Addendum to Critical Illness Insurance

Policy Terms VL-4

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Critical illness insurance provides financial protection in the event of serious illnesses covered by the insurance. Pursuant to this addendum, the scope of the critical illness insurance is extended to also cover certain medical events that may arise during pregnancy or childbirth. In addition, the insured is given access to psychological support in the form of counselling sessions when the insured experiences trauma in connection with pregnancy or childbirth.

The insurance is governed by the insurance certificate together with its endorsements and special terms, the company's critical illness insurance policy terms, this addendum, the company's general terms no. AS-1, and the provisions of the Insurance Contracts Act no. 30/2004, hereinafter referred to as ICA. Provisions in this addendum take precedence over provisions in the general terms where there is any conflict.

Definitions

Trauma: An event that causes severe stress reactions in an individual and leads to the person suffering from psychological difficulties in its aftermath.

The company: Vörður líftryggingar hf.

ICD: The International Classification of Diseases and Related Health Problems. The definitions of illnesses set out in these terms are from the World Health Organization (WHO), which maintains dedicated websites on ICD-10 and its regular updates. Updates in Iceland are guided by WHO directives on their entry into force.

Accident: A sudden, external event that causes bodily injury to the insured and occurs against their will.

Policyholder: The individual who enters into an individual contract with the company.

Insured: The individual to whom the insurance applies.

Insured event: An occurrence which, pursuant to the insurance contract, may give rise to payment of benefits.

Insurance certificate: The company's confirmation that an insurance contract has been concluded.

Chapter 1. Pregnancy- or Childbirth-Related Events

Art. 1. What does the insurance cover?

The insurance pays a lump sum equal to the sum insured if any of the following occurs during pregnancy or childbirth. Benefits are paid only once per pregnancy to the pregnant person even if more than one compensable event occurs. The sum insured is stated on the insured's certificate.

Benefits are paid if one of the following events or diagnoses occurs during pregnancy or childbirth:

a. **Pre-eclampsia.** Benefits are paid if pre-eclampsia develops in the pregnant person (ICD O14 or O15).
b. **Ectopic pregnancy requiring intervention.** If the foetus implants outside the uterus and must be removed by surgery or drug treatment (ICD O00).
c. **Pregnancy loss after 14+0 weeks.** Benefits are paid when pregnancy loss occurs after 14+0 weeks of pregnancy (ICD O02–O03) or pregnancy termination attributable to a confirmed diagnosis of a serious foetal abnormality (ICD O28).
d. **Severe morning sickness.** Pathological nausea and vomiting requiring hospitalisation or intravenous fluid administration, defined as severe hyperemesis gravidarum (ICD O21.1).
e. **Severe postpartum haemorrhage.** Benefits are paid if medical records from the maternity ward confirm blood loss of ≥1,500 ml in connection with delivery (ICD O72).
f. **Severe perineal tear.** A 3rd or 4th degree perineal tear, which can be confirmed by medical records from the maternity ward (ICD O70.2 or O70.3).
g. **Placenta accreta.** When the placenta grows abnormally deep into the uterine wall and does not separate normally after delivery (ICD O43.2).
h. **Placental abruption.** If the placenta separates before delivery of the child, benefits are paid (ICD O45).
i. **DIC (disseminated intravascular coagulation).** If a serious disturbance of blood coagulation occurs in connection with delivery, benefits are paid (ICD O72.3, D65).

Art. 2. What does the insurance not cover?

The company does not pay benefits for:

a. illnesses or conditions that existed before this addendum came into effect, including diagnoses or symptoms traceable to a condition that began prior to pregnancy. The coverage also does not extend to conditions that recur or worsen during the pregnancy or birth period due to a prior condition.
b. pregnancy termination for reasons other than those listed above
c. events or illnesses other than those specifically listed in this addendum
d. illnesses, physical defects, or other conditions attributable in any part to the consumption of alcohol, drugs, or narcotics
e. illnesses or conditions rooted in cosmetic or reconstructive procedures during pregnancy

Art. 3. General provisions

a. Benefits for pregnancy- and childbirth-related events are paid once per pregnancy, regardless of how many insurance certificates the insured may hold in force.
b. Once benefits have been paid for a specific event, benefits are not paid again on the insured's next pregnancy for the same event.
c. It is a condition of entitlement to benefits under this coverage that confirmation of the pregnancy- or childbirth-related event from a physician, midwife, or specialist is available.
d. The coverage is valid only while the insured's critical illness insurance is in force. No benefits are paid for events occurring before the insurance comes into effect or after it lapses.
e. The company is entitled to obtain information about the insured's prior health if such information is necessary to assess the insured's entitlement to benefits. The

company pays the cost of necessary medical certificates in connection with an insured event when obtained at the company's request.

Chapter 2. Congenital Health Condition of a Child

Art. 4. What does the insurance cover?

The insurance pays a lump sum equal to the sum insured to the policyholder if the insured's child is diagnosed with one of the following, provided the diagnosis is confirmed within 12 months of the child's birth. The sum insured is stated on the insured's certificate.

Entitlement to benefits does not arise until at least 30 days after the diagnosis has been confirmed by a specialist physician.

Benefits are paid for:

a. **Cerebral palsy.** A diagnosis of cerebral palsy confirming permanent motor impairment caused by damage to the central nervous system (ICD G80).
b. **Hydrocephalus.** Congenital hydrocephalus requiring medical treatment, such as surgery or ongoing monitoring (ICD Q03).
c. **Spina bifida.** A diagnosis of spina bifida involving neurological consequences and/or the need for surgery (ICD Q05).
d. **Congenital heart defects.** Heart defects requiring surgery within the first 6 months of the child's life (ICD Q20–Q26).
e. **Cleft palate and cleft lip.** A diagnosis of cleft lip and/or palate requiring surgery and/or specialised treatment (ICD Q35–Q37).
f. **Serious congenital structural abnormalities of the abdominal wall or diaphragm.** A diagnosis of congenital defects requiring immediate surgery after birth (ICD Q79.2, Q79.3).
g. **Chromosomal abnormalities.** Congenital disability or chromosomal abnormalities, confirmed by genetic analysis, requiring long-term care (ICD Q00–Q99).
h. **Club foot or serious limb abnormality.** A diagnosis of club foot requiring casting or surgery (ICD Q66.0, Q66.1, Q66.4) or absence of a limb (ICD Q71–72).
i. **Serious hypoxia.** Serious oxygen deprivation at birth resulting in cooling treatment (ICD P21.0).

Rare diseases

Even if a congenital condition does not fall under the diagnoses listed above, the insurance nonetheless pays benefits for rare, life-threatening, and hereditary diseases of the insured's child, or for a serious accident occurring to the child in the womb or at birth.

For benefits to be paid for a rare disease or accident, two of the following conditions must be met:

1. Confirmed medical diagnosis.
2. The disease/accident must involve reduced life expectancy and long-term care needs.
3. The disease/accident must involve physical or biological impairments causing serious reduction in quality of life and/or function.

Art. 5. What does the insurance not cover?

a. Health conditions of the child that existed before this addendum came into effect, including diagnoses or symptoms.
b. The sum insured is paid for only one of the diagnoses listed above, even if the child has multiple diagnoses and even if the insured holds more than one policy in force.
c. It is a condition of payment of benefits that the child survives for 30 days from the date of diagnosis, the date on which the procedure was carried out, or the date on which another insured event occurred.

Chapter 3. Counselling Sessions

Art. 6. What does the insurance cover?

The insurance provides the insured parent with up to five counselling sessions per pregnancy with a service provider designated and paid for by the company from time to time. All parents may avail of the sessions, regardless of who carries the child. The sessions may be individual sessions, therapeutic consultations, or comparable services aimed at supporting the insured in processing trauma, difficulties, or serious life experiences related to pregnancy or childbirth.

Art. 7. Entitlement to benefits

Entitlement to counselling sessions arises if the insured experiences one of the following during pregnancy or childbirth:

a. a compensable event pursuant to Chapter 1 or Chapter 2 of the insurance
b. antenatal or postnatal depression (ICD F53)
c. pregnancy loss before 14+0 weeks of gestation (ICD O01–O03, O36.4)
d. a difficult or traumatic birth experience
e. emergency caesarean section (ICD O82.1)
f. domestic violence
g. consequences of cerebrospinal fluid leak following epidural anaesthesia (e.g. spinal headache) (ICD G97.0)
h. very premature birth, meaning the child is born before 32+0 weeks of gestation and required hospitalisation following birth due to premature development (ICD P07)
i. multiple pregnancy of more than two children (ICD O30.2, O30.3)
j. in the event of pregnancy loss, the insured may also request counselling sessions for the insured's children, taking into account their age and circumstances

Art. 8. What does the insurance not cover?

The company does not provide counselling sessions for:

a. traumas or illnesses that began before the insurance came into effect or coverage commenced
b. events or illnesses other than those specifically listed as compensable in these terms

Art. 9. General provisions

a. Other additional costs that may arise in connection with treatment or events, such as travel costs or comparable expenses, are not covered by the insurance.
b. It is necessary to notify the company of the event in order to obtain approval for the treatment.

c. The company bears no responsibility for the quality or outcome of the service, only for ensuring that the insured is allocated the designated hours with a contracted service provider within a reasonable time.

These terms are valid from 15.10.2025

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