INSURANCE PLAN

MEDICAL ASSISTANCE

1st EURO

CONTRACT NO: MGENIB1100305SNN/042

2025-12-01 NP. DP76-60

Permanent Representation of Lithuania to the European Union

Between "The Policyholder",
Permanent Representation of Lithuania to the European Union
41-43 rue Belliard,
1040 Brussels
BELGIUM

On the one hand,

And "the Insurer",

MGEN, registered under the number SIREN 775 685 399,
regulated by the provisions of Tome II of *Code de la mutualité* and whose head office is located at 3 square Max-Hymans 75 748 PARIS CEDEX 15, France.

Represented by Mr `n his capacity as *Directeur Général (*CEO) and who declares that he has full power to conclude this contract.

On the other hand,

agree, effective May 1st, 2027, of the following provisions forming this group insurance agreement, hereinafter referred to as the "Contract":

Intermediated by Intermediated by: CARPS International, 168, rue de Grenelle, 75007 Paris, France, SIREN number 848141743 and registered with ORIAS under number 19001745

You have subscribed a Medical insurance plan for your Diplomatic personnel. The purpose of the plan is to reimburse from the first euro (EUR) the eligible medical expenses with reference to *Sécurité sociale* (the French universal healthcare program).

The Policyholder has designated ***CARPS International, 168, rue de Grenelle, 75007 Paris, France*** (registered with ORIAS under number 19001745), for the execution of its marketing and distribution activities, for the administration services.

The deriving rights and obligations,

- for yourself, hereinafter referred to as "The Policyholder",
- For your Diplomatic personnel, referred individually as a "Member",
- For MGEN, referred to as the "Insurer".

are set out in this Contract governed by the French law, and specifically by the provisions of *Livre II* of the French *Code de la Mutualité*.

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SECTION 1 - PURPOSE AND BASES OF THE CONTRACT

Article 1. PURPOSE OF THE GROUP CONTRACT

The purpose of this compulsory group insurance Contract is to provide benefits for the Diplomatic personnel of the Policyholder for reimbursements of medical expenses with reference to *Sécurité sociale* (the French universal Healthcare program).

It is subscribed with MGEN, collectively referred to as the "Insurer". This contract is regulated by *branche 2 – Maladie* (illness branch) and *branche 18 - Assistance* and *branche 20* - décès (Life branch) in accordance with article R.211-2 of the *Code la Mutualité* and by *Livre II* (Part II) of the said *Code* and any relevant French legislation in force.

The declarations of both the Policyholder and the Members shall serve as a basis for the purpose of this contract.
The contract is supplemented by an information notice provided to the Policyholder by the Insurer and which specifies in particular the benefits, the terms of their enforcement and the formalities to be completed in the event of a claim.

The aim of the contract is to insure all the eligible diplomatic staff (Diplomatic personnel as defined below) of the Policyholder.

Members have access to the content of the MGEN Statutes through the following website http://www.mgen.fr. In the event of a conflict of interpretation between this Contract and the provisions of the statutes of MGEN, the provisions of the Contract will prevail.

Article 2. START, DURATION AND RENEWAL OF THE CONTRACT

The Enrolment to the insurance is confirmed by this signed Contract between the Policyholder and the Insurer with the following information:

- contract number,
- effective date of the insurance,
- subscribing category,
- covered persons,
- area of cover,
- type and levels of benefits,
- premium amounts and payment modes,
- specific provisions if any.

The contract will be effective as of May 1st, 2027, for a period ending on December 31, 2028.

It is then renewed by tacit renewal each January 1st for a term of one year, unless terminated by one of the parties by means of a registered letter with acknowledgement of receipt, sent on or before the preceding October 31st.

The contract may be terminated at the initiative of the Insurer:

- at any time when the number of Insured Persons no longer represents the entire category of Diplomatic personnel as defined above,
- in the event of non-payment of premiums, according to the terms defined in the Contract.

The Insurer shall however guarantee the reimbursement of incurred expenses or approved treatments before the termination of the Contract.

Article 3. POLICYHOLDER'S OBLIGATIONS

The Policyholder undertakes:

- to enrol to the insurance, all existing and future Members who belong to the category of Diplomatic personnel as defined in this contract and declared as such to the Insurer, and for all the benefits of the Contract.

- to provide the following documents to the Insurer: a membership form signed by the Policyholder mentioning the category of Diplomatic personnel to be insured and declared as such to the Insurer, the level of benefits opted for and the premium rates.

The Policyholder must also provide:

- the list containing the names of the Members who belong to the category to be insured (Diplomatic personnel) and declared as such to the Insurer, and stipulating which of them:
  - are on work incapacitation or disability, as a result of an illness or an Accident and who are recipients of benefits in this regard,
  - have their employment contract suspended,
  - are on therapeutic part-time or on maternity/paternity leave,
- the individual enrolment form for each Member belonging to the category to be insured, whether they are present at work or on leave.

ANY INFORMATION PROVIDED BY A MEMBER OR ONE OF HIS/HER DEPENDANTS AND WHICH WILL TURN OUT TO BE ERRONEOUS, FALSIFIED, EXAGGERATED, OR ANY OTHER FRAUDULENT OR WRONGFUL ACTION FROM THEIR PART WILL RESULT IN THE DIRECT RESPONSIBILITY OF THE MEMBER AND THE RECOVERY OF SUMS PAID BY THE INSURER ON THE BASIS OF THIS INCORRECT DATA.

Membership is deemed to have been accepted by the Insurer on the day the Policyholder sends the documents which form part of the Contract.

The Policyholder delivers to the Insurer individual enrolment forms for eligible new Members **within 15 days of their starting date or their nomination (in case of a change of category).** If this timeframe is not respected, the enrolment will only be effective from the day of reception by the Insurer of the relevant documents, even if premiums have already been paid by the Policyholder on behalf of this Member.

Within 15 days of the beginning of each quarter: the Policyholder proceeds to premium payment according to article 23, along with the changes – if any - that have occurred in:

- the composition of the group category, with indication of the dates of entry/exit and the reason for departure (i.e return to the home country, long-term illness or other, retirement or early retirement, dismissal, resignation),
- the change of country of expatriation or residence,

- the family status,
- the address or Company name of the Policyholder or one of its subsidiaries.

At each annual renewal and, at the latest, on January 31st of the following financial year, the annual adjustment bordereau, mentioning the Insured Persons during the past financial year and which includes the dates of entry and exit of the Diplomatic personnel.

The Policyholder is also required:

- to provide each Member with the information notice summarizing the benefits, their implementation conditions and the formalities to perform in the event of a claim.
- to inform the Members in writing of the modifications to be made to their rights and obligations under the Contract such as reduction in benefits, premium amount modification or termination of membership.
- to inform all existing or future Members and their beneficiaries if applicable of their rights with regards to protection of personal data in accordance with Regulation (EU) 2016/679 of April 27, 2016 on the protection of natural persons with regard to the processing of personal data and the free movement of such data (known as the General Data Protection Regulation).

Non-compliance with the above obligations holds the liability of the Policyholder in respect of its Diplomatic personnel. The Policyholder agrees to document upon request and at any time the declarations made to the Insurer.

Article 4. GLOBALISATION OF RESULTS

For each calendar year and for all the policies of the same type to which this policy belongs, the Insurer shall draw up joint operating accounts according to the resources and expenses allocated to them.

Article 5. REVISIONS

The conditions of the contract take into account any relevant legislation in force on the effective date of the contract. However, should the legislation be modified, the Insurer reserves the right to revise the contract as soon as possible from the effective date of the new provisions.

The Policyholder nevertheless has the possibility of requesting, within thirty (30) days, the termination of the contract without notice. The termination will take effect on the first day of the calendar month following the request of the Policyholder or from the date of the legislation modifications if at a later date.

In this latter case, all benefits and premium amounts are maintained until the termination date regardless of the proposed modifications.

Article 6. STATUTE OF LIMITATIONS

All actions deriving from this Contract are limited to two years after the event giving rise to them. However, this two years limit shall start:

- **in the event of reticence, omission, false or inaccurate statement as to the risk incurred from the Member, as of the day on which the Insurer was informed of it**
- **in the event of an occurred risk, as of the day or the interested parties have been informed about it, if they can prove that they have ignored it until then.**

When the cause of the action by any Insured Person against the Insurer is third-party recourse, the time limit for the limitation only begins on the date this third-party initiates legal action against the Insured Person or has been compensated by the Insured Person.

Time limit is interrupted by one of the ordinary causes of interruption of statute of limitations (namely in particular the legal claim and recognition of the Insured Person's rights by the Insurer) and by the appointment of experts following the occurrence of a risk. The interruption of the limitation period for the action may also result from the mailing out of a registered letter with acknowledgment of receipt by the Insurer to the Member for the purpose of payment recovery, and by the Member or his Dependants to the Insurer for a claim settlement.

The limitation is extended to ten years for life insurance policies when the beneficiary is a person distinct from the policyholder, in insurance policies covering personal accidents, when the beneficiaries are the Dependants of the deceased insured party.

Prescription can be interrupted by the ordinary causes of interruption of limitation:

- **acknowledgement from the debtor of the rights of the creditor,**
- **legal action,**
- **A protective measure for enforcement or forced enforcement taken in application of the *Code de procédure civile*,**
- **The interpellation made to one of the joint debtors by a legal action or by an act of forced enforcement or the acknowledgement by the debtor of the rights of the creditor,**
- **The interpellation made to the principal debtor or its recognition for the cases of limitation applicable to deposits.**

Article 7. SUBROGATION

The Insurer will be subrogated to the rights of an Insured Person who is victim of an Accident in its action against the responsible third party, whether the third party's responsibility is whole or shared.

If the Insured Person has been directly compensated by the third party, the Insurer will request the recovery of the paid benefits if any.

Should an Insured Person makes the recovery impossible, whether by negligence or voluntary abandonment, this Insured Person will be obliged to reimburse the received amounts.

Article 8. PERSONAL DATA PROTECTION

In accordance with the Regulations (EU) 2016/679 of 27 April 2016 on the protection of individuals concerning the processing of personal data and on the free movement of such data (known as General Data Protection Regulation) and for the purpose of the management of the insurance contract, the personal data of the Insured Person may be transferred to the Insurer and to its delegates, service providers, subcontractors or reinsurers. Members are informed that processes concerning them, and their Dependants if any, are implemented for the signing, management and execution of this insurance contract along its commercial management. Personal data may also be used for control operations, fight against fraud and money laundering and the financing of terrorism, search for beneficiaries of

unpaid Life contracts, the implementation of legal and regulatory provisions, with respect of the enforcement of this contract.

Collected Data are indispensable for the implementation of these processing and are intended for the relevant departments of the Insurer and its outsourced Administrators as well as, where applicable, its subcontractors, providers or partners. The Insurer is liable to ensure that this data is accurate, complete and up to date when necessary. The data collected will be kept for the entire duration of the Contract which may be increased by legal prescriptions or in order to be compliant with the durations provided for by the CNIL *Commission Nationale de l'Informatique et des Libertés* (National Commission for Data Protection).

These personal data may be transferred to service providers or subcontractors which are established in countries outside of the European Union. These transfers may only involve countries recognized by the European Commission for having a satisfying level of protection of personal data, and recipients of the data must justify appropriate guarantees.

Members and/or Dependants have a right of access, rectification or deletion, limitation of the processing of their data, portability, opposition to processing, along with the right to provide instructions on the outcome of the data after their death. They can exercise their rights towards the ***Délégué à la Protection des Données de MGEN*** **(Data Protection Officer of MGEN**, 3 Square Max Hymans 75 748 PARIS CEDEX 15 **or at** dpo@vyv-ib.com. When exercising their rights, an identity document may be requested. In the event of a persistent conflict, they have the right to appeal to the CNIL on www.cnil.fr or at 3, place de Fontenoy - TSA 80715 - 75334 PARIS CEDEX 7, FRANCE.

Data related to medical information on the Members may be exploited for the conclusion, the management and the execution of the contract, as their processing is necessary in order to fulfil the obligations and to exercise the rights of the Insurer or the rights of the Members to social protection. These data are exclusively intended for the medical service of the outsourced Administrator. The exercise of rights is carried out by mail, along with an identity document, to the medical advisor of medical@vyv-ib.com.

Article 9. ADMINISTRATIVE AGREEMENT

A separate administrative agreement between the Insurer and *CARPS International, 168, rue de Grenelle, 75007 Paris, France* (ORIAS under number 19001745) is established.

It specifies the operations related to the Contract that the Insurer delegates to CARPS INTERNATIONAL, and precisely the obligations of the Administrator towards the Insurer with respect to risk acceptance, collection and administration of premiums, administration of medical benefits and production of statistics.

Article 10. CONTROL AUTHORITY

The Insurer's control body is *Autorité de Contrôle Prudentiel et de Résolution*, 4 place de Budapest 75436 PARIS CEDEX 09 FRANCE.

Article 11. SETTLEMENT OF DISPUTES AND ARBITRATION

The parties agree to meet each other in case of any dispute, litigation, contention or claim that may arise between them, and in order to do everything in their powers to reach an amicable settlement. Any dispute related to the interpretation or the execution of this Contract and which cannot be settled by mutual agreement, will be under the jurisdiction of the competent jurisdiction in Paris.

Article 12. INFORMATION - COMPLAINTS - MEDIATION

When Members or any Dependant wish to obtain details, they should contact **CARPS International, 168, rue de Grenelle, 75007 Paris, France – email: info@carps.fr** for any request or complaint related to:

- insurance enrolment conditions
- premium payments
- claims

It will be acknowledged receipt of the complaint within 10 days of its receipt, unless the matter is answered within this period. In any case and in accordance with the applicable law, a response will be sent before the expiry of a period of 2 months from the date of receipt of the complaint.

If the complaint has not been settled after the response, the Member or the Dependants may contact customer service - along with copies of the written responses made to them - at the following address: MGEN - Service Relations Clientèle, 3 Square Max Hymans 75 748 PARIS CEDEX 15 Email : clients@vyv-ib.com.

If all complaints handling procedures are exhausted, the claimant may contact the MGEN ombudsman by regular mail: **MED CONSO DEV - Médiation Consommation Développement, Centre d'Affaires Stéphanois SAS, Immeuble l'HORIZON - Esplanade de France - 3, rue J. Constant Milleret 42 000 Saint-Etienne Or on the website : https://www.medconsodev.eu/**

The Ombudsman's opinion is not binding and the parties can still proceed in the competent courts. The Ombudsman is not empowered to adjudicate on the conditions for admission to insurance. The terms and conditions of the Ombudsman interventions can be found on the dedicated website for mediation on: https://www.medconsodev.eu/

Article 13. LANGUAGE AND JURIDICTION

The competent courts are the courts of France.

Article 14. LIMITATION PROVISION

Should there be any risk of sanction, prohibition or restriction under United Nations resolutions regarding economic or commercial sanctions, or under the laws and regulations of the European Union, the United States of America or any other jurisdiction, the Insurer will not be held liable for the coverage of an insurance benefit, nor for the settlement of a claim or the implementation of services.

Article 15. MISREPRESENTATION

REGARDLESS OF THE ORDINARY CAUSES OF NULLITY, ANY RELUCTANCE OR INTENTIONAL FALSE STATEMENT FROM THE POLICYHOLDER SHALL HAVE FOR CONSEQUENCE THE NULLITY OF THE CONTRACT (ART. L.221-14 OF *CODE DE LA MUTUALITE*), IF THIS RELUCTANCE OR FALSE

DECLARATION CHANGES THE NATURE OF THE RISK OR REDUCES THE EVALUATION FOR THE INSURER, AND EVEN IF THE OMITTED OR DENATURED RISK BY THE MEMBER HAS NO INFLUENCE ON ITS REALIZATION.

ANY RELUCTANCE OR INTENTIONAL FALSE STATEMENT FROM THE POLICYHOLDER LEADS TO THE ENFORCEMENT OF THE SANCTIONS AS DESCRIBED IN ART. L. 221-14 OF *CODE DE LA MUTUALITE* : THE INSURER IS STILL ENTITLED TO COLLECT DUE PREMIUMS AS A COMPENSATION; THE MEMBER MUST REIMBURSE ANY BENEFIT PAID IN THE EVENT OF CLAIMS UNDER ITS CONTRACT.

FOR OPTIONAL INDIVIDUAL AND COLLECTIVE COVERS, THE OMISSION OR INEXACT DECLARATION OF THE MEMBER FROM WHOM BAD FAITH IS NOT ESTABLISHED DO NOT VOID THE BENEFITS PROVIDED IN THE ENROLMENT FORM OR IN THE GROUP CONTRACT (ART. L.221-5 OF *CODE DE LA MUTUALITE*).

IF THE DELIBERATE OMISSION OR FALSE DECLARATION IS DETECTED BEFORE ANY CLAIM, THE INSURER MAY DECIDE TO MAINTAIN THE ENROLMENT SUBJECT TO A PREMIUM INCREASE THAT MUST BE ACCEPTED BY THE POLICYHOLDER. IN DEFAULT OF ACCEPTANCE THEREOF, THE MEMBERSHIP OR THE CONTRACT ENDS 10 DAYS AFTER NOTIFICATION ADDRESSED TO THE MEMBER BY REGISTERED LETTER. THE INSURER MUST REFUND THE PORTION OF PREMIUM PAID FOR THE PERIOD WHICH IS NOT COVERED ANYMORE (ART. L.221-15 OF *CODE DE LA MUTUALITE*).

IF THE DELIBERATE OMISSION OR FALSE DECLARATION IS DISCOVERED AFTER THE REALIZATION OF THE RISK, THE BENEFITS ARE REDUCED IN PROPORTION OF THE PAID PREMIUMS AND THAT WHAT SHOULD HAVE BEEN COLLECTED IF THE DECLARATION OF THE MEMBER WOULD HAVE BEEN ACCURATE.

SECTION 2 - THE INSURED PERSONS

Article 16. ELIGIBLE PERSONS

All of the eligible Members of the Policyholder should be enrolled to this Contract.

Eligible Members are the Diplomatic personnel of the Policyholder.

The Members of the category of Diplomatic personnel to be insured must, at the time of their enrolment, complete and sign an individual enrolment form provided by the Insurer, mentioning - if any - their Dependants.

The Insurer may request the production of any additional information it deems necessary for the enrolment of the Dependants.

Article 17. DEPENDANTS

Are eligible for the medical care plan described in the Contract:

- the Member and her/his Dependant (s)

The following persons may be designated as Dependants:

- the Spouse: husband or wife of the employee who is neither divorced nor legally separated,
- the partner who concluded a *Pacte civil de solidarité* with the employee, aimed at organizing their common life according to article 515-1 of French *Code civil*, or any equivalent partnership agreement concluded under another legislation
- or in the absence of a Spouse or Partner, a cohabitant can be designated as Dependant

A cohabitant is defined as the person living with the Member and fulfilling together the following two cumulative conditions:

- they are both free of any former marriage or partnership agreement bond,
- cohabitation must be declared by the Member upon enrolment, along with a cohabitation certificate or proof of residency mentioning both names and a sworn statement that they live together. The certificate must be in force and legally recognized by a competent authority in the country of cohabitation. Termination of cohabitation must be declared in writing by the Member. Only one person can be enrolled as a cohabitant.

- The Child(ren) of the Member or Child(ren) of the spouse/partner/cohabitant as defined above and under the following conditions:

  - under the age of 18, provided they are financially dependent of the Member,

  - physically or mentally disabled, regardless of their age (proof of disability must be regularly provided to the Insurer) and if they meet the following cumulative conditions: not being employed or not to benefit from their own resources due to their work and be financially dependent of the Member.

A certificate of education will be requested on behalf of Dependants in higher education and will be forwarded to the Administrator upon enrolment and for each consecutive academic year thereafter.

If the Member does not fall within the French tax system, the quality of dependent child as defined above will be assessed according to the French legislation.

Dependants must be registered on the individual enrolment form in order to qualify for the Contract. Benefits cease for any Dependant from the moment they no longer fulfil the above conditions and in any event on the same date of the Member. Any change of situation must be brought to the attention of the Insurer, via the Administrator if any.

The benefits under the contract are provided only for the period during which the Dependant belongs to the category. However, in the event of the death of the Member, the benefits are maintained free of charge for the Dependants and for a period of one month.

Article 18. EFFECTIVE DATE OF THE BENEFITS

When the contract takes effect, the benefits start for each Member on the following dates:

Enrolled personnel at the date of commencement of the contract:

- **on the very same date.**

Eligible personnel enrolled after the effective date of the contract:

- **as soon as they become eligible provided the necessary information for the insurance coverage is communicated within 15 days following the eligibility,**

If the information is not received within 15 days of eligibility, coverage will start upon receipt of the necessary and valid information.

The benefits for the Dependants of the Member, as they are defined in this Contract, will take effect at the same time as the Member or as soon as they meet the conditions, whichever is the latest.

Article 19. TERMINATION OR SUSPENSION OF BENEFITS

Once admitted to the insurance the Member cannot be excluded from the contract as long as eligible, with the exception to the sanctions in the event of a misrepresentation.

The benefits will cease:

For each Member:

- **as soon as the Member ceases to belong to the category of Diplomatic personnel to which the Contract applies,**
- **on the date he becomes recipient of an old-age pension or a pension from a group retirement plan or recipient of a disability pension from *Sécurité sociale* or a local equivalent,**
- **in the event of misrepresentation,**
- **on the day of the Member's death.**

For all Members:

- **upon termination of this group insurance contract.**

In the event of suspension of the employment contract for any reason other than paid annual leave, illness, Accident, maternity or paternity, the benefits will be suspended for the same period and with the same consequences as a termination.

The benefits for the Dependants cease as soon as they no longer meet the conditions of the contract or when the Member is no longer covered.

The termination (or suspension) of the benefits will lead to the cancellation of the right to claim for any medical act and any treatment performed from the date of cessation for the Member and any Dependant.

SECTION 3 - BENEFITS

Article 20. AREA OF COVER

Benefits are effective in the area of cover as detailed in Appendix 1.

Article 21. BENEFITS

21.1 Nature of Benefits

The insurance coverage consists in reimbursing medical expenses incurred by the Insured Person, as from the first euro (EUR) and limited to the reasonable and customary costs.

Treatments must be recognised by local medical authorities and performed by practitioners exercising within a field in which they are qualified (in line with legislative, regulatory and other requirements in respect of professional standards in the given country).

If one of the Dependants is covered by a scheme of government healthcare program, the reimbursement amounts received from this agency shall be deducted from the benefits of the present Contract. If the spouse (or civil partner or cohabitant) is an employee, the benefits paid by the Insurer shall be complementing any medical insurance scheme from which this Dependant may benefit personally.

In the event of hospitalisation, the following medical expenses are covered:

- medical hospitalisation in public or private facilities,
- Hospitalisation and Surgery. Procedures carried out under general anaesthesia or in relation to trauma Surgery and surgical procedures carried out under local anaesthesia are deemed to be surgical procedures,
- related medical and paramedical costs provided in the context of Hospitalisation,
- local Emergency transportation of the patient by ambulance.

In case of Hospitalisation, local Emergency transport of the patient by ambulance is covered within the same country between the patient's residence or the location of the Accident and the nearest Hospital facility. Local Emergency transportation also covered if the patient's condition requires a further transfer from the original Hospital to another one nearby.

For any Hospitalisation, the prior approval of the Insurer is required, except in case of Emergency (see Definitions).
Conditions for which prior approval is required are indicated below.

In all other cases, coverages are defined in the table of benefits.

21.2 Table of Benefits

Benefits and maximum amounts mentioned in the Table of Benefits in Appendix 1 and are expressed in actual costs, per Insured Person and per calendar year. Medical expenses are reimbursed in euros (EUR) up to the maximums indicated in the Table of benefits in the Appendix.
The maximum amount of cover will be prorated over the 9-month term of the contract.

The maximum amounts benefits are determined for each benefit within the limits of the "reasonable and customary".
The "reasonable and customary" cost is the lowest amount between the cost requested by the service provider and the cost applicable in the same region for a similar service offered by providers of identical professional level. The "reasonable and usual" cost of a service varies according to the type of treatment, the quality of the service and equipment, the place and the country where the care is received. The Insurer reserves the right to limit the reimbursement of medical and related costs, as well as the duration of the Hospitalisation, to what generally is applicable in the region where the patient is treated.

The unreasonable and unusual nature may therefore result in reimbursement being refused or the amount of the reimbursement being capped.

In any event, the maximum amount of reimbursements under this contract is limited per Insured Person and per Insurance Year to the amount in Appendix 1.

21.3 Prior approval

Prior approval of the Insurer is required in the cases listed below – except in case of Emergency as per the definition:

- any Hospitalisation
- acts of Paramedics for series of acts above 10 sessions (unless specified otherwise in the table of benefits)
- dental prostheses and dental implants;
- prosthetics
- maternity ;
- laser refractive Surgery.

Except in case of an Emergency, each admission to a Hospital must be notified to the Insurer at least **15 days prior to the effective admission**. Acceptance by the Insurer is deemed obtained in case of no reply to the request within 5 working days.
In the absence of prior approval, during Hospitalisation or during any other treatment for which this approval is necessary, the Insurer reserves the right to decline the reimbursement.

If the treatment subsequently proves to be medically justified, the Insurer will then reimburse 80% of the Hospital expenses and 50% of the amount due for any other act requiring prior approval.

Prior approval is not necessary in case of an Emergency as defined in the contract. However, the Insurer must be notified within 48 hours or as soon as possible in the event of force majeure.

The provisions related to reasonable and customary costs in the country where care is performed shall apply in all cases.

21.4 Limitation of reimbursements to actual expenses

Reimbursements of Hospitalisation costs further to an illness, a maternity or an Accident may not exceed the amount of expenses remaining payable by the Member after reimbursements of any kind for which he is entitled.

Benefits of the same kind taken out with several insurers may be claimed within the limit of each coverage, irrespective of the date they were taken out. In this limit, the Insured Person may obtain additional payment by sending details of the reimbursements made by the other insuring body(ies).

The Insurer reserves the right to request explanation of medical bills, and may also request information of any reimbursement issued to the Insured Person from enforcing any other insurance contract the Insured Person would benefit from.

The Insured Person shall refund overpaid claims to the Insurer, as soon as possible. The Insurer may operate compensations between the refunded amounts and any claim which is due to the Member in relation with this contract.

Limitation of reimbursement to actual expenses is determined by the Insurer for each of the claimed benefits.

21.5 Claiming medical benefits

The claim list is provided by the Administrator and must be sent to him along with supporting documents.

No copies, photocopies or duplicates of invoices are accepted. As an exception, scanned copies sent by email are authorized for any invoice whose amount is less than **500 euros**. The Insurer may request, if necessary, any other document necessary for the enforcement of the benefit. The Member must keep in this regards all originals for a period of twenty-four (24) months from the date of medical care. During this period, the Insurer may claim the originals, in the absence of which the reimbursements made could be subject to refunds.

The Insurer/Administrator reserves the right to assess the health conditions of the Insured Person, to control of the performed medical acts and to request any Insured Person to provide all the necessary information for the processing of personal data in relation with the reimbursement requests. The Insurer shall have access to the personal medical files with all the legal confidentiality obligations attached thereto.

Any information provided by an Insured Persons which turns out to be incorrect, falsified, exaggerated or even any fraudulent act from their part will entail their liability and the recovery of sums unduly paid by the Insurer on the basis of this incorrect information.

21.6 Supporting documents

The claiming Member must send to the Insurer/Administrator a claim form along with the following supporting documents:

- hospitalisation: the supporting Hospitalisation documents (Hospital report, any paid invoices), indicating the names of the Hospital and the patient, dates of care and its cost,
- illness: medical prescriptions and detailed invoices,
- home birth: the child's birth certificate,
- banking details of the Member for reimbursement

The Insurer reserves the right to request any Insured person to provide them with the necessary information to process their personal data and related to reimbursement requests. The Insurer will be entitled to have access to their medical files with all the legal obligations of confidentiality attached thereto.

Any information provided by an Insured Person which turns out to be incorrect, falsified, exaggerated or even any fraudulent act from their part will entail their liability and the recovery of sums unduly paid by the Insurer on the basis of this incorrect information.

SECTION 4 - EXCLUDED RISKS AND BENEFITS

Excluded risks and benefits are detailed in Appendix 1.

SECTION 5 - DEFINITIONS

The terms and expressions used in this contract have the meaning mentioned below:

Accident: is a sudden, unexpected event which causes a bodily injury, and which is unintentional from the Insured Person. An acute disease or a chronic illness shall not be qualified as an Accident under this policy.

Member: the person who fulfils all eligibility criteria to be insured under this policy and who may enrol Dependants under the same policy. To qualify as a Member, the person must be an Expatriate of the Policyholder, and work on behalf of the Policyholder in a country other than his Country of Origin.

Insurance year: the period of cover guaranteed by the Insurer

Surgical devices and equipment: apparatuses and devices required during Surgery. This includes prostheses or devices such as joint replacement joints, screws, plates, valve replacement devices, endovascular stents, implantable defibrillators, and pacemakers.

Paramedics: nurses, assistant nurses, and other government certified medical workers

Dependant: the spouse or partner or cohabitant and/or any financially dependent child (as per eligibility criteria

Insured Person: any person - Member or Dependant - who is insured under this Contract

Check-ups: medical tests performed in the absence of any apparent clinical symptom. The purpose of these tests is to anticipate the detection of diseases. They include the following tests: blood pressure, cholesterol, heart rate, respiration, temperature, cardiovascular examination, neurological examination, cancer screening.

Thermal cure (spa treatment): prescribed medical treatment for a maximum period of 21 days using mineral spring water and its derivatives. The spa centre must provide a medical surveillance and follow-ups.

Ambulatory Surgery: surgical procedure carried out in a medical practice, Hospital, day or ambulatory medical centre, for which a Hospital or clinic stay is not necessary.

Waiting Period: period during which the Insured person cannot claim some benefits

Administrator: legal entity, which is entrusted the performance, on behalf of the Insurer, of policy administration (premium invoice, claims assessment and payment...)

Expatriate (adjective Expatriated): a person living outside his Country of origin, alone or with his Dependants and working for the Policyholder

Pharmaceutical costs: medical products - including insulin and hypodermic syringes - which have been prescribed by a physician for the treatment of an illness or to compensate for a deficiency of a vital substance to the body. The prescribed medication must have a proven medical effect and be

recognized by the regulatory and pharmaceutical controlling authorities in the country in which it is prescribed.

Childbirth expenses: incurred medical expenses related to natural or caesarean delivery if the latter is Medically Necessary or customary in the country of delivery. Any childbirth complication (and private room) will be covered under Inpatient Hospitalisation benefits.

Expenses related to parent accompanying a child of 16 years old or less: cost for the stay of a parent during the in-patient stay of a Dependant of less than 16 years old. If a Hospital bed is not available, a single accommodation within the Hospital (subject to availability) will be covered up to the indicated amounts. Any related costs such as meals are not covered under this benefit.

Deductible: a portion of the claimed expenses which is not reimbursed by the Insurer.

Organ transplant: Surgery consisting in transplanting an organ or tissues such as heart, heart / valve, heart / lung, liver, pancreas, pancreas / kidney, kidney, spinal cord, parathyroid, muscle / bone or cornea. The fees incurred for the acquisition of an organ are not reimbursable.

Hospital: is any establishment which is licensed as a medical or surgical Hospital in the country where it operates and where the patient is permanently supervised by a medical practitioner. The following establishments are not considered Hospitals: rest and nursing homes, spas, cure-centres and health resorts.

Hospitalisation: in-patient stay of at least 24 hours in a public or private Hospital facility, further to an Accident or an illness. It shall include the cost of medical or surgical Hospitalisation, medical and paramedical fees related to the Hospitalisation and transportation of the patient.

Surgery: medical acts performed under anaesthesia (general or local) or reaching an organ to be treated after incision are considered surgical acts.

Prescribed glasses and contact lenses: coverage of one eye examination per Insurance Year by an optometrist or an ophthalmologist and a pair of frames/lenses and contact lenses to correct vision.

Unexpected illness: any medically observed, sudden and unpredictable deterioration of health.

Medically Necessary: applies to the acts and equipment which are defined from a medical point of view as suitable and necessary. They must:

- be necessary to evaluate or cure a patient's condition, illness or injury
- be adequate for the patient's symptoms, diagnosis or treatment
- comply with commonly accepted medical practices and professional medical standards performed by the medical community at the time of care
- be performed for other reasons than the comfort or convenience of the patients or their doctor.
- have a proven and demonstrated medical effect.
- be considered the most suitable type and level.
- be performed with enough quantity and quality equipment and at the suitable level of care required by the patient's condition.

- be provided only during a suitable period of time to the patient's condition.

The term "suitable" takes into consideration patient safety and cost of treatment. "Medically Necessary" can also be applied to a Hospitalisation in the situation that care, or diagnosis cannot be carried out with safety and efficiency in outpatient facilities.

Insurer: the organization which covers the risk guaranteed under this contract, ie MGEN, 3 Square Max Hymans, 75748 PARIS Cedex 15, governed by the *Code de la mutualité*.

Orthodontics: use of devices to correct a malocclusion and to ensure the proper functioning and alignment of the teeth.

Country of Origin: The country the Insured Person holds a passport .

Country of Residence: the country, outside the Country of Origin, in which the Insured Person (Member and Dependant) has his habitual residence.

Statute of limitations: timeframe beyond which any party can no longer have the policy terms and conditions to be enforced.

Prescribed medical prostheses: any prescribed medical instrument, equipment or device that aids or supports the function or capacity of a limb or an organ, such as a speech aid (electronic larynx), crutches or a wheelchair, orthopaedic support/braces, artificial limbs, stoma supplies, graduated compression stockings, orthopaedic arch supports.

Dental prosthesis: prosthetic care, including placement of crowns, inlays, inlays and implants, as well as all necessary treatments, including reimbursement of laboratory costs and components.

Psychiatry - psychotherapy: mental disorder treatments by a psychiatrist who is specialist medical doctor

Psychology: treatment of mental disorders carried out by a psychologist

Psychotherapy: treatments for mental disorders carried out by a psychiatrist or psychologist

Benefits limits: may cover 2 types of limits in the Table of benefits:
- The overall annual limit is the maximum amount that the Insurer will pay for all benefits, per Insured person and per calendar year.
- Some benefits may also have respective limits which can be applied per calendar year or per benefit (dental, maternity, optical, etc.)

Rehabilitation: treatment is aimed at restoring a normal form and / or function after an Accident or serious illness. The rehabilitation process must begin within 30 days of hospitalisation for an Accident or an illness.

Home Care: prescribed medical care administered by a certified nurse at the Insured Person's home, immediately following or to replace hospitalisation or outpatient care.

Dental care: includes an annual dental check-up, simple fillings linked to tooth decays or devitalizations

Policyholder: the corporate entity which signs the contract for its Diplomatic personnel, and which is sole responsible for the premium payment.

Treatment: necessary medical procedure to cure or relieve illness, infection or injury.

Emergency dental treatment further to an Accident: the treatment must be administered within fifteen days of the Accident and consists in replacing healthy and natural teeth lost or damaged.

Ambulance transportation: it is an ambulance transport within the same country, between the patient's residence or the place of the Accident to the nearest Hospital or medical facility best suited to the situation in case of an Emergency or a medical need. Subsequent transfer to another facility is covered if necessary.

Emergency: term used in the event of an Accident or the onset of a serious illness requiring immediate medical assistance and treatment for the Insured Person. To qualify for Emergency under the terms of the contract the medical treatment must be performed within 24 hours by a general practitioner or a specialist whether in-patient or out-patient.

Mandatory vaccinations: mandatory immunizations or injections required by the health authorities of the country where the treatment is administered or by the authorities of the country to which the Insured Person travels. Vaccinations are covered only under the above conditions.

SECTION 6 - PREMIUMS

Article 22. PREMIUM AMOUNTS

22.1 Annual premiums excluding taxes

Premium amounts are indicated in Appendix 1.

22.2 Adjustment in case of modification of the legislative and regulatory provisions

The contributions may be reviewed in accordance with the provisions of the Contract.

22.3 Revision based on technical results

In accordance with the article 4, premium rates may be reviewed each January 1 depending on the technical results of the contracts of the same kind. The Insurer will notify of the new premium rates no later than October 31st of the current year.

In the event of a disagreement, the Policyholder may request the termination of his contract by registered letter within one month of notification of the premium review by the Insurer. The termination will take effect on the first day of the month following receipt of the letter by the Insurer. The Insurer will collect the prorated premium from January 1 to the termination date, on the basis of the premium rates previously in force.

Otherwise, the premium amounts will be calculated automatically according to the new bases notified.

Article 23. PAYMENT OF PREMIUMS BY THE POLICYHOLDER

Premiums are due by the Policyholder and are payable in euros (€) quarterly in advance.

In the event of non-payment of the premium or a fraction of the premium, a registered letter is sent to the Policyholder at least ten (10) days after the due date, informing him that at the end of a period of forty (40) days following the sending of the same letter, cancellation of the present contract shall be effective.

Done in two originals, in Paris,

For the Policyholder: **For the Insurer:**

D ınd signature

APPENDIX 1: AREA OF COVER, TABLE OF BENEFITS, EXCLUSIONS AND PREMIUMS

I. AREA OF COVER

Benefits are effective 24 hours a day in the event of illness or accident, in both private and professional life and in the following countries or areas

- **in all the countries of the chosen geographic area, among the following geographic areas:**
  Worldwide

It is agreed and understood that Members and their dependants shall not be covered in their country of origin if not listed in their respective zone of coverage

- **In other cases, after written agreement of the Insurer.**

II. TABLE OF BENEFITS

8. Inpatient and day inpatient treatment – reimbursement expenses:

No.	Healthcare services	Scope of services	Benefit limit	Reimbursement level
8.1	placement in a single ward of a hospital, meals	unlimited	unlimited	100%
8.2	consultation and supervision by all specialists and a psychologist	unlimited	unlimited	100%
8.3	psychiatric treatment	unlimited	unlimited	100%
8.4	inpatient psychotherapy	unlimited	unrestricted	100%
8.5	treatment of diseases of the nervous system	unlimited	unlimited	100%
8.6	surgery	unlimited	unlimited	100%
8.7	anaesthesia	unlimited	unlimited	100%
8.8	transplantation	unlimited	unlimited	100%
8.9	all diagnostic and laboratory tests and examinations	unlimited	unlimited	100%
8.10	physiotherapy treatment and other therapies provided by physicians	unlimited	unlimited	100%
8.11	all medications, immunisations, medical supplies, appliances and equipment (crutches, wheelchairs, walkers, splints), vitamins, supplements	unrestricted	Unlimited	100%
8.12	accommodation of one parent (staying with the child up to the age of 14 years) or accommodation and stay of an accompanying	unlimited	unlimited	100%

No.	Healthcare services	Scope of services	Benefit limit	Reimbursement level
	person, if required by the insured person's state of health, and meals			
8.13	tests for cancer, oncological consultation, oncological treatment (e.g. radiotherapy, chemotherapy, etc.)	unlimited	unlimited	100%
8.14	nursing care of the patient	unlimited	unlimited	100%
8.15	transfers or transport in the Insured Person's country of residence from one hospital to another	unlimited	unlimited	100%
8.16	HIV/AIDS drug therapy, including all related procedures, tests, therapies, rehabilitation	Unlimited	unlimited	100%
8.17	plastic surgery following accidents, accidents, complications of treatment, for the restoration or maintenance of health, excluding aesthetic surgery	unlimited	unlimited	100%
8.18	remedial, rehabilitative and sanatorium treatment in a single room prescribed by a physician and catering for at least 30 (thirty) calendar days per insurance year	unlimited	unlimited	100%
8.19	alternative medical care and treatment prescribed by physicians	unlimited	unlimited	100%

9. Pregnancy and childbirth, in case of complications – reimbursement expenses:

No.	Healthcare services	Scope of services	Benefit limit	Reimbursement level
9.1.	childbirth and care in the hospital of the mother's choice, including caesarean section	unlimited	unlimited	100%
9.2.	professional hospital care of the newborn	unlimited	unlimited	100%
9.3.	sterilisation, sterilisation or abortion prescribed by a physician	unlimited	unrestricted	100%

10. Pregnancy and childbirth – reimbursable expenses:

No.	Healthcare services	Scope of services	Benefit limit	Reimbursement level
10.1.	Childbirth and care in the hospital of the mother's choice or at home	unlimited	EUR 7000 per insurance year	100%

10.2.	professional care of the newborn in hospital and at home	unlimited	unlimited	100%
10.3.	pregnancy monitoring	unlimited	unlimited	100%
10.4.	professional postnatal care	unlimited	unlimited	100%
10.5.	infertility treatment	unlimited	2000 EUR per insurance year	100%

11. Outpatient treatment – reimbursed expenses (total benefit limit EUR 16 000, except for paragraphs 11.8 and 11.19):

No.	Healthcare services	Scope of services	Benefit limit	Reimbursement level
11.1.	consultations with a general practition and all specialists	unlimited	unlimited	100%
11.2.	psychological consultations	unlimited (25 visits per insurance year)	unlimited	100%
11.3.	speech therapist consultations	unlimited	unlimited	100%
11.4.	full check-up or examination of the Insured Person's normal physical health when the Insured Person is at least 18 years of age	unlimited	EUR 2000 per one year of insurance	100%
11.5.	outpatient surgical operations	unlimited	unlimited	100%
11.6.	MRI and CT scans, X-rays and other diagnostic and laboratory examinations and tests prescribed by physicians	unlimited	unlimited	100%
11.7.	all medicines, immunisations, medical supplies, devices and equipment (crutches, wheelchairs, walkers, splints) prescribed by a physician	unlimited	unlimited	100%
11.8.	medicines prescribed by physicians for the treatment of chronic, critical and other serious illnesses (not subject to the overall benefit limit of EUR 16,000)	unlimited	unlimited	100%
11.9.	vitamins and food supplements prescribed by physicians	unlimited	unlimited	100%
11.10.	physiotherapy, therapeutic gymnastics,	unlimited	1000 EUR	100%

	therapeutic massage course, by appointment with a medical practitioner, including the cost of the sports club.		per insurance year	
11.11.	restorative treatment by a physician following hospital treatment and/or injuries	unlimited	unlimited	100%
11.12.	ambulance (for emergency transport to hospital or transfer between hospitals when the physician decides it is medically necessary), emergency specialist care	unlimited	unlimited	100%
11.13.	home care provided by medical staff after hospitalisation	unlimited (providing 30 (thirty) calendar days per insurance year)	unlimited	100%
11.14.	prescriptions, certificates	unlimited	unlimited	100%
11.15.	vision correction aids	unlimited	EUR 600 per insurance year	100%
11.16.	dental treatment, diagnostics, care and materials, appliances, instruments and other	unlimited	EUR 2500 per insurance year	100%
11.17.	implantation, prosthetics	unlimited	3500 EUR per insurance year	100%
11.18.	orthodontic treatment	unlimited	1800 EUR per insurance year	100%
11.19.	injuries to teeth and jaws as a result of an accident – full reimbursement of expenses (not subject to the general limit of EUR 16,000)	unlimited	unlimited	100%
11.20.	rehabilitation and accommodation expenses by a physician	unlimited	1000 EUR per insurance year	100%
11.21.	Rehabilitation-sanatorium treatment by an inpatient and/or trauma physician	unlimited (providing 30 (thirty) calendar days per insurance year)	unlimited	100%

12. Other insurance benefits – reimbursable expenses:

No.	Healthcare services	Scope of services	Benefit limit	Reimbursement level

12.1.	chronic, critical and other serious illnesses	unlimited	unlimited	100%
12.2.	transportation of the Insured in case of medical emergency or need for further treatment in the Insured Person's country of residence	unlimited	unlimited	100%
12.3.	extenuating care of the Insured Person who is incurable, provided by medical staff	unlimited	EUR 30 000 in one insurance year	100%
12.4.	medical evacuation: in the event of a disaster, if the Insured Person's life is in danger and the Insured Person is in a country where adequate medical services cannot be provided The Insured Person shall be transported to the Republic of Lithuania or to the country of residence. Medical evacuations shall also be available in the USA to limit medical expenses if the Insured Person is able to travel by air and it is not detrimental to the health of the Insured Person	unlimited	unlimited	100%
12.5.	costs of repatriation of the Insured Person (transportation, handling, storage and related documentation) and the cost of an accompanying person	unlimited	unlimited	100%
12.6.	if the Insured Person is hospitalised in a country where, in the opinion of the attending physician, the medical services are inadequate or insufficient, the costs of transport to the nearest place where the appropriate level of services are provided and the costs of the	unlimited	unlimited	100%

	accompanying person (if the Insured Person is a child) shall be covered, including during postings and leave			

13. The sum insured shall mean the total (maximum) amount of benefits for health insurance services – it shall be equal to EUR 300,000 (three hundred thousand euro) per Insured Person per insurance year.

14. Medical or related expenses which are not included in the object of purchase and which are not covered by the terms and conditions of the Contract to be awarded:

14.1. illness or accident voluntarily caused by the Insured Person;

14.2. travel and hotel expenses related to medical care;

14.3. aesthetic procedures;

14.4. cosmetic surgery;

14.5. slimming and rejuvenating procedures;

14.6. orthopaedic shoes and soles;

14.7. general podiatry or other foot treatments unrelated to disease or injury;

14.8. nursing home care services (except where specifically mentioned);

14.9. care services, defined as supplies and services, including room, board and other institutional services, designed primarily to assist in activities of daily living;

14.10. care services for persons with disabilities or inadequate adaptation;

14.11. injury or sickness resulting from war or any war or terrorism-related activities in which the Insured Person is voluntarily and actively participating;

14.12. anything not prescribed by a physician or not intended for medical care.

14.13. Appliances and devices not related to the treatment of the illness but obtained from pharmacies, medical establishments (even with a physician's prescription), such as: dental cleaning devices (toothbrushes, interdental floss, gum/prosthetic brushes, irrigators), thermometers, pregnancy tests, condoms.

14.14. Parapharmaceuticals available in pharmacies, medical institutions (even with a physician's prescription), such as: anti-dandruff shampoos, hair loss shampoos, toothpastes, face, body, hand creams, micellar waters, shower creams or gels, sunscreens.

15. The Insurer will provide a direct, free, 24-hour helpline (telephone number) to advise the Insured only in case of emergency (repatriation or other).

16. The Insurer shall provide each Insured Person with a list of recommended medical facilities with which the Insurer has direct billing agreements, in the Insured Person's country of accreditation and in the Republic of Lithuania, and in other countries at the request of the Insured Person.

17. The health insurance coverage shall be valid during the Insured Person's leave for a minimum of 10 weeks per insurance year worldwide, in the USA, as provided for in paragraph 6 of the Technical Specification.

18. If medical evacuation is not possible due to the Insured Person's medical condition, the full cost of the Insured Person's full medical treatment shall be reimbursed until medical evacuation is authorised by a medical board.

III. EXCLUDED RISKS AND BENEFITS

EXCLUDED RISKS

THERE SHALL BE NO REIMBURSEMENT OF MEDICAL EXPENSES BY THE INSURER IF THEY OCCUR FURTHER TO THE FOLLOWING RISKS:

- **THE CONSEQUENCES OF A CIVIL WAR OR NOT, OF AN INSURRECTION, A RIOT, AN ATTACK OR A GRASSROOTS MOVEMENT, UNLESS THE INSURED PERSON DOES NOT TAKE AN ACTIVE PART IN THE EVENT, OR IS CALLED TO CARRY OUT A MAINTENANCE OR SURVEILLANCE ASSIGNMENT IN ORDER TO ENSURE THE SAFETY OF PERSONS AND GOODS ON BEHALF OF THE POLICYHOLDER,**
- **A CLAIM RESULTING DIRECTLY OR INDIRECTLY FROM THE DISINTEGRATION OF THE ATOMIC NUCLEUS,**

THE INSURER RESERVES THE POSSIBILITY OF MODIFYING THE COVERAGE FOR ONE OR SEVERAL SPECIFIC TERRITORIES, SUBJECT TO A FIFTEEN DAYS PRIOR NOTICE SENT TO THE COMPANY. THIS ONE MAY REFUSE THIS MODIFICATION AND TERMINATE THE POLICY BY SENDING THE INSURER A REGISTERED LETTER WITH ACKNOWLEDGEMENT OF RECEIPT WITHIN 30 DAYS FROM THE DATE OF RECEIPT OF THE ENDORSEMENT SUBMITTED BY THE INSURER. THE TERMINATION SHALL TAKE EFFECT ON THE FIRST DAY OF THE CALENDAR QUARTER FOLLOWING THE REFUSAL NOTIFICATION.

EXCLUDED BENEFITS

THE FOLLOWING BENEFITS ARE NOT COVERED UNDER THE CONTRACT, EXCEPT OTHERWISE MENTIONNED IN THE TABLE OF BENEFITS:

- **TREATMENTS PROVIDED OUTSIDE THE GEOGRAPHICAL AREA OF THE COVERAGE IF ANY**
- **ANY FORM OF EXPERIMENTAL OR UNCONTROLLED TREATMENT WHICH DOES NOT FOLLOW CUSTOMARY OR TRADITIONAL, COMMONLY ACCEPTED MEDICAL PRACTICES, UNLESS THE INSURER HAS GIVEN ITS SPECIFIC CONSENT, AND ANY FORM OF TREATMENT NON RECOGNIZED BY THE MEDICAL AUTHORITIES WHERE THE TREATMENT TOOK PLACE, OR IN THE COUNTRY OF ORIGIN OF THE COVERED PERSON;**
- **ANY PREVENTIVE TREATMENT, EXCEPTED THE MANDATORY VACCINATION REQUESTED ON THE COUNTRY OF EXPATRIATION, HEALTH CHECK-UP, AS WELL AS SCREENINGS,**
- **ANCILLARY OR "COMFORT" COSTS IN CASE OF HOSPITALISATION (TELEPHONE, TELEVISION, HOTEL, INTERNET)**
- **PRIVATE ROOM UNLESS SPECIFIED IN THE TABLE OF BENEFITS,**
- **TREATMENTS RELATING TO DRUG ADDICTION,**
- **DISINTOXICATION TREATMENTS,**

- COSTS INCURRED BY THE ACQUISITION OF AN ORGAN,
- ANY SURGERY OR TREATMENT RELATING TO GENDER REASSIGNMENT,
- MEDICAL CHECKS, STUDIES, TREATMENTS, CONSULTATIONS AND COMPLICATIONS RELATING TO STERILITY, STERILIZATION, SEXUAL DYSFUNCTIONS,
- ANY ELECTIVE/VOLUNTARY SURGERY AND/OR PLASTIC/AESTHETIC SURGERY,
- AESTHETIC TREATMENTS AND CONSULTATIONS, REJUVENATION CURES, SLIMMING CURES,
- THERMAL CURES UNLESS SPECIFIED IN THE TABLE OF BENEFITS,
- MEDICAL COSTS RELATING TO A STAY IN THALASSOTHERAPY CENTRE OR FITNESS CENTRE, UNLESS THIS STAY IS MEDICALLY PRESCRIBED AND PRIOR APPROVED,
- MEDICAL COSTS RELATING TO A STAY IN A REST HOME OR A CONVALESCENT HOME, EXCEPT IF THIS STAY RESULTS FROM AN HOSPITALISATION OR A SEVERE SURGERY ASSESSED BY THE INSURER'S DOCTOR,
- OUTPATIENT CONSULTATIONS OF PSYCHOTHERAPY, PSYCHOANALYSIS AND THE RELEVANT TREATMENTS,
- CONSULTATIONS, TREATMENTS AND COMPLICATIONS RELATING TO HAIR LOSS OR HAIR TRANSPLANTATION, UNLESS THIS TREATMENT RESULTS FROM A HAIR LOSS CAUSED BY A SERIOUS ILLNESS,
- TREATMENTS TO MODIFY THE REFRACTION OF AN EYE OR BOTH EYES (LASER EYE CORRECTION), INCLUDING REFRACTIVE KERATOTOMY (RK) AND PHOTOREFRACTIVE KERATOTOMY (PRK) UNLESS SPECIFIED IN THE TABLE OF BENEFITS,
- NON-PRESCRIPTION MEDICINES AND NON- PRESCRIBED PARA-PHARMACY;
- NON-PRESCRIPTION MEDICINES AND NON-MEDICINAL PRODUCTS COMMONLY USED, SUCH AS MEDICAL ALCOHOL, COTTON WOOL, SUNSCREENS, DENTAL HYGIENE PRODUCTS, ADHESIVE BANDAGES, SHAMPOOS;
- PERSONAL EXPENSES, SUCH AS TELEPHONE CALLS AND TELEVISION RENTAL ARE NOT REIMBURSED;
- SUNGLASSES ARE NOT REIMBURSED;
- ORTHODONTIA, UNLESS SPECIFIED IN THE TABLE OF BENEFITS.

ON A GENERAL BASIS REFERENCE IS MADE TO WHAT IS COVERED BY FRENCH *SECURITE SOCIALE* EXCEPT FOR DENTAL PROSTHESES OR CONTACT LENSES.

IMPORTANT: NO PAYMENT MAY BE MADE, DIRECTLY OR INDIRECTLY, TO A COUNTRY SUBJECT TO SANCTIONS EDICTED BY THE UNITED NATIONS, THE AMERICAN OFFICE OF FOREIGN ASSETS CONTROL (OFAC) OR THE EUROPEAN UNION.

IV. PREMIUMS

The premium rates are established monthly in a pro rata basis, as follows:

	Year 2027
Adult < 60 :	363 €
Child :	218 €
Adult > 60 :	560 €

It is specified that for the Insured Persons who pursue a professional activity on a part-time basis, the premium is payable in full.

MANDATORY TERMS AND CONDITIONS OF THE CONTRACT

1. These Mandatory Terms and Conditions of the Contract (hereinafter referred to as the "Terms and Conditions") shall form an integral part of the contract to be concluded (hereinafter referred to as the "Contract") and shall prevail over the Contract submitted by the Insurer in the event of any conflict, i.e. contradiction or inconsistency.

2. The Insurer shall undertake to provide the object of the procurement No. 4, health insurance services to diplomats, other civil servants, special attachés, their deputies, as well as members of their families referred to in Article 18 of the Law on the Diplomatic Service, and employees working under an employment contract (hereinafter referred to as the "Insured Persons") employed by the Policyholder, including the administration of insured events and claims (losses) (hereinafter referred to as the "health insurance services") in accordance with the requirements of the Technical Specification of the Terms and Conditions of the Public Procurement for Health Insurance Services of the Policyholder (hereinafter referred to as the "Terms and Conditions of the Procurement") (Annex 1 to the Contract) and the Insurer's proposal (Annex 2 to the Contract), and the Policyholder shall undertake to pay to the Insurer the premiums specified in the Contract.

3. The maximum value of the Contract shall be EUR 3.051.182,00 (three million fifty-one thousand one hundred eighty-two EUR) EUR excluding value added tax (hereinafter referred to as the "VAT").

4. The method of calculation of the price set out in the Contract shall be the fixed rate.

5. The Contract shall enter into force as from 1 May 2027 00:00 (Belgium time) in time and shall be valid until 31 December 2028 24:00, or until the total amount of the services reaches the maximum value of the Contract referred to in paragraph 3. This Contract shall remain in force until full performance of the obligations.

6. The Policyholder assigns the performance of the Contract to Chief Officer, the Insurer assigns the performance of the Contract to

7. Insurance premiums shall normally be paid once per calendar quarter. The insurance premiums shall be paid into the account specified by the Insurer within 14 (fourteen) working days from the date of receipt of the account.

8. Upon the entry into force of the Contract, the first premium shall be paid within 14 (fourteen) working days of receipt of the invoice.

9. The premium amounts of the newly insured Insured Persons shall be determined in accordance with the premiums set out in the Insurer's proposal. In the event that the insurance does not cover the whole month, the premium for the relevant month shall be calculated as follows: the monthly premium shall be divided by the number of days in the relevant month and multiplied by the number of days covered.

10. The insurance premium paid and not used, or the relevant part thereof, for the employees and/or their family members who are no longer insured (after the termination of the employment relationship with the Insured) (who leave together with the no-longer insured employee or no longer live together) shall be set off as part of the payment of the new premium for the next Insured Person or shall be refunded to the Policyholder to the bank account specified by the Insured Person.

11. The insurance premiums shall not be subject to change during the term of this Contract, except in the cases of premium revision referred to in this subparagraph:

11.1. a revision of the insurance premiums shall be carried out in the event of a change in the VAT rate. This provision shall apply when the VAT rate changes (increases or decreases) due to a

change in legislation and shall not apply when the VAT rate increases or the obligation to pay it arises due to circumstances beyond the Insurer's control. Premiums will not be recalculated or changed as a result of changes in taxes other than VAT.

11.2 The Insurance Premium may be revised (increased or decreased) by mutual written agreement of the Parties in the event of a change in the official medical inflation rates The Kingdom of Belgium. For the purposes of this subparagraph, the premium shall be increased or decreased if the official medical inflation rate is greater than 5% above the rate prevailing on the date of entry into force of the Contract and may be determined no earlier than 12 (twelve) months after the initial entry into force of this Contract and no more frequently than every 12 (twelve) months. Changes in medical inflation rates shall be provided on the basis of data from official institutions that calculate medical inflation.

12. The recalculated rates may not exceed the maximum allowable norms of health insurance and health care costs per year provided for in point 8 of the Schedule of the Amounts of Social and Other Guarantees Associated with Work in Diplomatic Missions, Consular Offices and Special Missions of the Republic of Lithuania approved by 27 December 2018 Resolution No 1393 of the Government of the Republic of Lithuania .

13. The Insured Person who, through his/her own fault, delays payment for services in accordance with the procedure and on time as provided for in this Contract, shall pay, at the written request of the Insurer, a default interest of 0.02 (two hundredths) per cent on the unpaid amount for each calendar day of delay;

14. If the Insurer, through its own fault, delays the payment of the insurance benefit or the return of the unused premium in accordance with the procedure and in due time as provided for in this Agreement, it shall pay, at the written request of the Policyholder, a late payment interest of 0.02 (two hundredths) per cent on the amount not paid in due time, for each calendar day of the delay;

15. The insurance benefit shall be paid directly to the Insured Person or to the healthcare provider no later than 10 (ten) working days after the date of confirmation of these expenses.

16. The Insurer shall pay the sum insured upon receipt of the Insured Person's documents confirming the Insurable Expenses, together with the request for reimbursement of such expenses.

17. The Insured shall submit the documents confirming the insurable expenses to the Insurer by e-mail.

18. The documents confirming the Insurable Expenses must be submitted to the Insurer no later than within 6 (six) months from the date of issue thereof. The documents confirming the expenses may be submitted in Lithuanian, English or another official language of the country of the healthcare provider and, if necessary, the Insurer undertakes to translate these documents into other languages itself.

19. Benefits shall be paid in euros.

20. **The Insurer shall undertake:**

20.1. to pay the Insured for the Insured Expenses for the premiums set out in this Contract in the event of the occurrence of the insured events provided for in the Technical Specification, within the limits set out in the Technical Specification and in accordance with paragraphs 15 and 16 of these Terms and Conditions;

20.2. to ensure the provision and management of information in electronic space, providing each Insured Person with an identification code and passwords assigned to him/her only, no later than 7 (seven) working days from the date of submission of the data on the Insured Person to the Insurer (date of sending the email);

20.3. to keep a record of the treatment and other services rendered to the Insured Person, informing only the Insured person about it in the electronic space at each time of payment of the insurance benefit;

20.4. as a data processor, to ensure the proper enforcement of Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data and repealing Directive 95/46/EC;

20.5. the provision of a direct, free of charge, 24-hour helpline (telephone number) to advise insured persons in case of emergency (repatriation or other);

20.6. to provide each Insured Person, upon request, with a list of recommended medical institutions with which the Insurer has direct billing agreements with medical institutions worldwide, provided that these institutions accept the direct payment. (specify countries);

20.7. to administer insured events and claims (losses) properly;

20.8. to insure newborn babies from the date of birth up to the age of 6 (six) months under the terms and conditions set out in the Technical Specification, provided that the Insurer is informed of the date of birth within 2 (two) weeks of the date of birth. If the notification is made more than two weeks after the date of birth, the newborn shall be insured from the date of notification;

20.9. to compensate the Policyholder for losses caused by the fault of the Insurer's employees;

20.10. to ensure the promptness, continuity and quality of service provision. Any deficiencies noted by the Policyholder shall be recorded in writing and shall be corrected at the Insurer's expense within 14 (fourteen) working days from the date of sending the electronic notification;

20.11. to communicate directly with the Healthcare Service Providers and other institutions that will provide the services provided for in this Contract;

21. The Insured Person shall undertake:

21.1. to use the services of the Insurer when necessary to insure the Insured Persons if they are to be insured;

21.2. to pay to the Insurer the insurance premiums in accordance with the procedure set out in paragraphs 7 and 8 of the Terms and Conditions;

21.3. to acquaint the Insured Persons with the terms of the Contract;

21.4. to submit to the Insurer by e-mail the completed data on the Insured Persons, indicating the beginning of the period of insurance coverage of the Insured Persons, which may not be earlier than 2 (two) weeks prior to the date of submission of the data;

21.5. within 2 (two) weeks after the birth of the child, to inform the Insurer of the date of birth of the child and provide other necessary information. If the notification is made more than two weeks after the date of birth of the child, the newborn shall be insured from the date of notification.

22. An agreement under which the Insurer engages third parties to perform part of the obligations provided for in the Agreement shall be considered a subcontracting agreement. Such an agreement shall be in writing. Subcontracting shall not create a contractual relationship between the Insured and the subcontractor. The Insured shall be liable for the actions or inactions of its subcontractors. The Customer's consent to the use of a subcontractor to perform the contractual obligations shall not relieve the Service Provider from any of its obligations under the Agreement.

23. Upon conclusion of the Agreement, but no later than the commencement of the Agreement, the Insurer undertakes to notify the Policyholder of the names, contact details and representatives of the sub-providers known at that time. The Policyholder also requires the Insurer to inform about changes in the aforementioned information throughout the performance of the Agreement, as well as about new sub-providers that it intends to use later.

24. If the insurer intends to use new subcontractors during the performance of the Contract that were not specified in the insurer's proposal, it must inform the policyholder in writing and, together with information about the new subcontractors, submit documents confirming compliance with the qualification requirements and the requirements for the absence of grounds for exclusion (where applicable).

25. Subcontractors are not used/engaged (selected) for the performance of the contract (if used, specified).

26. The policyholder shall provide for the possibility of direct settlement with sub-providers in accordance with the procedure established in this clause. The policyholder shall inform the sub-providers in writing of the possibility of direct settlement no later than within 2 (two) business days from the receipt of the information specified in subparagraph 23 of the conditions about the possibility of direct settlement, and the sub-provider, wishing to use such a possibility, shall submit a written application to the policyholder. In cases where the sub-provider expresses a desire to use the possibility of direct settlement, a tripartite agreement between the policyholder, the insurer and its sub-provider must be concluded, which describes the procedure for direct settlement with the sub-provider and provides for the insurer's right to object to unjustified payments to the sub-provider.

27. The terms and conditions of the Contract may be amended during its validity period without a new procurement procedure, without prejudice to the principles and objectives laid down in Article 17 of the Law on Public Procurement and in accordance with Article 89 of the Law on Public Procurement of the Republic of Lithuania. The terms and conditions of the Contract shall be amended only by written agreement of the Parties.

28. The Agreement may be terminated in the cases specified in Article 90 of the Law on Public Procurement of the Republic of Lithuania, upon giving the other Party 14 (fourteen) calendar days' notice.

C[illegible] be governed by the law of the Republic of Lithuania.