a planned health care service during which a treatment and/or diagnostic intervention procedure is performed. The service must comply with the list of ambulatory surgery services approved by the Minister of Health of the Republic of Lithuania applicable at the time of its provision. The duration of the service may not exceed 1 (one) bed day, which means that the Insured is admitted to the Health Care Institution and discharged from it on the same day.

1.1.2. **The Insured** shall mean a natural person specified in the Contract, whose Insurance Risk and property interests are insured.

1.1.3. **Day Surgery/Day Stationery Treatment Service** shall mean a planned treatment and/or diagnostic Health Care Service during which the care of the Insured is guaranteed for up to 24 hours (if necessary – up to 48 hours). The service must comply with the list of day surgery/day treatment stationery services approved by the Minister of Health of the Republic of Lithuania applicable at the time of its provision.

1.1.4. **The Policyholder** shall mean a person who concludes (concluded) or expresses the need to conclude a Contract with the Insurer for his own or another person's benefit.

1.1.5. **The Insurer** shall mean Compensa Life Vienna Insurance Group SE acting through the Lithuanian branch of Compensa Life Vienna Insurance Group SE, or its successors and assigns or successor in title (if applicable).

1.1.6. **Insurance Coverage** shall mean the obligation of the Insurer to pay the Insurance Indemnity to the Beneficiary under the terms and conditions and procedure set in the Contract upon occurrence of the Insurable Event.

1.1.7. **Insurance Indemnity** shall mean the amount of money payable by the Insurer to the Beneficiary under the Contract upon occurrence of the Insurable Event.

1.1.8. **The Beneficiary** shall mean the Insured or the Partner, or their successors and assigns, heirs who acquire the right to the Insurance Indemnity or the portion thereof in accordance with the procedure and terms established by the Contract and/or applicable law.

1.1.9. **The Insurance Premium** shall mean the amount of money payable by the Policyholder to the Insurer for the Insurance Coverage and related services provided under the Contract, the amount and terms of payment of which are determined in the Insurance Certificate (Policy).

1.1.10. **The Insurance Period** shall mean a period of time defined and stated in the Contract as specific time limits, during which the Insurance Coverage is valid.

1.1.11. **The Insurance Certificate (Policy)** shall mean a document confirming the Contract conclusion and its conditions and issued under the procedure and terms set by the Insurer during conclusion of the Contract and/or amendment s to its conditions. Upon issuance of a new or subsequent Insurance Certificate (Policy), all prior Insurance Certificates (Policies) to the same Contract shall become invalid.

1.1.12. **The Insured Risk** shall mean a probability for occurrence of the Insurable Event and/or the amount of possible damages or injuries caused by this Insured Event.

1.1.13. **The Sum Insured** shall mean the maximum amount of money indicated in the Insurance Certificate (Policy), within the limits of which respective property interests are insured.

1.1.14. **Insurance Rules** shall mean these health insurance rules, in accordance with which all Contracts on the health insurance product distributed by the Insurer are concluded.

1.1.15. **The Insurable Event** shall mean the event provided for in the Contract, upon the occurrence of which the Insurer undertakes to pay the Insurance Indemnity in accordance with the procedure and conditions provided for in the Contract..

1.1.16. **The Date of the Insurable Event** shall mean one of the following dates, on the basis of which it is determined whether the Insurable Event occurred during the validity of the Insurance Coverage:

a) In the case of the purchase of medical aids, the date on which the goods or aida are actually paid for. If goods or aids are bought in instalments, the date of payment of the first instalment shall be deemed to be such a date;

b) In case of provision of services, the date when the Insured actually receives the service;

c) In the case of a critical disease, the date of diagnosis of the critical illness.

1.1.17. **The E-Help System** shall mean an electronic system or program, the procedure and conditions of use of which are determined by the Insurer and which is intended for the exchange of documents, information and/or notices (including requests or other forms of expression of will) between the Insurer and the Insured.

1.1.18. **Long-Term Nursing/Care And Supportive Treatment** shall mean palliative care, supportive treatment, nursing/care at home, in a health care institution or other social support institution for people with severe chronic diseases when active treatment is not required.

1.1.19. **The Franchise** shall mean a part of the loss (expenses), which is reimbursed by the Insured himself in case of each Insurable Event.

1.1.20. **The War and State of Emergency** shall mean war or actions similar to war in their nature, irrespective of their forms or whether the war is officially declared or not, as well as military incursion or similar military actions, military government establishment, rebellion, mass riots, civil unrest, use of weapons, occupation, revolution, civil wars, uprisings, government upheaval, siege, declaration of martial law or the state of emergency or any other events or circumstances that threaten the constitutional order or public peace.

1.1.21. **The Client** shall mean a natural or legal person or their representative, including the Policyholder or the Insured, who uses the services of the Insurer or expresses a relevant interest or intention.

1.1.22. **The Card** shall mean a card issued by the Insurer and intended for the Insured, which confirms the provision of Insurance Coverage in accordance with the terms and conditions of the Contract.

1.1.23. **The Critical Disease** shall mean one or more diseases and/or surgeries provided for as indicated in clause14 of Addendum No.1 to the Insurance Rules, which meet the criteria for diagnosing such diseases or surgeries as defined therein.

1.1.24. **The Date of Diagnosing a Critical Disease** shall be one of the following dates:

a) In case of Critical Diseases referred to in sub-clauses 14.4.14–14.4.1.6 and sub-clause 14.4.1.13 (if a relevant surgery is performed) of clause 14 of Addendum No.1 to the Insurance Rules – the date of performance of surgery on the Insured;

b) In case of the Critical Diseases specified in sub-clause 14.4.1.7 of clause 14 of Addendum No. 1 to the Insurance Rules – the date when the Insured is placed on the official waiting list for surgery or the date when the Insured undergoes organ transplantation if the Insured was not placed on the list of patents waiting for organ transplantation;

c) In case of a critical disease referred to in sub-clause 14.4.1.1 of clause 14 of Addendum No. 1 to the Insurance Rules –the date of sampling of the histological examination on the basis of which a medical specialist diagnosed a disease;

d) In other events of other Critical Disaees provided for in Addendum No. 1 to the Insurance Rules – the date of diagnosing a Critical Disease for the Insured.

1.1.25. **Medical Aids** shall mean bandages, patches, syringes, insulin syringes, drip systems, stool collectors, bladder catheters, ostomy bags or collectors.

1.1.26. **Medically Reasonable Services** shall mean the health care services reasonably prescribed to the Insured by a competent doctor as necessary ones according to the Insured's complaints, established symptoms, and signs in the medical documentation.

1.1.27. **Medical Accessories** shall mean medical devices and medical aids; technical orthopedic aids; disposable instruments and appliances used for day surgery or ambulatory surgery services.

1.1.28. **Medical devices** shall mean glucometers and test strips for them, hearing aids, parenteral nutrition systems, drip infusion systems, pumps and inhalers.

1.1.29. **The Uninsurable Event** shall mean an event or circumstances, upon which occurrence the Insurer shall not pay the Insurance Indemnity.

1.1.30. **Non-reimbursable expenses** shall mean the expenses of the Insured specified in the Health Insurance Program, which are not reimbursed by the Insurer under the Contract, even if they are caused by Health Disorders.

1.1.31. **The Accident** shall mean an accident which occurs against the will of the Insured as a result of any abrupt, inadvertent, unexpected external forces and causes the bodily injury to the Insured including but not limited to sinking, heatstroke, sunstroke, chilblain, exposure to gas or other toxic substances which accidentally penetrate the body except for food poisoning.

1.1.32. **Alternative medicine** shall mean the services of diagnosis and treatment of diseases provided by a medical specialist in an alternative way in a health care institution, including acupuncture; electroacupuncture, bioresonance computer diagnostics; food intolerance tests; hydrocollonotherapy; phytotherapy; leech treatment; lithotherapy; apitherapy; aerophytotherapy; music and art therapy; chromotherapy; osteopathy; homeopathy; endobiogenic medicine; kinesiology; reflexology; Chinese medicine; Ayurveda; yoga; Reiki; autogenous training.

1.1.33. **Remote Health Care Services** shall mean health care services that are provided by means of communication in accordance with the procedure established by applicable law without the physical presence of the Insured.

1.1.34. **Technical Orthopedic Devices** shall mean splint and prosthetic systems, sticks, crutches, liners, compression stockings and postoperative shoes.

1.1.35. **The Partner** shall mean an entity with whom the Insurer has entered into a relevant agreement on the Insurer's Client Service and other conditions of cooperation in providing health insurance services. The Partner is not the representative of the Insurer. The list of partners is published on the Insurer's website.

1.1.36. **The Offer** shall mean the conditions under which the Insurer agrees to enter into the Contract.

1.1.37. **The CHIF** shall mean the Compulsory Health Insurance Fund.

1.1.38. **Radiation** shall mean a radioactive radiation, pollution or poisoning (intoxication), nuclear reaction or nuclear energy impact, as well as unauthorised use of nuclear weapons.

1.1.39. **Rehabilitation Treatment** shall mean a complex remedial measure applied due to the Insured's Health Disorder (acute condition, exacerbation of the disease or Injury) together with other treatment measures and/or as an adjunctive measure after ineffective or insufficiently effective pharmacological, surgical or immobilization treatment.

1.1.40. **The Contract** shall mean an insurance contract concluded between the Insurer and the Policyholder, according to which the Insurer undertakes to pay the Insurance Indemnity upon occurrence of the Insurable Event for the fee and under procedure set in the Contract, and o the Policyholder undertakes to pay the Insurance Premiums properly and on time and to perform other obligations assumed under the Contract The Contract consists of the following integral parts: Insurance Certificate (Policy), Insurance Rules, the Offer, terms and conditions or requirements stated in other documents related to the Insurance Contract or separately concluded by the parties (e.g., individual terms and conditions) including all addendums, amendments and supplements thereto and new versions.

1.1.41. **The Health Insurance Program** shall mean the insurance program (s) specified in Addendum No. 1 to the Insurance Rules, which determines the scope of the Insured Risk assumed by the Insurer and the nature of the Insurance Coverage.

1.1.42. **The Health Care Institution** shall mean an (natural or legal) entity that has a statutory licence and the right to provide health care services and wellness services in accordance with the procedure established by applicable law.

1.1.43. **The Healthcare Service** shall mean a service, aid and/or product (e.g., Pharmaceuticals, Medical Aids) set forth in the Contract and provided to the Insured in a Healthcare Institution, the purpose of which is to diagnose, nurse and treat diseases and Health Disorders, prevent them, help to recover and strengthen health, as well as to provide services and supply materials required for the restoration or improvement of health.

1.1.44. **Wellness Services** shall mean the services set forth in the Contract and provided to the Insured, the purpose of which is to prevent diseases, improve the immunity, resistance to diseases and/or Injuries of the Insured.

1.1.45. **Health Disorder** shall mean health or physiological condition of the Insured, which requires examination, treatment and/or other services set forth in the Contract.

1.1.46. **The Medical Speciaist** shall mean a health care professional who has a valid license for a specific activity that has been issued in accordance with the procedure meeting applicable requirements.

1.1.47. **Wellness/Rehabilitation Aids** shall mean the aids intended for rehabilitation, kinesitherapy, physical exercises and procedures, including massage tables and/or chairs, exercise machines, massagers, exercise mats and balls, weights, orthopedic/ergonomic pillows and mattresses and rubber bands.

1.1.48. **Pharmaceuticals** shall mean the pharmaceuticals registered by competent authorities in the Republic of Lithuania or the European Community, which have an ATC (anatomical-therapeutic-chemical) code and are purchased in Pharmacies.

1.1.49. **The Pharmacy** shall mean a legal entity or the division thereof which is licensed to engage in pharmaceutical activities, including the remote sale of pharmaceuticals.

1.1.50. **International Sanction** shall mean an economic or financial sanction, embargo or any other similar sanction, prohibition or restrictive measure imposed by decisions of the United Nations or by legal acts of the European Union or the Republic of Lithuania or the United States (including sanctions administered or applied by the Office of Foreign Assets Control of the U.S. Treasury Department), the United Kingdom or any other country.

1.1.51. **The Injury** shall mean an accident that occurs against the will of the Insured as a result of any abrupt, inadvertent, unexpected external forces and results in bodily injury and/or impairment of organ functions of the Insured.

1.2. References in the Contract to any document shall be construed as references to any amendments, supplements thereto or new versions.

GENERAL

2. GENERAL

2.1. Contract Terms and Conditions

2.1.1. The Insurance Rules determine the general terms and conditions of the Contract They shall be applicable to all Contracts that enter into force from the date of entry into force of the Insurance Rules, unless otherwise provided in the Contract. The Insurance Certificate (Policy) specifies and approves the specific terms and conditions of the Contract, including, but not limited to the Insurance Coverage, additional conditions or those agreed individually between the parties

2.1.2. These Insurance Rules are not subject to the Insurer's General Insurance Terms and Conditions.

2.2. Contract validity, interpretation and application

2.2.1. The Contract shall enter into force on the date of its signing, unless it provides for a different date or procedure for entry into force.

2.2.2. The Contract shall expire:

2.2.2.1. Upon expiry of the Insurance Period set forth in the Contract;

2.2.2.2. Upon payment of all Insurance Indemnities;

2.2.2.3. Upon the dissolution of the Policyholder as a legal entity unless there is no successor of its rights and obligations;

2.2.2.4. Upon termination of the Contract under procedure and in cases laid down in the Contract or applicable law;

2.2.2.5. If the Insured dies;

2.2.2.6. On other grounds for expiry of the obligations laid down by the applicable law.

2.2.3. If the Contract is concluded for a group of Insured Persons, then, on the grounds provided for in clause 2.2.2 of the Insurance Rules, the Contract may expire only in respect of a specific Insured (e.g., in respect of the deceased Insured or in respect of the Insured to whom all Insurance Indemnities have been paid). However, this does not change the validity of the Contract for other Insured.

2.2.4. In cases of existence of inconsistencies and/or contradictions among separate parts of the Contract, the Contract terms and conditions shall be determined and interpreted according to the rule, which grants the precedence to the terms and conditions stated in the antecedent document against the stated in the subsequent document in the following order: the Insurance Certificate (Policy), including documents establishing special or individually agreed conditions between the parties, the Offer (if submitted in writing) and Insurance Rules.

3. CLIENT IDENTIFICATION

3.1. The Client or his representative shall submit to the Insurer the following data and documents, required by the Insurer and having the form and content acceptable by the latter and conforming the identity, registration data, authorizations of the Client, other documents or data, related to the Contract conclusion, performance or termination and compliance with the requirements of applicable law.

3.2. The Insurer shall be entitled to not accept a proxy document that does not explicitly and unambiguously set forth the proxy rights or authorizations regarding conclusion, performance of respective transactions, or commission of actions and etc.

3.3. The Client shall inform the Insurer on changes, invalidity of any identification and/or proxy documents submitted to the Insurer or expiry thereof on other basis within a reasonable term. Otherwise, the Insurer shall be entitled to refer to documents and data submitted to it for such purpose at the latest.

3.4. The Insurer shall have the right to establish the procedure for identity verification for submission and receipt of notices depending on their nature as well as requirements for signing or approving specific documents. In case of any doubts, the Client must confirm the Client's will, identity, the date of the document and/or authenticity of the signature in the manner requested by the Insurer and acceptable to it. The Insurer shall have the right to refrain from performing any action or suspend the performance of its obligations under the Contract until the above doubts are resolved and the required confirmations are obtained.

CONTRACT CONCLUSION

4. INSURANCE CONTRACT CONCLUSION

4.1. The Contract shall be concluded provided that the Policyholder accepts the Insurer's Offer to conclude the Contract under the conditions specified therein. In any case, the Policyholder shall itself choose the desired nature and scope of the Insurance Coverage and the Insured Risk from the possible versions of the Health Insurance Program and/or other conditions agreed between the parties.

4.2. When concluding the Contract, the Policyholder (the Insured provided that the Policyholder gives its consent thereto and provides such an opportunity) may choose the following **Health Insurance Programs:**

4.2.1. Ambulatory treatment and diagnostics;
4.2.2. Stationary treatment;
4.2.3. Prenatanal care, childbirth and postnatanal care;
4.2.4. Dental services;
4.2.5. Pharmaceuticals and medical aids;
4.2.6. Vitamins, over-the-counter pharmaceuticals;
4.2.7. Optics;
4.2.8. Preventive and periodical health examinations and tests:
4.2.9. Vaccinations;
4.2.10. Rehabilitation treatment;
4.2.11. Medical services;
4.2.12. Wellness services;
4.2.13. All services;
4.2.14. Critical diseases.

4.3. The Insurer's Offer shall be valid for 30 (thirty) days from the date of its issuance, unless otherwise specified in the Offer.

4.4. Before concluding the Contract and/or during the term of validity of the Contract, the Insurer shall have the right to request information and data relevant to the assessment of the Insured Risk, the Client's needs and requirements, possibilities to fulfil obligations under the Contract and/or to comply with the requirements of applicable law. The Client shall provide complete, true and full information requested by the Insurer.

4.5. When assessing the Insured Risk, the Insurer shall have the right to take into consideration the age, health condition and other circumstances relevant to the Insured Risk.

4.6. The Contract shall be deemed to be concluded, all its terms and conditions shall be agreed and approved by the parties from the date of signing the Insurance Certificate (Policy), unless the Contract provides for otherwise.

4.7. Once the Contract is concluded, the Insurer shall issue the Cards to the Policyholder, and the Policyholder shall transfer them to each Insured personally and ensure the confidentiality of personal data, unless the parties agree otherwise.

4.8. The Policyholder shall inform the Insured (s) about the conclusion, amendment and/or termination of the Contract and properly familiarize with the terms and conditions of the Contract, as well as ensure that the Insured (s) duly and timely fulfils all the terms and conditions of the Contract, including the submission of consents, confirmations, data or other information requested by the Insurer.

5. HEALTH EXAMINATION

5.1. When concluding or amending the Contract; investigating a possible Insured Event; in case of reasonable doubts about the accuracy, reasonability, authenticity or completeness of the information provided by the Client; if new circumstances or facts related to the health of the Insured are revealed; or in other events when the Insurer needs additional information, the Insurer shall have the right to request a medical examination of the Insured in a medical institution acceptable to and indicated by the Insurer and/or the conclusions of the relevant medical expert. The Insurer shall pay the costs of the Insured's health examination if such examination is requested by the Insurer before concluding the Contract. If the Insured refuses to do so while investigating a possible Insured Event, the Insurer shall have the right to reduce the payable Insurance Benefit or refuse to pay it.

5.2. If necessary, the Insurer shall have the right to check the health condition or medical history of the Insured by making appropriate inquiries to the Partners, other medical institutions before concluding the Contract and during the entire term of the Contract, for example, when investigating the Insurable Event and etc. If the Insurer does not receive the above information, the Policyholder or the Insured shall provide the Insurer with the relevant data and/or documents by themselves.

6. INSURANCE PREMIUMS

6.1. The insurance Premium shall be determined by the agreement between the Policyholder and the Insurer for the entire Insurance Period. The Insurance Premium depends on the Insurance Programs chosen by the Policyholder, the Sum Insured, Insured Risk Assessment and other terms and conditions of the Contract.

6.2. Insurance Premiums shall be paid in accordance with the procedure and terms specified in the Insurance Certificate (Policy). In case of delay in payment of the Insurance Premium or the portion thereof, the late payment penalty provided for in the Contract may be charged, as well as the validity of the Insurance Coverage may be suspended or the Contract may be terminated at the choice of the Insurer.

6.3. The Insurance Premium shall be paid to the Insurer by a payment order or in any other non-cash manner acceptable to the Insurer in the currency of the Contract. If the Insurance Premium is paid in a currency other than the Contract currency, the Insurer shall have the right not to accept it or to deduct currency conversion and related costs from it.

6.4. When paying the Insurance Premium, the payment documents shall indicate the data required by the Insurer to properly identify the Insurance Premium and assign it to the Contract. The Policyholder shall be responsible for the payment of Insurance Premiums in accordance with the terms of the Contract.

6.5. The date of payment of the Insurance Premium shall be considered the date when the Insurer assigns the Insurance Premium credited to its bank account to the respective Contract. If the Insurer is unable to determine for which Contract the Insurance Premium has been paid, it shall be deemed unpaid until the Insurer identifies under which Contract the Insurance Premium has been paid and assigns it to the respective Contract.

WHAT WE INSURE AGAINST

7. INSURANCE OBJECT

7.1. Insurance object is the property interest of the Insured related to the health of the Insured and health care.

8. INSURANCE COVERAGE

8.1. The Policyholder is free to choose all or some Insurance Programs offered by the Insurer, their scope, other terms and conditions of the Contract. The Insured Risk assumed by the Insurer under the Contract will depend on this. By the agreement of the Policyholder and the Insurer, the Insured shall be provided with the Insurance Coverage the scope and limits of which are specified in the Insurance Certificate (Policy), annexes thereto, individual terms and conditions and the Insurance Rules.

8.2. Unless otherwise provided in the Contract, the Insurance Coverage under the Contract shall be valid only in the Republic of Lithuania, which means that Insurance Indemnities may be paid only for Health Care Services provided in the territory of Lithuania or other Insurable Events that occur in the territory of Lithuania.

8.3. The Insurance Coverage under the Contract shall take effect at 0:00 hours on the first day of the Insurance Period (unless the Contract stipulates that its entry into force depends on the date of payment of the first Insurance Premium or part thereof) and shall be valid until 24:00 hours on the last day of the Insurance Period or the day of termination or expiry of the Contract on other grounds.

8.4. The Insurer shall have the right to establish that the Insurance Coverage for the Insured comes into force provided only that the Card is activated and/or the consents, confirmations or other information, data or documents requested by the Insurer are submitted.

8.5. Insurance Coverage may be suspended in accordance with the procedure and conditions provided for in the Contract. If the Insurable Event occurs during the suspension of the Insurance Coverage, the Insurer shall not pay Insurance Indemnity.

9. INSURABLE EVENTS

9.1. For an event to be recognized as Insurable on, it must meet the following conditions:

9.1.1. The event must be provided for in the Contract and comply with the requirements and conditions set out therein, including the concepts and criteria provided for in each Health Insurance Program, which are defined in Annex No. 1 to the Insurance Rules, the parties may also agree on individual or special conditions;

9.1.2. With due consideration of the date of the Insurable Event, the event may occur after the entry into force of the Contract, during the Insurance Period, during the validity of the Insurance Coverage and within its limits;

9.1.3. if the event relates to the health care services provided in a health care institution, the medical specialist providing them shall act within the limits of the rights and competence established by applicable law and have a valid medical practice license issued by a competent state authority;

9.1.4. The event must exclusively and directly concern the Insured, and the costs (if applicable) related to the event must be borne by the Insured himself.

9.1.5. The event must be based on appropriate evidence and documents the form and content of which is acceptable to the Insurer.

9.2. Insurance indemnities shall be allocated for the payment or reimbursement of expenses incurred due to the Insurable Events provided for in the Contract and shall not exceed the Sum Insured specified in the Contract.

9.3. If the Insurable Event incurs continuous or partial expenses (for example, goods or aids are purchased by paying for them in instalments), then, depending on the date of the Insurable Event, in accordance with the procedure set in clause 1.1.16 of the Insurance Rules, in any case, only the expenses actually incurred during the Insurance Period may be reimbursed.

10. SUM INSURED

10.1. The Sum Insured shall be determined for each Health Insurance Program, for each Insured individually, unless otherwise provided in the Contract.

10.2. Upon payment of any Insurance Indemnity under the Contract, the respective Sum Insured shall be reduced by the amount of this Insurance Indemnity and the Sum Insured cannot be recovered.

WHAT WE DO NOT INSURE AGAINST

11. NON-PAYMENT OR REDUCTION OF INSURANCE INDEMNITIES

11.1. The Insurance Indemnities shall not be paid:

11.1.1. For Uninsurable Events which may be the same for all Health Insurance Programs or detailed separately for each of them;

11.1.2. For non-reimbursable expenses;

11.1.3. When the Insurable Event occurs during the period when the Insurance Coverage was suspended or was invalid on other grounds;

11.1.4. When the Insurer is released from paying the Insurance Indemnity in the cases specified in the Contract or applicable law.

11.2. The Insurer shall have the right to reduce the Insurance Indemnity or refuse to pay it in the following cases:

11.2.1. The obligations concerning the notification of the Insured Event as provided for in the Contract or by applicable law are breached or fulfilled improperly;

11.2.2. The date, circumstances and/or consequences of the Insurable Event, expenses incurred, other relevant data cannot be fully and accurately determined on the basis of the data or documents submitted by the person claiming the Insurance Indemnity or this person does not allow or hinders the investigation of the Insurable Event and obtaining the information required;

11.2.3. The Insurer was provided with fraudulent, erroneous, deliberately false or incomplete information or documents, or information that could affect the conclusion of the Contract, its terms or the Insured Risk was not disclosed to the Insurer, or other important information about the Health Care Services provided, the Health Disorder or other circumstances relevant to investigation or assessment of the Insurable Event was hidden;

11.2.4. The Contract was used for illegal purposes, including – for the purpose of obtaining profit or fraudulent receipt of Insurance Indemnity;

11.2.5. If the Insured is insured for the same risk under several insurance contracts concluded with different insurers (double insurance), then in case of the Insurable Event the Insurance Indemnity payable by the Insurer shall be reduced in proportion to the Insurer's share of liability. In any case, the total amount paid under all insurance contracts may not exceed the costs incurred by the Insured;

11.2.6. If the Insured refuses to undergo a medical examination when required by the Insurer in accordance with the procedure and conditions provided for in the Insurance Rules;

11.2.7. If the Policyholder or the Insured fails to perform the Contract or performs it improperly, which results in increase of the probability of the occurrence of the Insurable Event or increase of the loss/expenses to any extent;

11.2.8. In other cases and according to the procedure provided for and prescribed by the Contract and/or applicable law.

12. UNINSURABLE EVENTS

12.1. According to the Contract, any Health Insurance Program (unless otherwise stated in its description) shall treat the Health Disorders, as well as Health Care Services provided with regard to these disorders and other related diseases or conditions, other services or goods provided for in the Contract and any costs incurred, as Uninsurable Events if they are:

12.1.1. Related to a war and the state of emergency;

12.1.2. Related to Radiation, the use of chemical or biological substances for unpeaceful purposes;

12.1.3. Related to pandemics, as well as natural disasters, mass disasters caused by natural disasters;

12.1.4. Caused by the Insured's intentional injury or attempted suicide;

12.1.5. Arising from the unauthorized termination or change of the treatment prescribed by a doctor;

12.1.6. Incurred due to a planned or committed criminal act by the Insured or due to another act or omission contrary to law, morality and/or public order;

12.1.7. Caused by the intentional act or omission of the Policyholder or the Insured;

12.1.8. Caused or aggravated by the use of alcohol, narcotic, toxic or other dangerous substances, intoxication or other effects thereof.

UPON OCCURRENCE OF AN INSURABLE EVENT

13. NOTICE ON THE INSURABLE EVENT

13.1. The duty to inform of the Insurable Event falls on:

13.1.1. The Insured, if the Health Care Services or other services/goods provided for in the Contract are provided to the Insured by the Partner or any entity other than the Partner provided that the Insured does not use the Card for paying for them. In this case, the notice shall be submitted to the Insurer in writing or via the E-Help system.

13.1.2. The Partner if it provides the Insured with Health Care Services or other services/goods provided for in the Contract and the Insured uses the Card to pay for them in accordance with the procedure set by the Partner; In this case, the notice shall be submitted in accordance with the procedure provided for in the cooperation agreement between the Insurer and the Partner.

13.2. The notice on the Insurable Event must be submitted to the Insurer immediately upon learning of it, but in any case not later than within 30 (thirty) calendar days from the date of its occurrence.

13.3. Delayed submission of the notice on the Insurable Event shall be considered a material breach of the Contract, due to which the Insurer shall have the right to refuse to pay the Insurance Indemnity or reduce it.

14. INVESTIGATION OF THE INSURABLE EVENT

14.1. Upon receipt of the Notice on the possible Insurable Event, the Insurer shall carry out an investigation to identify the fact, causes, circumstances and consequences of the event and to determine the amount of the Insurance Indemnity.

14.2. The Policyholder, the Insured and the Beneficiary shall cooperate in investigation of circumstances of the event which can be acknowledged as the Insurable Event and guarantee that the Insurer could legally familiarize with the entire event-related information.

14.3. A person claiming to the Insurance Indemnity shall submit to the Insurer documents the form and wording of which is acceptable for the Insurer, which would acknowledge the possible Insurable Event and the circumstances and consequences thereof, as indicated in clause 15.1 or individually requested by the Insurer, and all other relative documents and information that have an effect on the assessment of the event or determination of the amount of the Insurance Indemnity.

14.4. The expenses related to the receipt and submission of supporting documents shall be borne by the person claiming for the Insurance Indemnity.

14.5. During investigation, the Insurer may request other natural persons and legal entities, competent institutions or organizations to submit information, explanations, documents and etc.

14.6. Upon receiving all required information, data, documents or other proofs, the Insurer shall valuate the circumstances of the event, the compliance thereof with the requirements of the Contract and shall make a decision on payment or non-payment of the Insurance Indemnity, the calculation of the Insurance Indemnity.

14.7. If during the investigation of the possible Insurable Event or, to justify the decision of the Insurer, the Insurer requires additional knowledge or an expert opinion with regard to any circumstances, facts or the assessment thereof, it shall be entitled to receive consultations, conclusions or opinions of professionals and experts in the specific field of knowledge. The expenses incidental to the provision of such services shall be borne by the Insurer.

14.8. If any disputes regarding assessment or decision of the Insurer arise between the parties to the Contract, the Insurer and the Policyholder or the Insured may agree upon investigation or assessment of the Insurable Event anew which would be performed by an independent expert (experts). The associated costs shall be borne by the initiator of the investigation/assessment, unless the parties agree otherwise. In this event, experts may not be the persons whose participation could cause the conflict of interests. Each party shall in writing provide an independent expert (experts) with all facts, data and documents which may have any influence on fair and reasonable assessment of the health condition of the Insured and/or other circumstances of the event and/or the amount of damage. Independent experts shall present their findings to all parties at the same time. Either party shall be entitled to disagree with the finding of the independent experts and apply to competent institutions and/or court for a resolution of the dispute in accordance with the procedure prescribed by applicable law

INSURANCE INDEMNITIES

15. CLAIM FOR THE INSURANCE INDEMNITY AND OTHER DOCUMENTS

15.1. The Insurable Event shall be investigated and the Insurance indemnity shall be paid after submission to the Insurer of the following documents the wording and form of which is acceptable to the Insurer:

15.1.1. The claim for payment of the Insurance Indemnity in the form set by the Insurer;

15.1.2. A document confirming the purchase of services and/or goods (an invoice) and document confirming payment (a cash receipt, a cash register receipt, a sales receipt, bank transfer statement, etc.);

15.1.3. Excerpts from medical documents or copies thereof, which reasonably indicate:

– The fact of the Insurable Event, the date and circumstances of the Insurable Event (e.g., a health disorder and the circumstances of its occurrence, course of development; objective condition of the Insured; prescribed examinations confirming the Health Disorder; results of performed tests, etc.);

– The code of a disease;

– Other information relevant to the proper and complete investigation of the Insurable Event or requested by the Insurer;

15.1.4. The prescription of a pharmaceutical or a medical aid, or other medical document or the copy thereof. For reimbursement from the Pharmaceuticals and Medical Aids sub-type of the Health Insurance Program, a prescription or other medical document is mandatory in all cases, regardless of whether a Pharmaceutical or a Medical Aid can be prescribed and purchased only with a prescription or over the counter. If a Pharmaceutical is purchased with an electronic prescription, the Insured shall:

– Make sure that the payment document contains information on the purchase of the relevant Pharmaceutical by an electronic prescription, or

– Provide the copy of such an electronic prescription or other medical document;

15.1.5. Copies of the individual activity certificate or business certificate of the person who provided the services (if services were provided by a person who is engaged in this business);

15.1.6. Consents or other documents or data required under the relevant Health Insurance Program;

15.1.7. Other documents, reasonably requested by the Insurer, proving the Insurable Event and its circumstances.

16. INSURANCE INDEMNITY

16.1. Once the Event is recognized as insurable one, the Insurer shall pay the Insurance Indemnity by reducing it by the Franchise amount and applying other restrictions for the calculation and/or payment of the Insurance Indemnity as provided for in the Contract.

16.2. The Insurance Indemnity shall be paid:

16.2.1. To the Partner in accordance with the procedure provided for in the Cooperation Agreement with the Partner, if the Partner provides the Insured with Health Care Services or other services/goods provided for in the Contract and the Insured pays for them by the Card in accordance with the procedure set by the Partner;

16.2.2. To the Insured, if the Health Care Services or other services/goods provided for in the Contract are provided to the Insured by the Partner or any entity other than the Partner, but the Insured does not use the Card for paying for them and pays by himself.

16.2.3. In the case provided for in clause 14.2.1.1 of Addendum No. 1 to the Insurance Rules – to the Insured.

16.3. The Insurance Indemnity shall be paid no later than within 30 (thirty) days from the date of receipt of all the information and/or documents in a form and wording acceptable to and requested by the Insurer, which are relevant to determination of the fact and circumstances and consequences of the Insurable Event and the amount of the Insurance Indemnity.

16.4. If the event is recognized as uninsurable one, the Insurer, within 30 (thirty) days from the date of receipt of all information relevant to determining the fact, circumstances and consequences of the event, shall inform about such decision and/or refusal to pay the Insurance Indemnity.

16.5. The Beneficiary shall immediately, but in any case not later than within 10 (ten) business days from the date of receipt of the respective Insurer's request, return to the Insurer the unreasonably paid Insurance Indemnities requested by the Insurer, including overpayments resulting from exceeding the Sums Insured.

16.6. The Insurer shall have the right to demand that a person claiming the Insurance Indemnity should open a bank account in his name with a bank or other credit institution operating in the Republic of Lithuania, to which the Insurance Indemnity could be transferred.

16.7. The Insurer shall have the right to deduct from the payable Insurance Indemnity the fees charged for a payment order (for example, currency conversion costs, fees for submission or execution of the payment order, etc.).

OTHER TERMS AND REQUIREMENTS

17. RIGHTS AND DUTIES OF THE PARTIES

17.1. Duties of the Policyholder:

17.1.1. To deliver to the Insurer or ensure that the Insured delivers detailed, complete and true information required for the conclusion and performance of the Contract;

17.1.2. Before entering into the Contract, to properly and diligently review the terms and conditions of the Contract, including the Insurance Rules;

17.1.3. To inform the Insured about the Contract concluded, amendments thereto or termination thereof, to properly and in detail familiarize the Insured with the terms and conditions of the Contract, including the Insurance Rules;

17.1.4. To pay the Insurance Premiums in accordance with the procedure and terms set in the Contract;

17.1.5. Being the main contact person of the Insurer, to ensure communication and cooperation with the Insured persons both during the conclusion and performance of the Contract, as well as when transmitting to the Insured persons the information related to the Contract, obtaining the necessary data or consents from the Insured persons, etc .;

17.1.6. To inform about the existing insurance contracts concluded with other insurers on the same Insured Risks that are included in the Contract concluded with the Insurer or, immediately within a reasonable time, to inform of new ones;

17.1.7. To take all possible actions to avoid or reduce the Insured Risk and follow the Insurer's instructions, if such are given to the Policyholder;

17.1.8. To immediately notify to Insurer increase of the Insured Risk or other circumstances that have a material impact on the terms and conditions of the Contract;

17.1.9. To provide the Insurer or its authorized representative with conditions for checking whether the Policyholder and the Insured follow the terms and conditions of the Contract;

17.1.10. Immediately, within a reasonable time from the occurrence or identification of relevant circumstances or facts, to inform the Insurer of any changes in the data, facts or circumstances provided to the Insurer at the time of concluding and/or amending the Contract, including but not limited to identification data (personal identification data, taxpayer data, data on the registration or legal status of a legal entity, information about the representative and his authorizations, etc.) and contact data (an address, a telephone number or an e-mail address);

17.1.11. Immediately, but in any case not later than within 1 (one) business day, to notify about termination of employment relationship with the Insured, to terminate the validity of the Insurance Coverage for such Insured and assume any losses incurred due to improper performance of this obligation. In this case, the Insurer shall terminate the validity of the Insurance Coverage for the Insured no later than on the next business day after receiving the relevant notice;

17.1.12. Properly and in a timely manner to perform all other duties and to follow all other conditions and requirements provided for in the Contract or by applicable law.

17.2. Duties of the Insured:

17.2.1. To diligently and thoroughly look through the terms and conditions of the Contract, including the Insurance Rules, and to follow them carefully and properly;

17.2.2. To provide the Insurer with the data, documents, consents, confirmations or other information requested by the Insurer and required for the conclusion and proper performance of the Contract, assessment of the Insured Risk or investigation of the Insurable Event;

17.2.3. On his own initiative and under his responsibility, in advance to negotiate and obtain the Insurer's consents or approvals for the provision of specific Health Care Services, if and when such are mandatory in accordance with the terms and conditions of the relevant Health Insurance Program;

17.2.4. To protect the Card from unauthorized use, damage or loss and be liable for any damage resulting from improper performance of this obligation;

17.2.5. Immediately, but in any case not later than within 1 (one) business day from the occurrence of the respective event, to inform the Insurer about the illegal use, loss, theft or any other loss of the Card;

17.2.6. When and as required by the terms and conditions of the Contract, to inform the Insurer of the Insurable Event and provide detailed and true information about the causes and circumstances of the Insurable Event and all related data, information and documents specified in the Contract;

17.2.7. To keep documents confirming the Insurable Event for at least 1 (one) year from the payment of the Insurance Indemnity, if only copies thereof have been submitted to the Insurer, and to deliver them upon the Insurer's request;

17.2.8. At the request of the Insurer, in the cases and according to the procedure provided for in the Contract, to undergo a health examination in the institution indicated by the Insurer;

17.2.9. At the request of the Insurer, in accordance with the procedure and terms provided for in the Contract, to refund to the Insurer the unreasonably paid Insurance Indemnities, including overpayments resulting from exceeding the Sums Insured;

17.2.10. Immediately, within a reasonable time from the occurrence or identification of relevant circumstances or facts, to inform the Insurer of any changes in data, facts or circumstances provided to the Insurer, including but not limited to identification data (personal identity data, etc.) and contact details (an address, a telephone number or an e-mail address);

17.2.11. Properly and in a timely manner to perform all other duties and to follow all other conditions and requirements provided for in the Contract or by applicable law.

17.3. Duties of the Insurer

17.3.1. To provide information about the Insurer, insurance services, dispute resolution procedures and essential information in the cases and in accordance with the procedure established by applicable law and the Contract;

17.3.2. Upon concluding the Contract, to issue the Insurance Certificate (Policy) to the Policyholder and the Cards assigned to each Insured or other document confirming the provision of Insurance Coverage under the Contract;

17.3.3. To provide information and advice on Health Insurance Programs;

17.3.4. Upon the occurrence of the Insurable Event, to pay the Insurance Indemnities under the terms and conditions provided for in the Contract;

17.3.5. Not to disclose confidential information about the Policyholder and/or the Insured received during the performance of the Contract unless otherwise provided for by the Contract and applicable law;

17.3.6. To issue to the Policyholder the copies of the Contract, if after concluding the Contract the Policyholder applies to the Insurer with such a request;

17.3.7. Properly and in a timely manner to perform all other duties and to follow all other conditions and requirements provided for in the Contract or by applicable law.

17.4. The Insurer shall have the right to establish and change the list of Partners, the conditions of cooperation with the Partner, requirements or restrictions regarding the provision of all or specific Health Care Services to Clients. In any case, the Partners shall not be authorized to interpret the terms of the Contract or to perform the obligations of the Insurer or the Client under the Contract.

17.5. Other rights of the parties are provided for in the Contract and by applicable law.

18. AMENDMENT OF THE INSURANCE CONTRACT

18.1. General provisions

18.1.1. The terms and conditions of the Contract may only be amended or supplemented by a written agreement between the Policyholder and the Insurer unless other clauses of the Contract or applicable law provides otherwise.

18.1.2. Before amending the terms of the Contract, the Insurer shall have the right to request additional information about the Client, the Insured's medical examination and etc.

18.2. Amendments to the Contract upon the initiative of the Policyholder

18.2.1. The Policyholder shall give to the Insurer a written notice on the desired amendment to the terms and conditions of the Contract not later than 30 (thirty) days prior to the effective date of the desired amendment.

18.2.2. Amendments to the list of Insured persons (termination of the Contract with respect to some Insured persons and/or inclusion of new Insured persons) shall be made with the consent of the Insurer and on terms and conditions agreed by both parties.

18.3. Amendments to the Contract upon the initiative of the Insurer

18.3.1. The right of the Insurer to amend the terms and conditions of the Contract is provided for in the Contract and by applicable law.

19. SUSPENSION AND RENEWAL OF INSURANCE COVERAGE

19.1. If the Policyholder fails to pay any Premium in full or in part within the time specified in the Contract, the Insurer shall have the right to notify this to the Policyholder in writing or in any other notification manner and indicate that, if the Policyholder fails to pay the Premium in full or in part within 30 (thirty) days from the date of dispatch of the notice, the Insurance Coverage under the Contract will be suspended and resumed only after the Policyholder pays all the Insurance Premiums due under the Contract.

19.2. If the suspension of the Insurance Coverage due to non-payment of the Insurance Premium lasts for more than 1 (one) month, the Insurer shall have the right to unilaterally terminate the Contract by giving to the Policyholder a written notice on termination of the Contract.

19.3. In case of circumstances when the Card is used by an unauthorized person or the Card is lost, the Insurer shall have the right to temporarily (until the violation is eliminated, the said circumstances are investigated or the proper discharge of obligations under the Contract is ensured otherwise, etc.) suspend the validity of Insurance Coverage to the respective Insured.

20. CONTRACT TERMINATION

20.1. Procedure for termination or expiration of the Contract

20.1.1. The Contract may be terminated upon a separate written agreement of the parties, written request of the Policyholder, court judgment or the Insurer's notice in cases and under procedure laid down in the Contract and/or the applicable law.

20.1.2. Upon termination or premature expiry of the Contract before the end of the Insurance Period on other grounds, the Insurer shall always preserve the right to the Insurance Premiums due but not paid before the respective termination or expiration of the Contract, as well as to the amounts that are formed as the difference between the Insurance Indemnities actually paid and the Insurance Premiums actually received (when the Contract provides for periodic payment of Insurance Premiums). The Policyholder must cover them no later than before the last day of the Contract validity.

20.1.3. Unless otherwise provided in the Contract, as well as in the Insurance Rules or applicable law, upon termination or expiry of the Contract before the end of the Insurance Period on other grounds, the Insurance Premiums paid shall not be refunded to the Policyholder.

20.2. Contract termination upon the initiative of the Policyholder

20.2.1. The Policyholder shall be entitled to terminate the Contract at any time during the Contract validity term, by giving to the Insurer a written notice no later than 30 (thirty) days prior to the planned date of the Contract termination.

20.2.2. If the Contract is terminated upon the initiative of the Policyholder due to the fault of the Insurer, the Policyholder shall be reimbursed the share of the Insurance Premiums paid by the Policyholder, which exceeds the amount of the Insurance Indemnities already paid and planned to be paid under the Contract.

20.2.3. If the Contract is terminated upon the initiative of the Policyholder through no fault of the Insurer, the Policyholder shall be reimbursed the Insurance Premiums actually paid for the remaining Insurance Period from the date of termination of the Contract less the costs of concluding and performing the Contract and the Insurance Indemnities paid and planned to be paid under the Contract. The amount payable shall be calculated 30 (thirty) days after the date of termination of the respective Contract and shall be paid within following 30 (thirty) days.

20.3. Contract termination upon the initiative of the Insurer

20.3.1. The Insurer shall have the right to terminate the Contract unilaterally, without recourse to court, by giving prior 30 (thirty) calendar days written notice before the expected date of termination of the Contract in case of the following material breaches of the Contract:

20.3.1.1. During the conclusion or validity of the Contract, the Policyholder and/or the Insured violates or improperly performs the established by applicable law duty to disclose full, complete, true and detailed information on circumstances affecting the Insured Risk assessment, the probability of the Insurable Event or its possible consequences and the terms and conditions of the Contract;

20.3.1.2. The Policyholder and/or the Insured fails to perform or improperly performs other obligations provided for in the Contract and, upon the Insurer's request, does not remedy the situation within the reasonable term set by the Insurer, which in any case may not be shorter than 14 (fourteen) calendar days;

20.3.1.3. There are other grounds for termination of the Contract provided for in the Contract or applicable law.

20.3.2. The Insurer shall have the right to terminate the Contract unilaterally, without recourse to court, by giving a written notice with an immediate effect (unless such a notice specifies other terms of entry into force) in case of the following material breaches of the Contract:

20.3.2.1. if the Policyholder delays payment of the Insurance Premium in full or in part within the time specified in the Contract and upon the receipt of the Insurer's notice with a request to cover the indebtedness within 30 (thirty) days from the dispatch of the notice, the Policyholder fails to effect all overdue payments within the specified term;

20.3.2.2. On the grounds and in accordance with the procedure provided for in clause 19.2 of the Insurance Rules;

20.3.2.3. The Policyholder does not respond to the submitted proposal to amend the terms and conditions of the Contract in accordance with the procedure established by applicable law or the Contract or refuses to do so;

20.3.2.4. There are other grounds for termination of the Contract provided for in the Contract or applicable law.

20.3.3. When the Contract is terminated at the request of the Insurer due to the fact that the Policyholder violates the terms and conditions of the Contract, no Insurance Premiums shall be refunded to the Policyholder.

20.4. Contract Termination upon Agreement of the Parties

20.4.1. The Insurer and the Policyholder may agree under a separate written agreement on other conditions and procedure of the Contract termination.

21. TRANSFER OF CONTRACTUAL RIGHTS AND OBLIGATIONS

21.1. Transfer of the Insurer's contractual rights and obligations

21.1.1. The Insurer shall be entitled to transfer the contractual rights and obligations to other insurer or insurers upon notifying such an intention and receiving a permit from a competent supervisory institution in events and under the procedure laid down by applicable law.

21.1.2. In the cases specified in the applicable law, the Insurer shall publish the intention to transfer its contractual rights and obligations at least in 2 (two) national newspapers and give the Policyholder at least 2 (two) month period to object to the Insurer with regard to respective intentions.

21.1.3. Within the terms specified in the relevant published notice, the Policyholder shall have the right to give to the Insurer a written notice of objection to the intended transfer of the Insurer's contractual rights and obligations.

21.1.4. If the Policyholder does not agree with the transfer of contractual rights and obligations and the change of the Insurer, it shall have the right to terminate the Contract within 1 (one) month from the date of transfer of contractual rights and obligations. In this case, the Policyholder shall be reimbursed the Insurance Premiums actually paid for the remaining Insurance Period from the date of termination of the Contract less the costs of concluding and performing the Contract and the Insurance Indemnities paid and planned to be paid under the Contract.

21.2. Transfer of the Policyholder's contractual rights and obligations

21.2.1. The Policyholder shall have no right to transfer its contractual rights and/or obligations to other persons unless the Insurer gives its prior written consent thereto.

22. NOTICES

22.1. All notices, applications or any other expression of will between the Insurer and the Client shall be executed in writing or in a manner equivalent to a written form and shall be delivered personally under signature, by regular mail, via the E-Help system or by e-mail according to the respective contact details indicated in the Contract or the latest contact details delivered to the other party for such a purpose.

22.2. The Client's notices to the Insurer shall be sent according to the Insurer's contact details and shall be deemed to be received upon their actual receipt. The Insurer's agents shall not be entitled to accept any notices on behalf of the Insurer.

22.3. Any written notice of the Insurer to the Client shall be deemed to be received, respective notification obligation of the party shall be deemed to be fulfilled and counting of the related terms shall start under the below indicated order and terms:

22.3.1. On the 5th (fifth) calendar day after its sending by registered mail;

22.3.2. On the day of sending via the E-Help System. If the notice is sent in this manner on a weekend or public holiday or after the expiry of working hours, it shall be deemed to be received on the next working day;

22.3.3. When delivering personally under signature – on the day when the receiver receives the notice delivered to him and signs that he received it.

22.4. A party shall not be entitled to make any claims regarding not receiving any notices or that the actions of the other party do not comply with the Contract terms and conditions, if the notice was sent according to the latest contact details provided by a party.

22.5. In cases and under the procedure laid down in the Contract and/or applicable law or in other exceptional cases, the Insurer shall be entitled to provide notices or essential information to the Clients publicly: in the Insurer's Client Service Divisions, on the Insurer's website and/or via mass media. In such cases the notices shall be deemed to be received on the date of their publishing.

23. CONFIDENTIALITY

23.1. The Contract terms and conditions and all the information received by the parties during performance of the Contract shall be deemed to be confidential and not publicly announced to any third parties without prior written consent of the concerned contractual party, except for disclosure of respective information to the extent required provided that the further protection of respective information is maintained:

23.1.1. To persons who lodged legitimate claims under the Contract;

23.1.2. When such information is public (except for cases when it becomes public due to the breach of the Contract);

23.1.3. To persons, providing audit services and performing the audit of the party's activities or financial statements under the Contract;

23.1.4. To attorneys at law who provide legal services related to the Contract, to any Party;

23.1.5. To shareholders/stakeholders and/or parent and/or subsidiary companies of the Party;

23.1.6. To expected legal successor or property acquirer of the Parties;

23.1.7. To persons who provide to the Insurer services related to the Contract conclusion, performance, accounting, administration or storage;

23.1.8. To a re-insurer if the Insured Risk is subject to re-insurance under the Contract;

23.1.9. To competent public authorities, including courts, law enforcement authorities, the State Tax Inspectorate and etc.;

23.1.10. To the distributor of the insurance product who mediated in concluding the Contract;

23.1.11. In other mandatory events provided for by the Contract and/or applicable law.

24. RESPONSIBILITY

24.1. The parties undertake to perform all obligations set out in the Contract in a due and timely manner, in good will and cooperation, carefully and according to the established good practice.

24.2. For delayed performance of the contractual monetary liabilities, the Insurer shall pay to the Policyholder the late payment interest amounting to 0.02% of the outstanding amount for each delayed day until due performance of monetary liabilities.

24.3. The Insurer shall not be liable for any losses incurred due to the Contract termination on the grounds set out in the Contract or applicable law.

24.4. The Insurer shall not be liable for the inability to use the Card as intended if this is caused by technical malfunctions. The Insurer shall eliminate such malfunctions within a reasonable time if they occur due to the fault of the Insurer.

25. APPLICABLE LAW, PROCEDURE OF DISPUTE SETTLEMENT

25.1. The Contract, its conclusion and interpretation shall be subject to the law of the Republic of Lithuania.

25.2. All and any disputes, disagreements or claims between the Insurer the Client, arising out of or related to the Contract shall be settled in a way of negotiations and in accordance with the procedure for examination and management of complaints established by the Insurer and published on its website www.compensalife.lt.

25.3. On request of a concerned party, disputes may be resolved in accordance with the procedure of amicable consideration and settlement of disputes established by applicable law. The Bank of Lithuania was provided with a competence to solve disputes between consumers and financial market players arising out of provision of financial services, in accordance with the procedure prescribed by the Bank of Lithuania. For more information see the address of the Supervision Service of the Bank of Lithuania and other contact details on the website: www.lb.lt.

25.4. In any case, if the parties fail to agree, such disputes shall be settled in competent court under the procedure prescribed by law of the Republic of Lithuania.

26. MISCELLANEOUS

26.1. The Insurer shall not provide the Insurance Coverage under the Contract and shall not be liable for paying the Insurance Indemnity or any other amount under the Contract or complying with any other contractual obligations if these acts could result in violation by the Insurer of any International Sanction. The Insurer shall not be liable for any claims or damages arising from the foregoing.

26.2. If at any time it becomes apparent that any provisions of the Contract are or become invalid, illegal or unenforceable, this shall in no way affect or invalidate the remaining provisions of the Contract, and such improper provisions shall be immediately replaced by written agreement of the parties with new ones that have the closest meaning, objectives, content and the same economic effect.