MetLife

ZPPSNP CI 1.4
Effective from 1 April 2017
Code: Group 160

SPECIAL INSURANCE CONDITIONS OF GROUP INSURANCE CRITICALL ILLNESS INSURANCE

1 INTRODUCTORY PROVISIONS
(RULES GOVERNING THE INSURANCE)

1.1 These Special Insurance Conditions are effective from 1 April 2017.

1.2 Critical illness insurance (hereinafter "CI") is governed besides the insurance policy terms and conditions and these special insurance conditions by the General Insurance Conditions of Group Non-Life Insurance 1.3 (hereinafter *"VPPSNP"*).

1.3 Critical illness insurance provides cover to an insured who is a member of the group defined in the insurance policy or whose name is included in the list of insureds which the policyholder regularly sends to the insurance company as agreed.

1.4. The CI insurance may be taken out independently or as supplemental insurance to basic term life or non-life insurance.

> **What is important**
> **The CI insurance is governed not only by these special insurance conditions, but also by the General Insurance Conditions of Group Non-Life Insurance (VPPSNP 1.3). Please remember to read the General Conditions.**

2 INSURANCE RISK, INSURED EVENT
(WHAT YOU ARE COVERED FOR)

2.1 The insurance risk is a critical illness of the insured.

2.2 The insured event occurs if the insured is diagnosed with any of the critical illnesses or termination any of the medical treatment listed in the relevant Schedule of Critical Illnesses, Diagnoses and Medical Procedures.

2.3 An insured event will only arise if the insured survives a minimum period of 30 days from when the critical illness listed in the Schedule of Critical Illnesses, Diagnoses and Medical Procedures was diagnosed or when a medical procedure listed in the Schedule of Critical Illnesses, Diagnoses and Medical Procedures was completed.

2.4 The benefit under this insurance will be provided only on condition that the Insured Person did not suffer from the critical illness or from the illness that led to the relevant medical procedure before the commencement of this insurance and neither did he/she have symptoms of the critical illness or of the illness that led to the relevant medical procedure during the waiting period.

MetLife

<u>What is important</u>
For procedures and obligations in the case of an insured event, see also paragraph 10.3 and Article 11 of VPPSNP.

1. **You should notify a claim without undue delay (fill in and post the appropriate form).**

2. **You should provide true explanation of the rise and scope of consequences of the event and support it with the documents required.**

3. **The insurance company will start investigation without undue delay to establish the extent of the benefit. The investigation must be completed within three months from the claim notification date.**

4. **The benefit is payable within 15 days from the end of investigation.**

Please note: The limitation period of 4 years starts to run from the insured event date. If you do not notify a claim within the above time limit, your claim will be forfeited and the insurance company will not pay you the benefit.

3 WAITING PERIOD

3.1 A waiting period of 90 days applied to the CI insurance. If an insured event occurs within the waiting period, the insurance will terminate.

4 INSURANCE BENEFIT
(HOW MUCH THE INSURER WILL PAY IN THE CASE OF AN INSURED EVENT)

4.1 If an insured event occurs the insurance company will pay a single benefit in the amount of the sum assured agreed for this cover in the insurance policy as at the date of the insured event.

4.2 The insurance company will pay the insurance benefit at the most for one insured event.

4.3 The insurance benefit is paid to the insured.

5 TERM AND CESSATION OF INSURANCE
(HOW LONG THE COVER LASTS)

5.1 The term of this insurance is the same as the term of the basic group life insurance, but no longer than to 65th birthday of the insured. If this cover was agreed later, its inception is specified in the endorsement to the insurance policy and it is agreed for the whole term of the basic group life or non-life insurance, but no longer than to 65th birthday of the insured.

5.2 Cover in respect of the insured ceases upon the payment of the benefit.

6 INSURANCE PREMIUM
(PRICE OF INSURANCE)

6.1 The amount of premium and the premium payment frequency are specified in the insurance policy.

7 EXCLUSIONS
(WHAT IS NOT COVERED BY THIS INSURANCE)

7.1 This insurance shall not apply exclusions provided in Article 12 paragraph 1 of VPPSNP under letters b), e) and g) - k). Others exclusions listed in VPPSNP are applied.

7.2 No benefits will be paid in connection with the following cases:

a) in connection with acquired immune deficiency syndrome (AIDS) or the HIV virus or mutations or variations of the virus, provided the HIV infection was not acquired by transfusion, by exercising one's profession, by a physical attack against the Insured Person or by providing non-professional first aid during a traffic accident.

a1) HIV infection acquired during a blood transfusion shall mean proving the presence of the HIV virus (human immunodeficiency virus) in the serum, provided all the following conditions are met:

a1.1) The infection was demonstrably transmitted into the Insured Person's body by a blood transfusion carried out in an EU Member State while the insurance was in force.

a1.2) A written admission of liability of the institution that carried out the transfusion or a court judgment with a legal force clause confirming such liability is submitted to the Insurance Company.

a1.3) The Insured Person does not suffer from hemophilia.

The Insured Person shall submit to the Insurance Company all results of blood tests and undergo a medical examination at the request of the Insurance Company conducted by the health care facility authorized by the Insurance Company.

a2) An HIV infection acquired during performance of one's profession shall mean proving the presence of the HIV virus (human immunodeficiency virus) in the serum, provided all the following conditions are met:

a2.1) The infection was demonstrably transmitted into the Insured Person's body at the time that the insurance was in force
- while performing regular duties related to the Insured Person's profession as per the list below
- as a result of a physical attack while the Insured Person was exercising his profession as per the list below
- while handing blood or other bodily fluids and such handling relates to the Insured Person's profession

a2.2) Seroconversion occurred within the six months that followed transmission of the infection

a2.3) The Insured Person provided a negative result of a test for the presence of the HIV virus and antibodies against the HIV virus; the test has to be carried out no later than five days after transmission of the infection

a2.4) The Insured Person documented the presence of the HIV virus or antibodies against the HIV virus no later than 12 months after transmission of the infection

a2.5) The Insured Person provided documentation proving that the HIV infection

is an occupational disease in compliance with the Decree of the Ministry of Health No. 104/2012 Coll., on assessing occupational diseases

a2.6) If the infection is transmitted as a result of the Insured Person being physically attack while exercising his profession, the event has to be reported to the appropriate authorities with jurisdiction in the given matter, thoroughly investigated in line with recognized methods, and the results of the investigation have to be provided to the Insurance Company in the form of a report or record.

List of professions where an Insured Event can occur while the profession is being exercised:

a) medical physician or dentist
b) general nurse
c) medical laboratory technician or laboratory assistant or worker
d) attendant or driver of means of transportation for the sick and injured
e) medical or radiology assistant
f) medical rescue worker or ambulance driver
g) midwife
h) firefighter
i) police officer
j) prison security officer

a3) An HIV infection acquired during a physical attack against the Insured Person or when providing non-professional first aid during a traffic accident shall mean proving the presence of the HIV virus (human immunodeficiency virus) in the serum, provided all the following conditions are met:

a3.1) The physical attack or traffic accident was reported to the appropriate authorities with jurisdiction in the given matter, the incident was duly investigated in line with recognized methods, and the results of the investigation were provided to the Insurance Company in the form of a report or record.

a3.2) Seroconversion occurred within the six months that followed transmission of the infection.

a3.3) The Insured Person provided a negative result of a test for the presence of the HIV virus and antibodies against the HIV virus; the test has to carried out no later than five days after transmission of the infection.

a3.4) The Insured Person documented the presence of the HIV virus or antibodies against the HIV virus no later than 12 months after transmission of the infection.

b) any illness or medical procedure that is not specifically listed in the List of Critical Illnesses, Diagnoses and Medical Procedures,

c) if the critical illness is caused by or medical procedure is needed as a result of the influence of alcohol, drugs or other intoxicating or addictive substances, or intentional incorrect ingestion of medicines or narcotics or as a result of alcohol consumption;

d) in connection with a mental illness or disorder of the Insured Person.

8 DEFINITIONS

(DEFINITIONS OF MEANINGS)

8.1 **Date of diagnosis** – the moment when all the relevant symptoms were identified and the diagnosis established and recorded in medical records maintained by the relevant healthcare facility or a medical specialist qualified to make proper assessment of the illness.

8.2 **Waiting period** - the period of time during which the Insurance Company will not provide benefits for occurrences that would otherwise be insured events. The waiting period begins to run at the commencement of the CI insurance.

9 SCHEDULE OF CRITICAL ILLNESSES, DIAGNOSES AND MEDICAL PROCEDURES

9.1 The Schedule of Critical Illnesses Diagnoses and Medical Procedures contains the following items:

a) Acute myocardial infarction,
b) Cerebrovascular accident (stroke)
c) Malignant neoplasms (tumors)
d) End-stage (terminal) renal failure
e) Vital organ transplantation
f) Bypass of coronary arteries
g) Blindness
h) Deafness (loss of hearing),
i) Benign brain tumor,
j) HIV infection from blood transfusion,
k) Occupationally acquired HIV infection,
l) HIV infection resulting from physical assault or lay first aid provided after traffic accident
m) Critical tick-borne illness,
n) Multiple sclerosis,
o) Coma
p) Severe dementia,
q) Alzheimer´s disease,
r) Aortic surgery,
s) Bacterial meningitis,
t) Heart valve surgery,
u) Spinal muscular atrophy,
v) Progressive bulbar polio,
w) Amyotrophic lateral sclerosis and primary lateral sclerosis,
x) Paralysis,
y) Parkinson´s disease,
z) Chronic lung failure, aa) Crohn’s disease,
bb) Primary (idiopathic and familial) pulmonary hypertension, cc) Encephalitis,
dd) Poliomyelitis (Cerebral palsy), ee) Aplastic anaemia,
ff) Tetanus.

9.2 **ACUTE MYOCARDIAL INFARCTION** means the death of a part of the heart muscle as a result of a sudden occlusion or blockage of the coronary artery through which blood is supplied to the area. The diagnosis of acute myocardial infarction must be evidenced by history of typical chest pain, significant rise of cardiac enzymes to levels considered diagnostic for infarction and recent electrocardiographic (ECG) changes indicative of an acute myocardial infarction.

No benefits will be payable under this insurance if:

a) the Insured Person suffered any acute myocardial infarction before the commencement date of this insurance,
b) the illness was diagnosed as angina of any type,

c) the illness was diagnosed as an microinfarction with only a slight rise of levels of Troponin-T and if no electrocardiographic (ECG) changes or other clinical symptoms were detected.

9.3 **CEREBROVASCULAR ACCIDENT (STROKE)** is a cerebrovascular event producing clinically provable neurological sequelae which in the acute phase last more than 24 hours and subsequently result in permanent neurological deficit with persisting clinical symptoms measurable by special examining technique after 6 weeks from the event; the diagnosis of cerebrovascular accident must be supported by the evidence of new corresponding changes on a computerized tomography (CT) scan or nuclear magnetic resonance imaging (MRI) scan.

For the above definition, the following is not covered:

a) illness diagnosed as transient ischemic attack,
b) symptoms of impaired function of the central nervous system were caused by migraine,
c) symptoms of impaired function of the central nervous system were caused by trauma, hypoxia (insufficient oxygenation of blood) and/or a vascular disease,
d) symptoms of impaired function of the eye and/or optic nerve were caused by trauma, hypoxia (insufficient oxygenation of blood) and/or a vascular disease,
e) symptoms of a vestibular disorder were caused by its insufficient oxygenation (ischemia).

9.4 **MALIGNANT NEOPLASMS (MALIGNANT TUMOURS)**, commonly called **CANCER**, are tumors characterized by uncontrolled growth and spread of malignant cells and invasion and destruction of normal tissue. The Insured Person is obliged to submit to the Insurance Company a medical report in which the tumor malignancy diagnosis is supported by clear histological evidence and confirmed by a qualified oncologist or pathologist.

For the purposes of the definition of an Insured Event, the term ”malignant neoplasm” or “malignant tumor” (cancer) includes:

a) solid malignant tumors,
b) leukemia (excluding chronic lymphocytic leukemia in stage A according to the Binet staging system, or 0 and 1 according to the Rai classification, respectively),
c) malignant lymphomas,
d) Hodgkin's disease,
e) malignant bone marrow disorders,
f) metastatic skin cancers. Excluded from cover are:

a) chronic lymphatic leukemia in stage A according to the Binet staging system, or 0 and 1 according to the Rai classification,
b) tumors showing malignant changes of carcinoma in situ,
c) cervical dysplasia and/or cervix cancer CIN-1, CIN-2 or CIN-3,
d) conditions histologically described as premalignant (precancerous) or as non-invasive cancers,
e) prostatic cancers histologically described according to the TNM classification as stage T1 (including T1a or T1b), or of lesser stage according to any other equivalent classification,
f) melanomas of the skin that are according to clinical and pathological classification less than stage IIA (it means lesser than stage T2b according to the TNM classification, histologically verified depth of invasion less than 2 mm with no ulceration),
g) any hyperkeratosis and occurrence of basal cell carcinomas or squamous cell carcinomas,
h) any tumor in the proven presence of HIV infection (AIDS) in the Insured Person´s body.

9.5 **END-STAGE (TERMINAL) KIDNEY FAILURE** means the total and irreversible failure of both kidneys to function. Evidence has to be provided to the Insurance Company that the Insured Person underwent regular renal dialysis for more than 3 months. The Insured Event occurs when the last day of the 3months period has elapsed.

9.6 **MAJOR ORGAN TRANSPLANT (MAJOR ORGAN FAILURE ON WAITING LIST)** means the inclusion of the Insured Person for at least 6 months as a recipient on an official waiting list for a transplant of at least one whole human organ of the list below. The Insured Event occurs when the last day of the 6months period has expired. For the purposes of the CI insurance, the medical procedure (surgery) shall mean transplantation of at least one whole human organ of the list of organs below:

a) heart,
b) lung,
c) liver
d) kidney,
e) pancreas,
f) human bone marrow transplantation using hematopoietic stem cells preceded by total bone marrow ablation.

The transplantation of the whole human organ must be medically necessary and in the Insured Person´s medical documentation it must be supported by evidence of irreversible end-stage failure of the relevant organ. Transplantations of bone marrow not covered by this insurance:

a) transplantations not preceded by total bone marrow ablation,
b) transplantations of human bone marrow using other than hematopoietic stem cells.

9.7 **CORONARY ARTERY BY-PASS SURGERY** means the open-heart surgery of the Insured Person to correct narrowing or blockage of one or more coronary arteries using vein grafts. Angiographic (coronarographic) evidence of the underlying disease and a written report of a cardiologist confirming that the surgery was medically necessary must be provided by the Insured Person to the Insurance Company.

All cases of non-surgical intra-arterial catheter based procedures, such as angioplasty (PTCA), rotablation, laser techniques, or any other similar techniques are excluded from cover.

9.8 **BLINDNESS (LOSS OF SIGHT)** means total and irreversible loss of sight in both eyes as a result of an acute illness. The total and irreversible character of blindness in both eyes must be attested by the report of a medical specialist (ophthalmologist) confirming that the total blindness in both eyes cannot be corrected by any of the medical procedures known at the time of the claim. Cases of total and irreversible loss of sight in both eyes as a result of an accident are excluded.

9.9 **DEAFNESS (LOSS OF HEARING)** means total and irreversible loss of hearing of all sounds for a continuous period of at least 12 months in both ears as a result of acute illness. The total and irreversible character of the deafness in both ears must be attested by the report of a medical specialist (otologist) confirming that the total deafness in both ears cannot be corrected by any of the medical procedures known at the time of the claim. Cases of total and irreversible loss of hearing in both ears as a result of an accident are excluded.

9.10 **BENIGN BRAIN TUMOUR** means a tumor located in the cranial vault and meeting both of the following criteria:

a) it is a non-malignant tumor in the brain tissue or a non-malignant intracranial tumor the growth of which causes damage to the brain,
b) presence of the tumor necessitates a neurosurgery or (if the tumor is inoperable) causes a permanent neurological deficit with persisting clinical symptoms.

The presence of the benign brain tumor must be confirmed by a neurologist or neurosurgeon in a written medical report.

For the above definition, the following diagnoses are not covered:

a) cysts,
b) granulomas,

c) malformations of the arteries of the brain,
d) malformations of the veins of the brain,
e) hematomas,
f) tumors of the pituitary gland,
g) tumors of the spinal cord.

9.11 **HIV INFECTION FROM BLOOD TRANSFUSION** means proving the presence of HIV (Human Immunodeficiency Virus) in serum, if all the following criteria are fulfilled:

a) infection was demonstrably passed on the Insured Person through a blood transfusion received within the territory of the EU member states during the period insured of the CI 1.4 insurance,

b) the institution which provided the transfusion admits liability in a written confirmation or there is a final court verdict that cannot be appealed indicating such liability and this confirmation or verdict is provided to the Insurance Company,
c) the infected Insured Person is not a hemophiliac.

The Insured Person is obliged to provide all the blood tests results to the Insurance Company and to undergo, on the Insurance Company's request, an examination in the medical institution authorized by the Insurance Company.

No benefit is payable under this condition if the Insured Person was infected with HIV in any other manner than through blood transfusion or if a licensed cure for HIV infection has become available prior to the Insured Event notification date.

9.12 **OCCUPATIONALLY ACQUIRED HIV INFECTION** means proving the presence of HIV (Human Immunodeficiency Virus) in serum, if all the following criteria are fulfilled:

a) HIV infection was demonstrably transferred to the Insured Person's organism during the term of the CI 1.4 insurance
    - while the Insured Person performed his/her normal work duties in his/her occupation listed below,
    - through a physical assault of the Insured Person performing his/her occupation listed below,
    - while the Insured Person occupationally handled blood or other bodily fluid in relation to his/her occupation,
b) seroconversion took place during 6 months after the transmission of infection,
c) the Insured Person attested the negative result of the test for the presence of HIV virus or HIV antibodies; the examination must be carried out within 5 days after the transmission of infection,
d) the Insured Person attested the presence of HIV virus or HIV antibodies within 12 months after the transmission of infection,
e) the Insured Person provided the documentation proving, in accordance with the Ministry of Health regulation No. 104/2012 Coll., on recognition of occupationally-related diseases, that HIV was occupationally acquired,
f) if infection was transmitted as a result of physical assault of the Insured Person while performing his/her profession, the event must be reported to the appropriate law enforcement authorities, properly investigated in accordance with the established procedures and the outcome of the investigation must be submitted to the Insurance Company in the form of a report.

The list of occupational groups exposed to the HIV risk in the workplace and covered by this insurance:
a) doctors and dentists,
b) nurses,
c) medical laboratory technicians, laboratory assistants and other laboratory workers,
d) ancillary hospital workers,

MetLife

e) medical and radiology assistants,
f) paramedics and drivers of emergency medical services,
g) midwives,
h) fire-fighters,
i) policemen/policewomen,
j) prison officers.

9.13 **HIV INFECTION RESULTING FROM PHYSICAL ASSAULT OR LAY FIRST AID PROVIDED AFTER TRAFFIC ACCIDENT** means HIV infection acquired by the Insured Person as a result of a physical assault or in connection with lay first aid provided after a traffic accident. To prove that HIV contamination resulted from such circumstances, the following criteria must be fulfilled:

a) the physical assault or traffic accident were reported to the appropriate law enforcement authorities, the matter was properly investigated in accordance with the established procedures and the outcome of the investigation was submitted to the Insurance Company in the form of a report,
b) seroconversion took place during 6 months after the transmission of infection,
c) the Insured Person attested the negative result of the test for the presence of HIV virus or HIV antibodies; the examination must be carried out within 5 days after the transmission of infection,
d) the Insured Person attested the presence of HIV virus or HIV antibodies within 12 months after the transmission of infection,

9.14 **CRITICAL TICK-BORNE ILLNESS** means a severe form of tick-borne meningoencephalitis or Lyme disease, which is caused by tick bites. Symptoms of the disease must appear in a period of 3 months following the tick bite and persist continuously for at least 6 months, and the diagnosis of the disease must be documented in accordance with the criteria below, respectively.

Tick-borne meningoencephalitis (TBME) is encephalitis or meningitis caused by specific arboviruses which are usually transmitted by ticks in areas with generally known epidemic occurrence of tick-borne meningoencephalitis. The condition is considered documented if all of the following criteria are met:

a) the Insured Person attested history of a tick bite recorded in his/her medical documentation, including the date,
b) the Insured Person stayed in an area with generally known epidemic occurrence of TBME,
c) the Insured Person receives proper treatment for TBME either in hospital or as an outpatient,
d) the Insured Person attested the presence of TBME antibodies in serum and/or in the cerebrospinal fluid and an increase in the IgM antibodies level proving an acute infection,
e) severe neurological and/or psychiatric sequels caused by TBME are confirmed by a qualified medical specialist.

Lyme disease is a bacterial, inflammatory infectious disease with severe skin, neurological, cardiac and joint symptoms and manifestations. The condition is considered documented if all of the following criteria are met:

a) the Insured Person attested history of a tick bite recorded in his/her medical documentation, including the date,
b) the Insured Person definitely attested the presence of the bacteria Borrelia burgdorferi,
c) the Insured Person attested the presence of specific antibodies to Lyme disease (IgM and IgG proving an acute infection),
d) manifestations caused by Lyme disease and the severity of its consequences are confirmed by a qualified medical specialist.

9.15 **MULTIPLE SCLEROSIS** means an inflammatory disease of the central nervous system with cores of demyelination of the central nervous system. The diagnosis must be made by a consultant neurologist and documented by results of a magnetic resonance imaging (MRI) and/or computer tomography (CT) scans and another test (liquor analysis, evoked potentials

examination, determination of serum autoantibodies, etc.). Disease of the central nervous system due
to any other causes (e.g. diseases of blood vessels or bacterial or viral diseases) must be unequivocally excluded.

The disease must show permanent and irreversible neurological deficits. Neurological deficits mean at least one of the following conditions of the Insured Person:

a) paralysis in both upper limbs or both lower limbs making it impossible for the Insured Person to perform some of activities of daily living (e.g. to feed himself/herself once food has been prepared and made available),
b) serious walking impairment which can be neurologically verified,
c) the Insured Person is confined to a wheelchair.

The irreversibility of neurological deficits must be diagnosed and confirmed by a neurologist no sooner than 6 months after the first occurrence of a permanent neurological deficit resulting from multiple sclerosis.

9.16 **COMA** means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the life support systems are required.
Coma must result in permanent and irreversible neurological deficit causing permanent and irreversible inability of the Insured Person to perform one or more of the following activities of daily living:

a) to move indoors from room to room on level surfaces,
b) to feed him/herself once food has been prepared and made available,
c) to communicate with his/her environment by verbal speech.

Permanent and irreversible neurological deficit causing the permanent and irreversible inability of the Insured Person performing one or more of the above listed activities of daily living is not a required condition for an Insured Event, if the coma has lasted without interruption for at least 2 months.

9.17 **SEVERE DEMENTIA** is a chronic or persistent organic mental disorder characterized by significant general loss of brain capacity resulting in memory disorders, impaired reasoning, impaired abstract reasoning and personality changes. The diagnosis must be confirmed by a medical specialist on the basis of standardized diagnostic methods and tests. Benefit will be payable only if the medical findings confirm that the loss or impairment of brain functions caused by this disease is permanent and irreversible and the condition of the Insured Person is due to the disease so severe that it requires continuous supervision and care of the Insured Person by another person so that the Insured Person does not endanger himself/herself or his/her environment.

No benefit will be payable if the disease resulted from excessive consumption of alcohol or from drug abuse.

9.18 **ALZHEIMER´S DISEASE** is a progressive and degenerative brain disease characterized by cortex atrophy and typical histopathological changes in the brain cells. The diagnosis must be confirmed by a medical specialist on the basis of standardized diagnostic methods and tests. Benefit will be payable only if medical findings confirm that the loss or impairment of brain functions caused by this disease is permanent and irreversible and the condition of the Insured Person is due to the disease so severe that it requires continuous supervision and care of the Insured Person by another person so that the Insured Person does not endanger himself/herself or his/her environment.

No benefit will be payable if the disease is caused by inappropriate use of alcohol, drugs or other substances.

9.19 **AORTIC SURGERY** means the undergoing of surgery on the thoracic or abdominal aorta (the term “aorta” includes the thoracic and abdominal aorta, but not its branches). The purpose of the surgery is to repair or correct an aneurysm, narrowing, obstruction or traumatic rupture or tearing (dissection) of the aorta through surgical opening of the chest or abdomen. Benefit will be payable if medical findings confirm the above facts and the surgery is determined to be medically necessary by a medical specialist.

No benefit will be payable if the aortic surgery was necessitated by a disease or illness caused by or acquired as a result of excessive consumption of alcohol or substance abuse.

9.20 **BACTERIAL MENINGITIS** means an inflammatory disease which affects the membranes (meninges) surrounding the brain and spinal cord and which is caused by a bacterial infection. Benefit will be payable if medical findings confirm that the disease caused any of the following permanent and irreversible neurological deficits:

a) limited mobility (the Insured Person is unable to walk without help on level surfaces), or
b) inability of the Insured Person to feed himself/herself once food has been prepared and made available), or
c) inability of the Insured Person to communicate with his environment by verbal speech.

9.21 **HEART VALVE SURGERY** means the undergoing of open-heart surgery via thoracotomy to replace or repair a defect or abnormalities of the heart valve. Benefit will be payable if medical findings support the diagnosis and the heart valve surgery is confirmed to be medically necessary.

No benefit will be payable if the surgery was necessitated by a disease or illness caused by or acquired as a result of excessive consumption of alcohol or substance abuse.

9.22 **SPINAL MUSCULAR ATROPHY** is a progressive degenerative disease of the nervous system, which leads to excessive loss of motor neurons of the brain and spinal cord. Benefit will be payable if medical findings confirm that the disease caused either of the following permanent and irreversible neurological deficits:

a) limited mobility (the Insured Person is unable to walk on level surfaces), or
b) inability of the Insured Person to feed himself/herself once food has been prepared and made available).

9.23 **PROGRESSIVE BULBAR POLIO** is a progressive degenerative disease of the nervous system, which leads to excessive loss of motor neurons of the brain and spinal cord. Benefit will be payable if medical findings confirm that the disease caused a permanent and irreversible neurological deficit consisting in the Insured Person ´s inability to feed himself/herself once food has been prepared and made available.

9.24 **AMYOTROPHIC LATERAL SCLEROSIS AND PRIMARY LATERAL SCLEROSIS** is a progressive degenerative disease of the nervous system, which leads to excessive loss of motor neurons of the brain and spinal cord. Benefit will be payable if medical findings confirm that the disease caused either of the following permanent and irreversible neurological deficits:

a) limited mobility (the Insured Person is unable to walk without help on level surfaces), or
b) inability of the Insured Person to feed himself/herself once food has been prepared and made available).

9.25 **PARALYSIS** means a total and irreversible loss of use of at least two entire limbs due to injury or disease affecting the spinal cord. A limb means the entire upper limb or the entire leg. The diagnosis must be confirmed by a neurologist.

9.26 **PARKINSON´S DISEASE** is a slowly progressive disorder of the central nervous system, where degenerative changes of central (brain) neurons and their death result in not enough dopamine produced in certain regions of the brain. The disease is covered if there is a definite diagnosis made by a neurologist and if medical findings support existence of all of the three conditions below:

a) symptoms of the disease persist despite the fact that the Insured Person properly takes prescribed drugs,
b) the disease shows signs of progressive deterioration,
c) the disease caused permanent and irreversible neurological deficit in the form of reduced mobility (the Insured Person is not capable of walking without help on flat surfaces).

No benefit will be payable if the disease is caused by inappropriate use of alcohol, drugs or other substances.

9.27 **CHRONIC LUNG FAILURE** is the end stage lung disease. Benefit is payable if medical findings confirm that as result of the disease the Insured Person continuously needs oxygen therapy for at least 8 hours a day and if his/her forced expiratory volume in 1 second (FEV1) is permanently less than 1 liter.

9.28 **CROHN´S DISEASE** is a chronic granulomatous inflammatory bowel disease. The diagnosis must be supported by histo(patho)logical evidence and at the same time the medical finding must confirm that the disease has caused a fistula, bowel obstruction or perforation.

9.29 **PRIMARY (IDIOPATHIC AND FAMILIAL) PULMONARY HYPERTENSION** means pathological increase of pressure in pulmonary arterial vessels, causing structural, functional or circulatory disorders in the lungs which result in an enlargement of the right ventricle of the heart. The disease is covered under this insurance if medical findings confirm that both these conditions occur as a direct result of the disease:

a) permanent and irreversible physical impairment, or dyspnea, is at least Class IV of the NYHA classification of cardiac impairment,
b) pulmonary artery pressure has been higher than 30 mm Hg for at least 6 months.

9.30 **ENCEPHALITIS** means inflammation of the brain (cerebral hemispheres, brainstem or cerebellum). Benefit is payable if medical findings confirm that the disease caused any of these neurological pathologies: mental retardation, blindness, deafness, speech disorder, hemiplegia or paralysis, and this condition has lasted for at least 6 weeks and is the cause of any of the following permanent and irreversible neurological deficits:

a) limited mobility (the Insured Person is unable to walk without help on level surfaces), or
b) inability of the Insured Person to feed himself/herself once food has been prepared and made available, or
c) inability of the Insured Person to communicate with his/her environment by verbal speech.

9.31 **POLIOMYELITIS (CEREBRAL PALSY)** is an acute polio virus infection which leads to movement disorders and/or respiratory insufficiency. Benefit is payable if medical findings confirm that the disease caused permanent and irreversible neurological damage, which is permanent and irreversible paralysis of the limbs.

9.32 **APLASTIC ANAEMIA** means a chronic bone marrow failure which results in anemia, neutropenia and thrombocytopenia. The disease is covered if the aplastic anemia diagnosis is confirmed by a hematologist and if medical findings confirm that the disease has led to the occurrence and persistence of all of these conditions:

a) concentration of granulocytes in blood is less than 500 per mm3 and of thrombocytes less than 20 000 per mm3,
b) at least one of the following treatments is provided to the Insured Person:
   - regular blood transfusions for a period of at least 2 months,
   - bone marrow transplantation.

No benefit will be payable if aplastic anemia occurs as a consequence of certain types of treatment of another disease or if it is first diagnosed within the first 2 years after the CI 1.4 commencement date and the disease was at the same time related to chronic general anemia of which the Insured

MetLife

Person was aware before the CI 1.4 commencement date.

9.33 **TETANUS** means an acute infection caused by the bacteria Clostridium tetani. Benefit will be payable if medical findings confirm that the disease caused muscle weakness and respiratory insufficiency lasting for a period of at least 4 weeks and if the Insured Person is treated for the disease in an inpatient department of a hospital. The condition is not covered if the Insured Person did not receive tetanus vaccines in accordance with the applicable vaccination schedule.

[ZPPSNP CI 1.4]