PERSONAL INSURANCE (Corporate clients)

Terms and conditions No. 0102.01
Valid from 18.12.2025

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VIENNA INSURANCE GROUP

BTA and Policyholders conclude Personal Insurance Contracts on the basis of these Terms and conditions.

CONTENT

GENERAL INSURANCE CONCEPTS AND CONDITIONS

1. INSURANCE CONTRACT CONCEPTS

Insured person – a person whose property interests are insured:

a) In the case of property insurance – according to the insurance contract, the owner of the insured property or a person specified in the contract in writing;

b) In the case of civil liability insurance – a person whose property interests arising from civil liability are insured;

c) In the case of personal insurance – a natural person specified in the insurance contract, whose health, life or physical condition is insured by the insurance contract.

Policyholder or you – a person who has either applied to BTA in order to conclude an insurance contract or who has received an offer from BTA to conclude an insurance contract or who has concluded an insurance contract with BTA for his/her own benefit or for the benefit of others.

Insurer or we – AAS "BTA Baltic Insurance Company", represented by the branch in Lithuania, hereinafter referred to as BTA.

Insurance premium – the amount of money specified in the insurance contract, which the policyholder must pay to BTA for insurance coverage under the terms and conditions of the insurance contract.

Insurance interest – the interest of the Insured person not to suffer losses due to the occurrence of the insured event.

Insurance benefit – the amount of money paid upon the occurrence of an insured event or the provision of services, if this is provided for in the insurance contract.

Insurance object – property interests related to a person's life, health, property or civil liability.

Insured risk – the probability of an event, the occurrence of which is possible in the future and which does not depend on the will of the Policyholder and/or the Insured person.

Insurance amount – the amount of money specified in the insurance contract or calculated according to the method specified in the insurance contract which the insurance benefit may not exceed.

Insurance contract certificate (policy) – a document confirming the conclusion of an insurance contract and covering the terms and conditions of the insurance contract agreed upon by BTA and the Policyholder.

Parties to the insurance contract – the Policyholder and BTA.

Insurance contract – an agreement between BTA and the Policyholder under which the Policyholder undertakes to pay the insurance premium of the agreed amount within the time limits set in the insurance contract, to perform other obligations laid down in the insurance contract, and BTA undertakes to pay the insurance benefit to the person specified in the insurance contract in the event of an insured event in accordance with the provisions of the insurance contract.

Insured event – an event specified in the insurance contract, upon the occurrence of which BTA must pay an insurance benefit.

Double insurance – cases where the Policyholder concludes several insurance contracts for the same insured risks in several or the same insurance company. In such a case, the Policyholder must notify BTA in writing of the conclusion of another insurance contract and indicate the insurance amount and other terms and conditions of the contract. Otherwise, upon payment of the insurance benefit, the Insurer shall acquire the right to recover the relevant part of the insurance benefit.

Deduction – the part of the insurance benefit, which is defined in the insurance contract, which shall not be indemnified by BTA. The deduction shall be defined in terms of a specific monetary amount and/or percentage of loss unless otherwise specified in the insurance policy. If the insurance contract provides for several types of deductions for the same risk, the higher of them shall always apply.

Compensatory principle – the principle of insurance that calculates the insurance benefit on the basis of the amount of losses incurred as a result of the insured event.

Beneficiary – the person specified in the insurance contract or the person appointed by the Policyholder and, in the cases specified in the insurance contract, also the person appointed by the Insured person who is entitled to the insurance benefit.

Non-insured event – a case where BTA shall not pay the insurance benefit.

Incomplete insurance – cases where the determined insurance amount is lower than the insurance value. In such a case, upon the occurrence of the insured event, BTA pays out a part of the benefit proportional to the ratio of the insurance amount and insurance value.

Additional insurance – cases where only part of the property value or insured risk is insured. In this case, the Policyholder has the right to conclude an additional insurance contract with the same or another insurance company. In this case, the insurance amount under several insurance contracts cannot exceed the insurance value.

Application for an insurance contract – a document in the form prescribed by BTA, in which the Policyholder provides the necessary information for the conclusion of an insurance contract. An application may not be submitted if the Policyholder provides BTA with information that BTA considers sufficient to assess the insured risk. Acceptance of an application for the conclusion of an insurance contract shall not obligate BTA to conclude an insurance contract.

Written document:

a) concluded in written form and covering all necessary details, including a signature corresponding to the applicable legal acts in the Republic of Lithuania;

b) transmitted by telegraph, facsimile or other telecommunications terminal equipment, provided that the safety of the text is ensured and the signature can be identified, including electronic mail.

Security contribution – an established monetary obligation to the state for the purposes of financing the State Defense Fund.

Persons related to the Policyholder and/or the Insured person, who are also obliged to fulfill the obligations assigned to the Policyholder:

a) Persons who live together with the Policyholder or the Insured person;

b) Persons who are responsible for the insurance object under the agreement with the Policyholder or the Insured person;

c) Persons who have an insurance interest together with the Policyholder or Insured person, or other persons specified in the insurance contract;

d) Persons related to the Policyholder or Insured person in employment, service provision or other legal relations, and have an obligation to act in accordance with safety requirements.

2. VALIDITY OF INSURANCE COVERAGE

2.1. The period of insurance shall be the period of time during which the insurance coverage shall be valid.

2.2. Insurance coverage shall take effect on the date specified in the insurance contract at 00:00, but not before the insurance premium or first instalment thereof is paid, provided that:

2.2.1. The date of payment of the insurance premium or of the first instalment thereof is not specified in the insurance contract;

2.2.2. The beginning of the period of insurance shall coincide with the date of payment of the insurance premium or the first instalment thereof;

2.2.3. The date of payment of the insurance premium or of the first instalment thereof is earlier than the date of payment of the insurance premium or of the first instalment thereof is earlier than the.

2.3. In cases where the entry into force of insurance coverage is linked to the payment of the insurance premium or the first instalment thereof, insurance coverage shall take effect on the next day at 00:00 after the day of the receipt of the money, but not earlier than the date specified in the insurance contract.

2.4. The insurance benefit shall not be paid in the event of an insured event prior to the entry into force of the insurance coverage.

2.5. If the insurance contract provides that the premium must be paid after the first day of the commencement of the insurance period, the insurance coverage shall take effect on the first day of the insurance period at 00:00.

2.6. The insurance contract shall be valid until the last day 24:00 of the insurance period provided for in the insurance contract if the insurance contract does not expire other reasons.

3. POLICYHOLDER'S OBLIGATION TO DISCLOSURE INFORMATION

3.1. Before signing an insurance contract, the Policyholder undertakes to provide BTA with the correct and complete information requested by BTA, which is related to the insurance object and is necessary to assess the risk of the insurance. If the Policyholder intentionally fails to disclose information that is necessary to assess the risk of the insurance or deliberately provides false or incomplete information, BTA shall have the right to claim nullity of the insurance contract. In this case, BTA shall not refund insurance premium.

3.2. If the insurance contract for the same insurance object is extended immediately after the expiry of the previous contract, and the Policyholder or the Insured does not indicate that the information has changed since the conclusion of the previous insurance contract, BTA shall consider that the information previously provided has not changed.

3.3. During the period of validity of the insurance contract, the Policyholder shall notify in writing immediately of any changes during the period of validity of the insurance, which may increase the risk of the insurance. The changes to be notified shall be:

3.3.1. Significant changes related to the insurance object;

3.3.2. Changes in the manner in which the insurance object is used;

3.3.3. Other material circumstances which increase the risk of insurance.

3.4. If the information provided to BTA on the insurance object and the insured risk changes, which increases the risk of the insurance, as well as where BTA is misled as a result of a non-material mistake by the Policyholder, BTA shall have the right to propose to the Policyholder to change the terms and conditions of the insurance contract, including the amount of the insurance premium, within one month from the day of becoming aware out about it.

3.5. If the Policyholder does not agree to change the terms and conditions of the insurance contract or does not reply to BTA within 1 month from the date of dispatch of the notification of the proposed new terms, BTA shall be entitled to terminate the insurance contract at the end of the period referred to in this sentence without separate notification.

3.6. If BTA proves that knowing about the increased risk would not have entered into an insurance contract, BTA shall have the right to terminate the insurance contract within 2 months of becoming aware of the increased risk.

3.7. Violation of the obligation of the Policyholder to disclose the information shall also cause other legal consequences established in the legal acts of the Republic of Lithuania.

4. INSURANCE PREMIUM AND PROCEDURE OF PAYMENT THEREOF

4.1. The Policyholder shall be obliged to pay the insurance premium to BTA, within the prescribed amount and within the specified time limits, as provided for in the insurance contract:

4.1.1. Your insurance premium consists of:

a) the premium for insurance coverage;

b) a 10% security contribution, as provided for in the Law on Security Contribution of the Republic of Lithuania.

4.1.2. If the full insurance premium is not paid, the portion corresponding to the security contribution shall be credited first, and the remaining amount shall be credited towards the premium for insurance coverage.

4.2. The insurance premium shall be deemed to have been paid:

4.2.1. In case the insurance premium is paid by wire transfer – from receipt of the amount of money to the bank account of BTA or an authorized insurance intermediary;

4.2.2. In case the insurance premium is paid by other payment methods – from the date specified in the specific document confirming the fact of payment of money. You can find the list of payment methods by visiting our website www.bta.lt or by calling (8 5) 2600 600.

4.3. If the Policyholder fails to pay the insurance premium within the time specified in the insurance contract, the Policyholder shall pay BTA 0.02% late interest for each day of delay, but no more than 10% of the total insurance premium outstanding. BTA will not apply the above-mentioned late interest in cases where:

4.3.1. The insurance premium is paid in a single payment;

4.3.2. The insurance premium is paid in installments – for the first payment.

4.4. If the policyholder fails to pay the insurance premium or part thereof within the time specified in the insurance contract (unless the entry into force of the insurance contract is linked to the payment of the premium or part thereof, in which case the insurance contract shall not enter into force and shall be cancelled without a separate notification from the insurer 10 days after the premium payment deadline), BTA shall inform in a written document stipulated in the contract that if the Policyholder fails to pay the insurance premium or a part thereof within 30 days from the date of sending the written document, the insurance contract will expire.

5. CONCLUSION OF INSURANCE CONTRACTS WITH TELECOMMUNICATIONS TERMINAL EQUIPMENT

5.1. The insurance contract may be concluded by means of telecommunications terminal equipment, i.e., mail, internet, e-mail, telephone and other means of exchange of information.

5.2. When an insurance contract is concluded by a Policyholder who is a consumer, the guidelines for concluding non-life insurance contracts, which are publicly available at www.bta.lt, shall apply to such a contract. The guidelines for the concluding non-life insurance contracts provide, inter alia, for a procedure for the right of withdrawal, i.e., the right to withdraw from the concluded insurance contract.

5.3. A consumer is a natural person who concludes an insurance contract for purposes other than business or professional activity.

6. EXPIRY AND AMENDMENT OF THE INSURANCE CONTRACT

6.1. The insurance contract shall expire on the last day of the insurance period at 24:00, unless the Policyholder and the BTA have agreed otherwise.

6.2. The Policyholder shall be entitled to terminate the insurance contract at any time by informing BTA in writing 15 days in advance. In this case, the insurance contract will be deemed to be terminated on the date specified in the notice, but not earlier than on the 15 (fifteenth) day after the notice of termination has been received.

In this case:

6.2.1. If the insurance benefit has not been paid or the claims have not been made during the period of validity of the insurance contract, BTA shall return to the Policyholder part of the insurance premium, excluding the costs of the conclusion and execution of the contract (30% of the amount to be reimbursed) within 20 calendar days after the receipt of the Policyholder's notification;

6.2.2. If the insurance benefit has been paid and/or reserved or claims have been filed during the term of the insurance contract, BTA shall return to the Policyholder part of the insurance premium, which is equal to the difference between the unused part of the insurance premium for the period of validity of the insurance contract and the paid insurance benefit, excluding the costs of the conclusion and execution of the contract (30% of the amount to be reimbursed) within 20 calendar days after the receipt of the Policyholder's notification.

6.2.3. The refundable amount of the insurance premium is calculated based on the total amount of the insurance premium you have paid, including the 10% security contribution, as provided for in the Law on Security Contribution of the Republic of Lithuania.

6.3. The terms and conditions of the insurance contract may be supplemented or amended only by a written agreement between the BTA and the Policyholder.

6.4. The insurance contract may be terminated on other grounds established in the insurance legislation of the Republic of Lithuania regulating the contractual legal relations of insurance.

7. GENERAL RESERVATIONS

7.1. Unless otherwise stipulated in the insurance contract, BTA shall not pay the insurance benefit due to:

7.1.1. Terrorist acts (acts involving the use of force or violence or threats of such acts by or on behalf of any the third party acting individually or in collaboration with any organization or government in interest thereof, for political, religious, ideological or ethnic reasons and with intent to is to put the government or society or part of it at risk); losses resulting from preventive action against terrorist acts shall also not be indemnified;

7.1.2. War, invasion, hostile acts of a foreign state, military or similar surgeries, such as civil war (whether or not war has been declared), riot, strike, insurrection, rebellion, revolution, state of war, marauding, vandalism, sabotage; strike, lockout, disturbances of public order amounting to

a coup or riot, confiscation of property, nationalization, if caused or sanctioned by the state authorities, whether lawful or not; other political risks and all other losses or costs incurred directly or indirectly due to the prevention of such actions shall also not be indemnified;

7.1.3. Direct or indirect nuclear explosion, exposure to nuclear energy or radioactive preparations, direct or indirect radioactive contamination;

7.1.4. Intentional actions of the Policyholder, the Insured person or the Beneficiary.

7.2. BTA shall not be entitled to provide insurance services and shall not be obliged to pay insurance benefits or provide other types of benefits under the insurance contract, if such provision of insurance services or benefits, as well as the payment of insurance benefits would cause:

7.2.1. BTA to violate sanctions, prohibitions or restrictions imposed by resolutions of the United Nations Organizations or trade or economic sanctions, normative acts of the European Union, the Republic of Lithuania, the United Kingdom or the United States of America;

7.2.2. The reinsurance company, to which the insurance contract was submitted for reinsurance, to violate applicable sanctions, prohibitions or restrictions, which are established by the legal acts of the state where the reinsurance company is registered.

7.3. An insured event shall not be considered and losses shall not be indemnified if they have occurred directly or indirectly due to:

7.3.1. Legal acts issued by the State;

7.3.2. In the event of a declared extreme or emergency situation, as well no damages will be indemnified, that are directly or indirectly related to any measures intended to avoid an extreme or emergency situation;

7.3.3. Epidemics or pandemics.

8. OBLIGATIONS OF THE POLICYHOLDER IN THE EVENT OF AN INSURED RISK

8.1. In order for the Policyholder or the Insured person to acquire the right to receive the insurance benefit in the event of the insured risk, he/she must:

8.1.1. Immediately inform the BTA of the occurrence of any possible insured event within 3 working days (unless otherwise specified in the special terms and conditions of these Terms and conditions) in accordance with the procedure laid down in the special terms and conditions of these Terms and conditions. If the Policyholder or the Insured person informs the BTA of the occurrence of the insured risk late, the Policyholder or the Insured person shall prove that it was not possible to inform in time;

8.1.2. Immediately inform the competent services (e.g., medical institution, fire and rescue department, police, emergency services, etc.);

8.1.3. Comply with all the instructions given by the BTA and take all measures to minimize damage and prevent its occurrence or increase;

8.1.4. Enable BTA to inspect the site of the event, to conduct an investigate and to interview witnesses in such a way that the BTA could determine the cause and amount of the loss;

8.1.5. Provide all the information and documents requested by the BTA, including commercial secrets, if known to the Policyholder or Insured person, in order to enable the BTA to determine the causes of the occurred insured risk and the amount of the damage;

8.1.6. If it is possible to maintain the site of the event intact until the arrival of the BTA representative unless BTA has given other instructions. This clause shall not apply to the extent necessary to comply with the requirements of clause 8.1.3. of these General Insurance Concepts and Conditions;

8.1.7. If the insurance object cannot be preserved without changing its condition after the event due to the fulfilment of the requirements of clause 8.1.3 of the General insurance definitions and conditions or due to other legal and reasonable reasons, take care that photos of damaged property are taken as soon as possible or the damaged property filmed in order to record losses, and send photos or video to BTA by e-mail: zalos@bta.lt or in another manner suitable for BTA.

8.2. If the Policyholder, the Insured person or the Beneficiary, intentionally or negligently, fails to comply with the obligations laid down in the Terms and conditions, the BTA shall be entitled to reduce or refuse to pay the insurance benefit.

9. INSURANCE BENEFIT

9.1. BTA shall pay the insurance benefit no later than 15 days after the date of receipt of all the information relevant to the determination of the fact, circumstances, consequences of the insured event and the amount of the insurance benefit.

9.2. If the event is an insured event and the policyholder and the BTA disagree on the amount of the insurance benefit, at the request of the Policyholder, the BTA shall pay the amount equal to undisputed benefit by the parties, where determining an exact amount of damage takes more than 3 months.

9.3. If the BTA delays the payment of the insurance benefit due to its own fault, the BTA shall pay 0,02% default interest from the amount of the insurance benefit due for each day of delay, however not exceeding 10% of the amount of the insurance benefit not paid in due time.

9.4. The payment of the insurance benefit shall set off all insurance premiums (for the current year of insurance) for which the payment deadline has expired on the date of payment of the insurance benefit. With the consent of the Policyholder, premiums the payment term for which is not expired may be included. In cases when the insurance object is ruined, destroyed or lost as a result of the insured event, the payment of the insurance benefit shall be subject to the deduction of any premiums not paid under the contract.

9.5. In the event that the BTA is unable to recover the refund of the benefit due to intentional acts or gross negligence on the part of the Insured person, the BTA may not pay the insurance benefit in the part where the claim is not possible or, if the insurance benefit has already been paid, claim the refund of the benefit from the Policyholder.

9.6. Upon the request of the person entitled to claim the insurance benefit, the BTA shall provide such person with access to the available documents on the basis of which BTA has made a decision to pay the insurance benefit or refused to pay the insurance benefit or issue copies of documents for a fee not exceeding the cost of issuing copies.

9.7. BTA shall not grant access to documents available and shall not provide a copy of documents to a person entitled to claim insurance benefit if

9.7.1. BTA has submitted documentation to law enforcement authorities for investigation of the circumstances of the appearance of the insured risk;

9.7.2. The documents contain a commercial secret of another person which person entitled to claim insurance benefit is not entitled to receive;

9.7.3. The documents contain personal data which person entitled to claim insurance benefit is not entitled to receive.

10. COMPLAINT HANDLING AND DISPUTE RESOLUTION PROCEDURE

10.1. The procedure for examination of complaints by BTA regarding dissatisfaction with the insurance contract or the insurance services provided, filed by the person requesting the award of the insurance contract, the Policyholder, the Insured person, the Beneficiary or another person entitled to claim the insurance benefit, is publicly available at www.bta.lt.

10.2. All disputes arising between the parties to the insurance contract shall be settled by negotiation. If the peaceful settlement is not reached, all disputes arising from the insurance contract and related to the breach, termination or invalidity of the insurance contract shall be settled in the court of the Republic of Lithuania in accordance with the laws of the Republic of Lithuania, in the courts of the Republic of Lithuania according to the address of the registered office of the BTA Lithuanian branch.

11. PERSONAL DATA PROCESSING

11.1. As a processor of personal data, BTA processes the data of natural persons in accordance with the personal data processing requirements defined in 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 (General Data Protection Regulation) and other legal requirements.

11.2. The principles of personal data processing and privacy policy implemented by BTA are published at www.bta.lt.

12. SUBROGATION AND THE RIGHT OF REGRESSION CLAIM

The insurer who has paid the insurance benefit shall be entitled to claim the amounts paid from the person responsible for the damage (subrogation or right of recourse). The Policyholder, the Insured person, or the Beneficiary shall provide all the information requested by BTA so that the Insurer can properly exercise the right of claim transferred to it.

13. CONFIDENTIALITY

The Parties undertake not to disclose confidential information obtained on the basis of an insurance contractual or pre-contractual legal relationship to third parties, nor to use such information in a manner that would infringe the interests of the other party to the insurance contract. BTA shall have the right to provide all necessary information to independent experts and reinsurers which was received on the basis of the contractual or pre-contractual relations, as well as to store it in BTA databases. This obligation shall not apply when the parties, in accordance with the requirements of the legislation of the Republic of Lithuania, are obliged to provide information to the competent state authorities.

14. OTHER TERMS AND CONDITIONS

14.1. Any notification which the Policyholder or the BTA must transmit to each other shall be made within the time limits specified in these Terms and conditions in one of the following ways:

14.1.1. By servicing to the Policyholder, at the addresses specified in the insurance policy or other written documents or in the notifications of the parties regarding the change of registered office addresses;

14.1.2. By sending the registered postal correspondence shipment;

14.1.3. By e-mail, where the parties have provided for this method of notification in the contract, or by tacit consent to the exchange of information in this way.

14.2. BTA shall have the right to transfer its rights and obligations under the insurance contract to another or other Insurers in accordance with the procedure established by legal acts. If the policyholder objects to the transfer of rights and duties under insurance contracts, he shall have the right to terminate the insurance contract within one month from the transfer of the rights and duties. In such a case, the Policyholder shall be reimbursed with the insurance premiums he has paid for the remaining period of the validity of the insurance contract.

14.3. Legal acts of the Republic of Lithuania shall apply to contractual insurance legal relations.

14.4. The insurance contract shall be concluded according to these general and special terms and conditions. If the special and/or individual terms and conditions of insurance specified in the contract (insurance policy)

and in these General Insurance Concepts and Terms and Conditions differ, the special and/or individual insurance terms and conditions shall prevail.

14.5. The Policyholder, the Insured person, the Beneficiary and other persons who acquire rights on the basis of an insurance contract shall comply with the obligations laid down in these Terms and conditions.

14.6. These Terms and conditions shall enter into force on the date of approval by the BTA Board if the BTA Board has not indicated the other date of entry into force of the Terms and conditions.

14.7. In case of contradictions or discrepancies between languages, the Lithuanian text shall prevail.

14.8. These Terms and conditions are published on the BTA website at the address http://www.bta.lt.

14.9. Consumer disputes with the insurer are handled by the Supervision Service of the Bank of Lithuania, Žalgirio str. 90, LT09303, Vilnius, website: www.lb.lt.

SPECIAL TERMS AND CONDITIONS

1. WHAT IS WHAT?

Intoxication condition – the Insured person's death due to an Accident will be recognized as an insured event even if the Insured person's blood alcohol concentration exceeds 0.4 permille. However, regardless of whether the Intoxication condition was selected, the event will not be recognized as insured if the Insured person was driving any vehicle at the time of the event, when the alcohol concentration in his/her blood exceeds the limit established by the legal acts of the country where the event took place and permitted for the vehicle driver.

Renewed contract – an insurance contract that enters into force on the day following the expiry of the previous contract concluded with the Insurer. The contract is considered renewed only if the Insured person is the same person as in the expired contract. If a new Insured person is included in the renewed contract, the conditions of the renewed contract are not applicable to him/her. If new insurance options are selected in the renewed contract, the conditions of the renewed contract do not apply to such insurance options.

Participation in competitions and training organized by the sports organization – participation in any kind of sports activities, trainings or competitions organized by a sports organization. Sports organizations include sports clubs, sports centers, sports schools, sports bases, sports federations, associations and societies with the status of a legal entity, other organizations and institutions engaged in sports activities that provide opportunities for practicing physical culture and sports, training athletes, organizing sports competitions and other physical culture and sports events. Individual or group sports activities that are not organized by a sports organization and are only a form of leisure for the Insured person are not considered Sports.

Increase/decrease in insured risk – the change or occurrence of the circumstances provided for in these Terms and conditions, the insurance certificate and/or other documents submitted to the Insurer, which may have a significant impact on the probability of the occurrence of the insured event and the amount of possible damage caused by this event. An increase/ decrease in insured risk is considered to be a change in the Insured person's work activity, sports activities or other form of activity specified in the insurance certificate.

Traffic event – a sudden, unexpected event that occurred during the validity of the insurance contract, beyond the control of the Insured person, in which at least one moving vehicle was involved, and people who were in the vehicle specified in the insurance certificate were killed or injured at the time.

You or the Insured person – a natural person specified in the insurance certificate (policy) (hereinafter referred to as the insurance certificate) who has an insurance interest and for whose benefit the insurance contract was concluded, or an employee of the Policyholder working for the benefit of the Policyholder under an employment contract concluded between the Policyholder and the Insured.

Critical Disease – the disease specified in clause 24.4., the first symptoms of which have been identified and the diagnosis of the disease has been confirmed during the period of validity of the insurance contract. The date of the disease is considered to be the day of the application to the health care institution, when the first symptoms of the disease were recorded, as a result of which the diagnosis of Critical Disease (hereinafter – Final Diagnosis) was confirmed no later than 1 month after the initial application.

Temporary incapacity for work – a period during which you are temporarily unable to perform the work obligations provided for in your employment contract due to an Injury recognized as an insured event in accordance with the terms and conditions of these Terms and conditions, and this is substantiated by medical documents and documents confirming incapacity for work.

Leisure activities – an active recreational activity, hobby, vacation, games, sports activities and other similar activities, with the exception of activities classified as Dangerous activities or Participation in competitions and training organized by a sports organization.

We or the Insurer – AAS "BTA Baltic Insurance Company", represented by a branch in Lithuania.

Accident – a sudden, unexpected, event beyond your control, which happened to you during the validity of the insurance contract, at a specific time and at a specific place and the cause of which was the effect of external forces, causing your injury, loss of working capacity or death.

Accident during a traffic event – a sudden, unexpected event beyond the Insured person's control that occurred during a traffic accident and caused the Insured person's Injury, Loss of working capacity or death.

Loss of working capacity – an event when, due to an Injury (which is recognized as an insured event according to the terms and conditions of these Terms and conditions), no later than within 1 year from its date, the competent state authority has established a 50% or higher level of loss of working capacity for you (for persons under 18 years of age – the level of disability), which must be confirmed twice by the competent state authority, provided that the second confirmation is accepted no earlier than 1 year after the first confirmation and during which a 50% or higher level of lost working capacity is determined (for persons under 18 years of age – the level of disability).

Repeated fracture – a bone fracture that occurred during an accident due to previous fracture of the same bone.

Pathological fracture – bone fracture due to changes in bone structure or fracture occurring in pathologically changed bones.

Dangerous activity – activities specified in clauses 3.2.1 – 3.2.11 of the Terms and conditions.

Plastic surgery – a surgery, the purpose of which is to remove clearly visible defects of the face/body, left as a result of an Injury, which is recognized as an insured event under the terms and conditions of these Terms and conditions.

Illness – a disease specified in clause 27.2., the first symptoms of which have been identified and the diagnosis of the disease has been confirmed during the period of validity of the insurance contract. The date of illness is considered the day of contacting the health care institution, when the first symptoms were recorded, which confirmed the diagnosis of the disease after the tests.

Vehicle – motor vehicle completed by the factory manufacturer, serially produced, registered according to the established procedure, with a license plate issued to it, intended for transporting people and/or transporting goods.
Injury – an injury that occurred during the period of the insurance contract due to an Accident and which is specified in the Annex to the Terms and conditions "Injuries to Bones, Soft Tissues and Internal Organs" – Table No. 1 (hereinafter – Annex 1) or in the Annex "Table of Long–Term Injuries Consequences of Insurance Benefits" Table No. 2 (hereinafter – Annex 2).

2. WHAT IS INSURED

2.1. The object of the insurance is the property interest related to your Injury, Loss of working capacity, death due to an Accident, as well as the Critical Disease and/or Illness specified in the Terms and conditions, and in the case of Personal Civil Liability, your personal civil liability towards Third Parties.

2.2. Insurance amount – the amount of money specified in the insurance certificate, up to which We will pay the insurance benefit. The insurance amount is determined by agreement between the Insurer and the Policyholder for each selected insured risk.

2.3. Insurance coverage is valid worldwide (unless otherwise specified in the insurance certificate), except for Daily allowance, Loss of working capacity, Medical expenses and Personal civil liability insured risks, which are valid only in the Republic of Lithuania.

3. VALIDITY OF INSURANCE COVERAGE DURING SPORTS OR DANGEROUS ACTIVITIES

3.1. Insurance coverage is valid for you during work, daily activities, leisure activities, except for activities that are classified as dangerous activities or participation in competitions organized by sports organizations, trainings. In the insurance certificate, it is necessary to select the risk of participation in competitions and trainings organized by a sports organization, if you participate in any type of sports activities, trainings or competitions organized by a sports organization. In any case, the insurance coverage is not valid for you for activities that are specified in these Terms and conditions as Dangerous activities or for activities specified in clauses 4.1.12 – 4.1.13 of the Terms and conditions.

3.2. Dangerous activities must be selected in the insurance certificate if your activity includes:

3.2.1. Mountaineering, mountain climbing above 3000 meters using special mountaineering equipment, spleneology, expeditions to mountains, jungles, deserts or other uninhabited places;

3.2.2. Motor sports;

3.2.3. Driving over 74 kW motorcycles (and as a passenger), water and snow motorcycles, quadricycles, go-karts. However, insurance coverage is not valid if you participated in competitions or training with the listed vehicles;

3.2.4. Bicycle sports;

3.2.5. Water sports (windsurfing, surfing, water skiing, sailing and similar activities), underwater diving to a depth of 30 meters. However, the insurance coverage does not apply to underwater swimming or diving at a depth greater than 30 meters;

3.2.6. Parachuting;

3.2.7. Equestrian sports, American football, handball, rugby, baseball, hockey;

3.2.8. Fighting and contact sports: boxing, kickboxing, fighting without rules (MMA), oriental martial arts, wrestling (does not apply if the Insured person's age at the beginning of the insurance period is up to 16 years inclusive);

3.2.9. Gliding, piloting a hot air balloon (except for flying as a passenger);

3.2.10. Any sports activity related to jumping from a height, performing turns, maneuvers, figures, with or without acrobatic elements (including parkour, trickery, bungee jumping);

3.2.11. It does not include the activities specified in clause 4.1.13 as non-insured events.

4. IN WHICH CASES THE INSURANCE COVERAGE IS INVALID

4.1. The insurance coverage is invalid and the insurance benefit is not paid if the Accident occurred due to the circumstances specified in the General Terms and Conditions of the Terms and conditions, and also when:

4.1.1. You committed an act for which criminal liability is provided;

4.1.2. You were arrested or when your freedom was restricted due to serving a sentence;

4.1.3. You took part in a fight (except in cases where the limit of necessary defense is not exceeded or the use of physical force is directly related to the performance of official duties, or when the competent authorities establish the fact that you were attacked and/or beaten by third parties);

4.1.4. You have worked in jobs dangerous to health or life, which require special qualification training and a corresponding permit issued by competent institutions (commissions), which you do not have (i.e. work with high-voltage equipment, high-altitude and underground work, work with specialized machines, explosive materials, digging wells, etc.);

4.1.5. You flew as a passenger in an aircraft that is not intended for the transport of passengers;

4.1.6. You attempted suicide or intentionally harmed yourself;

4.1.7. You have been treated with alternative medicine methods;

4.1.8. Before the event or during the event, you used narcotic, psychotropic, toxic substances, as well as medications, the use of which is not medically justified and which was not prescribed by a doctor for the treatment of a specific case;

4.1.9. While serving in the military, you participated in military exercises, surgeries, peacekeeping missions or any military action;

4.1.10. You voluntarily risked your life, except to save the life of another person;

4.1.11. You drove any vehicle (land, air or water) while under the influence of alcohol, drugs, in a state of toxic intoxication or without a valid driver's license or license of the relevant category, as well as if you drove the vehicle knowing that the driver of the vehicle is under the influence of alcohol, drugs, in a state of toxic intoxication or does not have a valid driver's license or license of the appropriate category. This provision does not apply only if the blood alcohol concentration of the person driving the vehicle does not exceed the permitted rate for the driver of the vehicle established by the legislation of the country where the incident occurred, and this is confirmed by breathalyzer testimony or medical documents;

4.1.12. You have been skiing with a snowboard or alpine skis not on specially designated alpine ski tracks;

4.1.13. You engaged in aerobatics, paragliding, B.A.S.E. jumps, bushido, kickboxing, fights without rules and other similar activities, motor sports, motocross, participated in competitions or trainings while riding jet skis, motorboats (scooters), snowmobiles, quad bikes, unless otherwise specified in the insurance certificate;

4.1.14. You participate in competitions and trainings organized by a sports organization, except in cases where the activity Participation in competitions and trainings organized by a sports organization was selected for you in the insurance certificate;

4.1.15. You engaged in Dangerous activities, except for cases where Dangerous activities were selected in the insurance policy.

4.2. According to the terms and conditions of the Terms and conditions, Accidents are also considered non-insured events if:

4.2.1. They occurred during surgeries, as well as the consequences of surgeries;

4.2.2. They are related to developmental disorders, congenital diseases and/or anomalies;

4.2.3. The occurrence of a Critical Disease or the occurrence of an accident was influenced by your health disorders, due to which the competent state institutions had already determined the level of incapacity for work or disability or a mental illness;

4.2.4. They occurred due to any (including Critical) diseases and/or seizures caused by diseases (such as diabetes mellitus, epilepsy or other diseases causing convulsions), mental illness or injury, affective states, chronic neurological diseases with coordination or muscle weakness manifestation (for example, Parkinson's disease, myopathy, Multiple Sclerosis, etc., but not limited to these examples);

4.2.5. They are related to childbirth, termination of pregnancy, medical errors;

4.2.6. They are related to AIDS and other diseases caused by HIV infection;

4.2.7. They were caused by global disasters, natural disasters, epidemics, pandemics, etc.

4.3. Events specified as non-insured under separate risks are also considered non-insured.

4.4. We have the right not to pay the insurance benefit if you did not go to a healthcare facility for treatment in time (within 72 hours from the moment of the Accident) or you reported the event to us late, and as a result we cannot verify the exact circumstances of such an event, and the medical documents do not confirm that the event occurred during the period of validity of the insurance contract.

4.5. We have the right to carry out an additional examination of the Insured person's state of health at our own expense, with the help of medical experts or other specialists, in order to determine the circumstances, causes and extent of damage of an event that can be recognized as insured or non-insured.

5. WHAT TO DO UPON OCCURRENCE OF AN EVENT

Upon occurrence of an event, you, the Policyholder or your authorized persons must:

5.1. Register the event no later than within 30 calendar days after the event, which can be recognized as insured. If you are receiving inpatient treatment in a health care facility, the insured event and its circumstances must be reported no later than 30 calendar days after the last day of your inpatient treatment. The indemnity is not paid when we are notified of the insured event late and as a result we cannot verify the date and circumstances of such an event, and the medical documentation does not confirm the presence of the insured event during the validity period of the insurance contract. We have the right to reduce the insurance indemnity by 50% if you have unreasonably delayed notifying us of the insured event and this has affected our obligation to pay the insurance benefit;

5.2. If it was stated in the insurance certificate that the insurance coverage is only valid for the Insured person at work or on the way to/from work – provide us with documents proving that, in accordance with the laws of the Republic of Lithuania, regulating the investigation of accidents at work, on the way to/from work, the event has been investigated and recognized as an Accident at work, on the way to/from work;

5.3. Exempt doctors from keeping the treatment secret and authorize our representative to get acquainted with your medical and other documents related to the Accident;

5.4. Allow us to carry out an additional examination of your medical condition due to the Accident. We oblige our medical experts or other specialists carry out this assessment. The costs related to the actions specified in this clause are paid by us.

INJURIES

6. WHAT IS INSURED

The insured event is your Injury, if such a risk is specified in your insurance policy and in Annex 1 or 2 (depending on which annex is selected in the insurance policy).

7. IN WHICH CASES THE INSURANCE COVERAGE IS INVALID

A non-insured event is:

7.1. Injury not specified in the insurance policy and Annex 1 or 2 (depending on which annex is selected in the insurance certificate);

7.2. injury of the same bone, joint, articular structures, soft tissues or organs of other parts of the body, if this area was affected by a disease before the injury (eg: Osteoporosis, Rheumatoid arthritis, Psoriasis or others) or it is a pathological fracture;

7.3. Repeated fracture occurring within one year after the previous fracture of the same bone;

7.4. Repeated injury to the soft tissues and articular structures of the same joint (e.g. sprain, tear, etc.) occurring within one year after the previous injury to the soft tissues and articular structures of the same joint;

7.5. Graft ruptures;

7.6. Event caused by the removal of osteosynthesis structures, their breakage and/or dislocation;

7.7. Fracture and/or dislocation of joint prostheses, rupture and/or dislocation of implants;

7.8. Hernias (abdominal wall, diaphragm, intervertebral discs), radiculopathy/neuropathy caused by physical exertion/tension (including weight lifting);

7.9. Injury caused by treatment of cosmetic procedures, surgeries, prosthetics and their complications;

7.10. Event due to repeated injury of the same bone, joint, articular structures, soft tissues or organs of other parts of the body, when there are still residual consequences of the previous Trauma;

7.11. Injury, the fact of occurrence of which is not confirmed by primary medical documentation and/or diagnostic tests during the insurance period;

7.12. Event caused by infectious complications caused by infectious agents (e.g., phlegmon, abscess, rose and other similar diseases).

8. WHAT WE WILL PAY FOR AND IN WHAT WAY

8.1. The insurance benefit is calculated as a percentage of the sum insured, specified in the insurance policy under Annex 1 or 2 of the risk of injury (depending on which annex is selected in the insurance policy), taking into account the nature of the injury, which is indicated in the medical documents from the medical institution.

8.2. Insurance benefits due to Injury are paid to the Insured person, unless otherwise stipulated in the insurance contract.

8.3. The number of insurance benefits due to Injury is unlimited, but the total amount of benefits during the validity period of the insurance contract due to one or more insured events cannot exceed the insurance amount specified in the insurance policy for the risk of Injury.

8.4. The amount of insurance benefits due to injuries to one organ during one insured event cannot exceed the insurance benefit that would be paid in the event of the loss of that organ or the loss of its functions.

8.5. The insurance benefit is paid in the following way:

8.5.1. For one Injury, the insurance benefit is paid only in accordance with one clause of the relevant article, providing for the most serious injury specified in that article;

8.5.2. For bone fractures, dislocations, syndesmolysis, the benefit is paid if the injuries are confirmed by X-ray examination (computed tomography or magnetic resonance examination);

8.5.3. In the case of muscle, tendon, ligament tears, the insurance benefit is paid only if it is confirmed by instrumental (ultrasound, computer tomography or magnetic resonance) and/or other objective research methods;

8.5.4. A fracture of one bone in several places is considered as a fracture of one bone and the insurance benefit is paid for the most severe fracture of the corresponding place;

8.5.5. For injuries to one organ sustained during one insured event, the insurance benefit paid may not exceed the amount allocated for the loss of that organ;

8.5.6. When paying an insurance benefit due to the loss of functions of a body part/organ, the benefits paid due to the injury of this organ are deducted from it;

8.5.7. When the insurance benefit is paid for bone fracture and/or dislocation and surgery, the insurance benefit is not paid for injury to ligaments and/or tendons in the same area;

8.5.8. Insurance benefits provided for in Annex 1 or 2 for surgeries performed for fractures of one bone (primary fracture, repeated fracture, dislocation, syndesmolysis or pseudoarthrosis) are paid in addition to the insurance benefit for fracture (dislocation, syndesmolysis), but no more than 2 times. The insurance benefit is not paid for the removal of osteosynthesis structures;

8.5.9. For bone fragments (shards) splitting (tearing), damage to the integrity of tangential bone surfaces, impact, impression, avulsion (detachment of part of the bone due to strong contraction of the muscle at the place of its attachment) fractures, abruption (detachment of bone structures, growths), the insurance benefit is paid only if submitted medical documents confirming the immobilization of the damaged area for at least 3 weeks;

8.5.10. If Osteopenia is diagnosed, the insurance benefit is reduced by 30%;

8.5.11. In case of a stress fracture, the insurance benefit is reduced by 50%. The benefit for surgery due to a stress fracture is not paid.

8.6. In the event of an Injury not specified in any of the clauses of Annex 1 or 2 (depending on which annex is selected in the insurance policy), the decision on the insurance benefit is made by our expert doctor.

8.7. In case of the Insured person's death due to an Accident, the insurance benefit under the Injury insured risk is not paid.

8.8. Upon occurrence of an event that can be recognized as an insured event, you, the Policyholder or your authorized persons must provide us with all documents related to the event (with their translation into the national language), substantiating the fact, circumstances and amount of the indemnified event, including:

8.8.1. Notification of the event online www.bta.lt;

8.8.2. Documents from a health care institution with a description of the fact, date, diagnosis, examinations and treatment of the injury;

8.8.3. Consent to the processing of personal data (upon our request).

LOSS OF WORKING CAPACITY (DUE TO INJURY)

9. WHAT IS INSURED

The insured event is Loss of working capacity due to an injury determined for you no later than 1 year from the date of the event (for persons under 18 years of age – the level of disability due to an injury).

10. IN WHICH CASES THE INSURANCE COVERAGE IS INVALID

A non-insured event is if:

10.1. The level of lost working capacity (for persons under 18 years of age – the level of disability) was determined for you no later than 1 year after the date of the Accident;

10.2. The level of loss of working capacity is less than 50%, the level of disability has not been determined for persons under 18 years of age;

10.3. The loss of working capacity (for persons under 18 years of age – disability level) occurred due to illnesses or their complications, including Critical Diseases or Illnesses;

10.4. An event that, based on the terms and conditions of the Terms and conditions, was recognized as non-insured according to the risk of Injury.

11. WHAT WE WILL PAY FOR AND IN WHAT WAY

11.1. In the case of loss of working capacity, we will pay you an insurance benefit, which is calculated from the insurance amount specified in the insurance policy for the risk of loss of working capacity:

11.1.1. The insurance benefit is calculated proportionally from the insurance amount specified for this insured risk, according to the level of lost working capacity or the level of disability (according to clause 11.2);

11.1.2. The insurance benefit is paid if a 50% or higher level of lost working capacity or the level of disability specified in clause 11.2 is determined for persons under the age of 18;

11.1.3. If the first commission of the competent state institution determines a 50% or higher level of lost working capacity or the level of disability specified in Clause 11.2 for persons under the age of 18, 10% of the calculated possible insurance benefit is paid;

11.1.4. If the second commission of the competent state institution determines a 50% or higher level of lost working capacity or the same or higher level of disability for persons under the age of 18, the remaining final part of the insurance benefit corresponding to the level of lost working capacity or the level of disability is calculated and paid;

11.1.5. If the nature of the injury (e.g. amputation, loss of an organ, etc.) allows us to conclude that the loss of work capacity or disability is unquestionable and corresponds to 11.1.2., then in such a case we pay the insurance benefit without waiting for the term provided for in clause 11.1.4.

11.2. For persons under 18 years of age, the insurance benefit is paid after determining:

11.2.1. Severe level of disability – 100% of the insurance amount specified for this insured risk;

11.2.2. Moderate level of disability – 75% of the insurance amount specified for this insured risk;

11.2.3. Light level of disability – 50% of the insurance amount specified for this insured risk.

11.3. If, due to the same insured event, insurance benefits have already been paid to you due to Injury, then those insurance benefits are included in the amount of the insurance benefit payable as a result of Loss of working capacity or disability for persons under 18 years of age.

11.4. If you had already been diagnosed with a loss of working capacity or disability before the Accident and as a result of this Accident the level of Loss of working capacity or disability has increased, we calculate the amount of the insurance benefit (percentage of the Loss of working capacity risk insurance amount) as the difference between the existing level of Loss of working capacity/disability and the level of working capacity/disability that has changed after the Accident.

11.5. If you have a level of Loss of working capacity/disability determined not only due to the consequences of the insured event, but also due to concomitant diseases, we determine the amount of the insurance benefit taking into account only the Loss of working capacity caused by the injuries caused by the insured event. If it is not possible to objectively determine the proportion of the causes of Loss of working capacity/disability, we consider that all causes of Loss of working capacity/disability are equal.

11.6. Upon occurrence of an event that can be recognized as an insured event, you, the Policyholder, or your authorized persons must provide us with all documents related to the event (with their translation into the national language) substantiating the fact, circumstances and amount of the indemnification of the insured event, including:

11.6.1. Notification of the event online www.bta.lt;

11.6.2. Certificate from the Disability and Working Capacity Assessment Office, which indicates the level of work ability or disability, both primary and repeated;

11.6.3. Documents from a health care institution with a description of the fact, date, diagnosis, examinations and treatment of the injury;

11.6.4. Consent to the processing of personal data (upon our request).

DEATH (DUE TO INJURY)

12. WHAT IS INSURED

The Insured event is the Insured person's death due to Injury within 1 year from the date of the Accident.

13. IN WHICH CASES THE INSURANCE COVERAGE IS INVALID

A non-insured event is:

13.1. Death of the Insured person, the cause of which is alcohol poisoning;

13.2. Death of the Insured person when the Insured person consumes alcohol before or during the event. The provision of this clause does not apply if any one of the following conditions is met:

13.2.1. If the concentration of alcohol in the Insured person's blood does not exceed 0.4 promille and this is confirmed by medical documents;

13.2.2. When concluding the insurance contract, the Insured person had chosen the Intoxication condition and it is specified in the insurance certificate;

13.2.3. At the time of the event, the Insured person was traveling by means of transport (air, water, land) as a passenger, except for the case specified in clause 4.1.11.

13.3. Death of the Insured person, which occurred as a result of suicide.

13.4. Death due to diseases or their complications, including Critical Diseases or Illnesses.

13.5. An event which, based on the terms and conditions of the Terms and conditions, was recognized as non-insured under the risk of Injury.

14. WHAT WE WILL PAY FOR AND IN WHAT WAY

14.1. In the event of an insured event, the insurance benefit is equal to the insurance amount specified in the insurance policy for this risk. If due to the same event that caused the death of the Insured person, insurance benefits have already been paid for Injuries, Loss of working capacity, Sickness benefits, Daily allowance, Expenses for education, Expenses for a tutor, Expenses for children, Plastic surgeries, Psychological support, then the insurance benefit payable due to the death of the Insured person is reduced by the amount of insurance benefits paid due to this event.

14.2. The insurance benefit is paid:

14.2.1. We pay all costs associated with obtaining additional documents and medical examination requested by us;

14.2.2. If according to the last written appointment submitted by the Policyholder known to us, other persons should receive the insurance benefit, who have not submitted applications to receive the insurance benefit, they are also informed about the decision made regarding the payment of the insurance benefit;

14.2.3. If an insurance certificate with a changed designation of the Beneficiary or a separate written designation that replaces the previous written designation is submitted to the Insurer (authorized person) after the payment of the insurance benefit, the Insurer does not satisfy the claims of the persons who submitted it;

14.2.4. Insurance benefits are taxed according to the procedure established by the legal acts of the Republic of Lithuania;

14.2.5. Insurance benefits due to Injury and/or additional risks are paid to the Insured person, unless otherwise stipulated in the insurance contract. The Policyholder has the right to appoint one or more Beneficiaries who, upon the occurrence of the insured event, acquire the right to receive the insurance benefit or part of it. The Policyholder must notify the Insurer in writing about the designated Beneficiary. If the Policyholder appoints a person who is not the Insured person as the Beneficiary, such appointment is valid only if the Policyholder provides the Insured with the Insured person's written consent;

14.2.6. The insurance benefit is paid to the Policyholder only if the Policyholder provides the Insured person's written consent and if the Policyholder is named as the Beneficiary in the insurance certificate. Otherwise, the benefit is paid to the legal heirs of the Insured person;

14.2.7. If the Insured person dies without receiving the insurance benefit that should have been paid to him/her due to Injury and/or additional risks, it is paid to the Beneficiary.

14.3. Allocation of insurance benefit upon the death of the Insured person:

14.3.1. The Policyholder has the right to appoint one or more Beneficiaries who, upon the occurrence of the insured event (death), acquire the right to receive the insurance benefit or part of it. The Policyholder must notify the Insurer in writing about the designated Beneficiary. The Beneficiary can only be appointed after receiving the written consent of the Insured person. If the Policyholder has not appointed a Beneficiary, the insurance benefits payable due to the death of the Insured person shall be inherited in accordance with the law;

14.3.2. The Policyholder can change or cancel his/her appointment. If the Beneficiary was appointed with the consent of the Insured person, then the Beneficiary can be canceled only with the consent of the Insured person;

14.3.3. If the Beneficiary of the insurance benefit is designated in the insurance contract, after the death of the Insured person due to the insured event, the insurance benefit is paid to the Beneficiary. The insurance benefit is paid to the Policyholder only if the Policyholder provides the Insured person's written consent and if the Policyholder is named as the Beneficiary in the Insurance certificate;

14.3.4. The insurance benefit is paid to the Insured person's heirs, if the Beneficiary is not appointed in the insurance contract or the Insured has not received the Insured person's written consent. The insurance benefit is paid to the Insured person's heirs when:

14.3.4.1. The Beneficiary died before the Insured person and no other Beneficiary was appointed;

14.3.4.2. The Insured person and the Beneficiary died on the same day.

14.3.5. In the cases indicated in clauses 14.3.4.1. and 14.3.4.2. of the terms and conditions of the insurance, the insurance benefit is paid to the Insured person's heirs if one person has been appointed as the Beneficiary. If several persons have been appointed as Beneficiaries, then the insurance benefit is paid not to the heirs, but to the remaining appointed Beneficiaries, with a proportional increase in the parts of the insurance benefit allocated to them;

14.3.6. If the court recognizes that it is unknown where thee Insured person is, the insurance benefit is not paid;

14.3.7. When the court declares the Insured person to be dead, the insurance benefit is paid if the court decision states that the cause of the Insured person's death could have been an Accident and the presumed date of death was during the period of validity of the insurance contract.

14.4. Upon occurrence of an event that can be recognized as an insured event, the Policyholder or the Beneficiary must provide us with all documents related to the event, substantiating the fact, circumstances and amount of the indemnified event, including:

14.4.1. Notification of the event online www.bta.lt;

14.4.2. A copy of the Insured person's death certificate;

14.4.3. Documents issued by law enforcement authorities/health care institutions;

14.4.4. Inheritance documents;

14.4.5. Consent to the processing of personal data (upon our request).

MEDICAL EXPENSES (DUE TO INJURY)

15. WHAT IS INSURED

The insured event is the expenses incurred by you in the Republic of Lithuania due to medically justified treatment services and measures prescribed by a doctor, which you need for the treatment of an Injury, recognized as an insured event according to these Terms and conditions and/or their Annex 1 or 2 (regardless of whether the annex is selected in the insurance policy). Treatment costs are reimbursed for a maximum of 6 months. Injuries recognized as an insured event.

16. IN WHICH CASES THE INSURANCE COVERAGE IS INVALID

A non-insured event is and it will not be indemnified for the following:

16.1. Medical expenses when your Injury is not recognized as an insured event according to the terms and conditions of these Terms and conditions;

16.2. Health care services and/or treatment provided outside the Republic of Lithuania medical facilities and medical goods purchased outside the Republic of Lithuania;

16.3. Health care services and/or treatment, the date and validity of which cannot be determined based on the medical documentation provided or received;

16.4. Diagnosis and treatment that was carried out by non-traditional (alternative) medicine or other similar methods;

16.5. Cosmetic, plastic, cosmetology, beauty and other similar procedures;

16.6. Organ transplant surgeries, bone marrow transplants, hemodialysis procedures;

16.7. Accommodation services in sanatoriums and other rehabilitation treatment centers;

16.8. Glasses, contact lenses, their care products, production of glasses, artificial lenses, etc.;

16.9. Medical devices (such as thermometers, inhalers, testers, heaters, hearing aids, scales, blood pressure measuring devices, glucometers, etc.);

16.10. Food supplements, vitamins, anabolic steroids, weight-reducing, potency-increasing drugs, contraceptives, hygiene and cosmetic products, medicines and products for the treatment of various addictions, as well as drugs not registered in the countries of the European Union;

16.11. Damage and/or repair of implants/prostheses;

16.12. Costs related to the issuance and/or submission of medical and other documents;

16.13. Services and consultations of a psychiatrist and/or psychologist (except in cases where the insured event is confirmed according to the risk of incapacity).

16.14. Other expenses, not stated in clause No. 17.2.

17. WHAT WE WILL PAY FOR AND IN WHAT WAY

17.1. The insurance amount for the risk of medical expenses is specified in the insurance policy. The insurance benefit for one insured event cannot exceed 50% of the amount specified in the insurance policy for this risk.

17.2. Within the limits of the insurance amount specified in clause 17.1., we will reimburse expenses for:

17.2.1. Consultations with medical specialists (traumatologist, surgeon, neurologist, radiologist, dentist, etc.);

17.2.2. Surgeries and procedures (wound suturing, wound dressings, injections, infusions);

17.2.3. Diagnostic tests (laboratory, functional, radiological, instrumental) necessary for the diagnosis and treatment of the injury, prescribed by the doctor and medically justified, necessary for the confirmation and treatment of the injury;

17.2.4. Purchase or rental of medicines, medical aid and orthopedic equipment (bandages, plasters, syringes, splints, sticks, crutches, aids for self-service) registered by the State Medicines Control Service in the countries of the European Union and purchased in pharmacies or stationary health care institutions of the Republic of Lithuania;

17.2.5. Rehabilitative treatment prescribed by a doctor and medically justified, necessary for the treatment of the consequences of injury (physiotherapy procedures, individual or group physiotherapy sessions, therapeutic massage, consultations of a physiotherapist, occupational therapist, speech therapist);

17.2.6. Treatment of dental injuries, dental prostheses, dental implantation;

17.2.7. Treatment and services in an inpatient health care facility that are not reimbursed from the mandatory health insurance fund (comfort services, for example, treatment in a single or double ward, additional care, nursing, premiums for medical aids, medicines).

17.3. Upon occurrence of an event that can be recognized as an insured event, you, the Policyholder or your authorized persons must provide us with all documents related to the event (with their translation into the national language upon request by us) substantiating the fact of the event, the circumstances and the amount of the payment, including:

17.3.1. Notification of the event online www.bta.lt;

17.3.2. Medical certificate with a doctor's prescription for the medicines, medical devices and/or procedures you have purchased;

17.3.3. Financial documents confirming expenses (receipts, paid invoices, bank statements, etc.);

17.3.4. Consent to the processing of personal data (upon our request).

DAILY ALLOWANCE (DUE TO INJURY)

18. WHAT IS INSURED

18.1. The insured event is the inability to perform the work functions provided for in the valid employment contract, due to an Injury recognized as an insured event according to these Terms and conditions and/or their Annex 1 or 2 (regardless of whether the annex is selected in the insurance policy), while you are working under the employment contract, and this is confirmed by a certificate of incapacity for work issued to you by a medical institution of the Republic of Lithuania or an equivalent document from a competent institution.

18.2. A certificate of incapacity for work or an equivalent document from a competent authority must be issued for an Injury that is recognized as an insured event and specified in the insurance policy and annex 1 or 2 (depending on which annex is selected in the insurance certificate).

19. IN WHICH CASES THE INSURANCE COVERAGE IS INVALID

An event is considered non-insured, if your Temporary incapacity for work:

19.1. Occurred as a result of an Injury not recognized as an insured event;

19.2. Lasts less than 3 calendar days in a row;

19.3. Occurred as a result of an injury you experienced when you did not work according to an employment contract and when you did not receive an official income;

19.4. Not confirmed by a certificate of incapacity for work or an equivalent document from a competent authority or confirmed by a certificate of incapacity for work or an equivalent document from a competent authority issued outside the Republic of Lithuania.

20. WHAT WE WILL PAY FOR AND IN WHAT WAY

20.1. The insurance amount for this insured risk is specified in the insurance certificate for the entire insurance period, and the insurance benefit is paid as specified in clauses 20.2. – 20.5.

20.2. The insurance benefit, which is 1% of the insurance amount indicated in the insurance policy for this risk, is paid for each working day when you were temporarily incapable for work, starting from the first day of temporary incapacity, provided that the temporary incapacity lasts for 3 or more calendar days from in a row, due to one insured event – for no more than 30 consecutive days of Temporary incapacity for work due to the same Injury.

20.3. If your benefit due to Injury according to Annex 1 or 2 is set at 2% or less (not including additional benefits according to the Notes to the Articles), the insurance benefit for Daily allowance risk is paid for no more than 10 consecutive days of Temporary incapacity for work.

20.4. Upon occurrence of an event, the Policyholder, You or the Beneficiary must provide us with all documents related to the event (with their translation into the national language) substantiating the fact of the insured event, the circumstances and the amount of the payment, including:

20.4.1. Notification of the event online www.bta.lt;

20.4.2. List of certificates of incapacity for work from the Electronic Certificates of Incapacity for Work (EPTS) system or an equivalent document from the competent authority, which indicates the reason and duration of the incapacity for work. The certificate of temporary incapacity for work must be issued in the Republic of Lithuania;

20.4.3. Copy of the employment contract (upon our request);

20.4.4. Consent to the processing of personal data (upon our request).

SICK BENEFITS (DUE TO INJURY)

21. WHAT IS INSURED

An insured event is your treatment in an inpatient health care facility due to an Injury recognized as an insured event according to these Terms and conditions and/or their Annex 1 or 2 (regardless of whether the annex is selected in the insurance certificate) (hereinafter – hospitalization).

22. IN WHICH CASES THE INSURANCE COVERAGE IS INVALID

An event is considered non-insured and insurance benefit is not paid for hospitalization:

22.1. Due to Injury, not recognized as an insured event;

22.2. For rehabilitative, restorative and/or sanatorium treatment;

22.3. For preventive treatment and care;

22.4. Continuously lasting less than 3 calendar days in a row.

23. WHAT WE WILL PAY FOR AND IN WHAT WAY

23.1. The insurance amount for the risk of medical expenses is specified in the insurance certificate for the entire insurance period, and the insurance benefit is paid as specified in clauses 23.2. – 23.3.

23.2. The insurance benefit, which is 1% of the insurance amount indicated in the insurance policy for this risk, is paid to the Insured person for each day of hospitalization, starting from the first day of hospitalization, but with the condition that the hospitalization lasts at least 24 hours a day and at least 3 calendar days in a row, due to one insured event – no more than 45 days of hospitalization in a row due to the same Injury.

23.3. Upon occurrence of an event that can be recognized as an insured event, you, the Policyholder or your authorized persons must provide us with all documents related to the event (with their translation into the national language), substantiating the fact, circumstances and amount of the indemnified event, including:

23.3.1. Notification of the event online www.bta.lt;

23.3.2. Documents from a health care institution regarding inpatient treatment;

23.3.3. Consent to the processing of personal data (upon our request).

CRITICAL DISEASES

24. WHAT IS INSURED

24.1. An insured event is considered to be a disease specified in clause 24.4, the first symptoms of which were detected and the Final diagnosis was confirmed during the validity period of the insurance contract, but not earlier than after the end of the Waiting Period.

24.2. Final diagnosis – a diagnosis of a Critical Illness proven by appropriate laboratory, histological and instrumental medical tests (in accordance with the criteria specified in paragraph 24.4 of the Terms and conditions for a Critical Illness) and confirmed in writing by a specialist doctor.

24.3. Waiting period – a period calculated from the date of entry into force of the insurance contract, during which the insurance benefit is not paid if the Insured develops the first symptoms of the disease or if the Final diagnosis of the disease is established. Unless otherwise specified in the insurance contract, the Waiting period is 30 days. If an insurance contract is concluded with the Policyholder and there was no break of more than 30 days between the previous and the newly concluded insurance contract (Renewed contract), the Waiting period is not established.

24.4. List of Critical Diseases:

24.4.1. Myocardial infarction (I21) – irreversible damage (necrosis) of the heart muscle caused by a lack of oxygen due to acute insufficiency of blood flow to the heart. This diagnosis must be based on all the criteria listed below, corresponding to the signs of a first myocardial infarction:

24.4.1.1. In case of characteristic complaints, new changes in the electrocardiogram have appeared, confirming an acute myocardial infarction;

24.4.1.2. An increase in at least one of the enzymes characteristic of infarction (LD H (lactate dehydrogenase), KFK (creatine kinase), KKM B (creatine kinase MB isoenzyme), troponin, etc.) is detected in the blood serum;

24.4.1.3. The diagnosis is confirmed by a cardiologist treating inpatient.

24.4.2. Stroke (I60–I64) – a brain damage caused by acute cerebrovascular insufficiency. This diagnosis must be based on all of the criteria listed below:

24.4.2.1. Clinical symptoms characteristic of a stroke persist for more than 3 months after their onset with appropriate treatment;

24.4.2.2. The diagnosis is confirmed by a neurologist based on clinical symptoms and objective examinations (such as magnetic resonance imaging, computer tomography, etc.).

24.4.3. Aortic aneurysm (I71) – an abnormal dilation of a blood vessel (aorta) that may rupture and cause severe internal bleeding:

24.4.3.1. The diagnosis is confirmed by objective examinations (echoscopy of internal organs, aortography, computer tomography, magnetic resonance scanning, etc.);

24.4.3.2. Urgent or scheduled aortic prosthetic surgery (endovascular stenting) was performed.

24.4.4. Aneurysm of the brain (I67.1) – an abnormal dilation of a blood vessel in the brain that may press on surrounding tissue or rupture and cause severe bleeding:

24.4.4.1. The diagnosis is confirmed by objective examinations (computed tomography, magnetic resonance scanning, cerebral angiography, head and cerebrospinal fluid examination, etc.);

24.4.4.2. Urgent or scheduled brain aneurysm surgery was performed;

24.4.4.3. For asymptomatic cerebral aneurysms, which are only observed during periodic examinations, the insurance benefit is not paid.

24.4.5. Bechterew's disease (M45) – complete immobility of the spine caused by the onset of joint ossification due to chronic inflammatory disease:

24.4.5.1. The diagnosis is confirmed by a rheumatologist;

24.4.5.2. X-rays confirm the changes in the spine characteristic of the disease (the spine has grown into a solid bone);

24.4.5.3. Human tissue compatibility antigen HLA B27 Ag is found in the blood.

24.4.6. Addison's disease (E27.1; E27.2; E27.4) – insufficiency of the adrenal cortex caused by bilateral damage to the adrenal glands, leading to partial or complete disappearance of the hormonal

function of the adrenal glands:

24.4.6.1. The disease is confirmed by an endocrinologist;

24.4.6.2. The insured person is treated with hormones for 3 months and such treatment continues;

24.4.6.3. Decreased levels of cortisol and increased levels of adrenocorticotropic hormone (ACT H) are found in the blood.

24.4.7. Rheumatoid arthritis (M05) – autoimmune origin, chronic, constantly progressing, inflammation of many joints, causing their deformation:

24.4.7.1. The diagnosis is confirmed by a rheumatologist;

24.4.7.2. An increased amount of rheumatoid factor is found in the blood;

24.4.7.3. Changes in the joints characteristic of the disease are determined after an objective (x-ray, computed tomography, magnetic resonance) examination.

24.4.8. Systemic lupus erythematosus (L93, M32) – a chronic inflammatory autoimmune disease, when the immune system begins to destroy (damage) the healthy tissues of the body:

24.4.8.1. The diagnosis is confirmed by a rheumatologist;

24.4.8.2. A blood test (after serology) shows antibodies against native DNA or antibodies against or antibodies against Sm antigen or Lupus cells.

24.4.9. Cancer (C00–C96) – the uncontrolled growth of abnormal cells and the ability of these cells to destroy surrounding tissue and spread to other parts of the body (metastases). This diagnosis must be confirmed by an oncologist, and a histological examination must confirm the malignant process. The diagnosis established on the date of receipt of the histological examination is considered to be finally confirmed.

24.4.9.1. The following illnesses are not considered an insured event:

a) Cancer of any organ, if the Insured person has been diagnosed with cancer at any time earlier in life, regardless of whether the diseases are related;

b) Benign or precancerous tumors;

c) Tumors that have not spread and are in place (in situ) (Tis*);

d) Cervical dysplasia CIN I–III;

e) Bladder cancer TA* stages;

f) Prostate cancer, histologically determined as T1*.
* according to the international TNM system.

24.4.10. Chronic renal failure (N00–N19) – incurable loss of function of both kidneys, requiring continuous hemodialysis and/or kidney transplant surgery:

24.4.10.1. Incurable loss of kidney function is confirmed by a nephrologist;

24.4.10.2. Hemodialysis is continuously performed for 6 months or the Insured person is registered for a kidney transplant surgery or has undergone a kidney transplant surgery.

24.4.11. Multiple sclerosis (G35–G37) – an autoimmune disease of the central nervous system in which the covering of nerve fibers disappears (demyelination):

24.4.11.1. The diagnosis is confirmed by a neurologist;

24.4.11.2. Changes characteristic of the disease are determined by magnetic resonance imaging;

24.4.11.3. Examination of the cerebrospinal fluid reveals an increase in the IgG index and oligoclonal bands in the cerebrospinal fluid.

24.4.12. AIDS (B20–B24) – acquired immunodeficiency due to infection with the human immunodeficiency virus (HIV):

24.4.12.1. The diagnosis is confirmed by the specialists of infectious disease and/or AIDS center;

24.4.12.2. The result of an HIV test is positive;

24.4.12.3. A blood test shows a decrease in CD4 cells (200 or less).

24.4.13. Blindness (H54.0–H54.4) – total and irreversible loss of vision due to disease:

24.4.13.1. Irreversible vision loss is confirmed by an ophthalmologist 3 months after the diagnosed disease or injury;

24.4.13.2. Loss of vision is confirmed by objective (skiascopy, refractometry, spectral compensation, etc.) examinations;

24.4.13.3. Due to vision loss in one eye, half of the insurance benefit is paid;

24.4.13.4. In case of loss of eye(s), the insurance benefit can be paid without waiting for 3 months.

24.4.14. Transplantation of heart, lungs, liver, pancreas (Y83.0) – transplantation of organs taken from one person to another person for the purpose of treatment (due to illness or injury):

24.4.14.1. The insured person is the recipient of the organ;

24.4.14.2. A transplant surgery has been performed or the Insured person has been added to the official waiting list for such a surgery.

24.4.15. Muscular dystrophy (G71) – genetically inherited primary muscle diseases characterized by muscle weakness and thinning (atrophy):

24.4.15.1. The disease is confirmed by a geneticist and a neurologist;

24.4.15.2. The diagnosis is confirmed after morphological muscle and/or electromyographic examination and muscle–specific enzyme (creatine phosphokinase) tests.

24.4.16. Type I diabetes (E10) – a disease that disrupts insulin production, resulting in increased blood glucose levels:

24.4.16.1. The diagnosis is confirmed by an endocrinologist;

24.4.16.2. A blood test shows an increase in glucose and/or an increase in glycated hemoglobin (HbA1c);

24.4.16.3. Continuous treatment with insulin injections.

24.4.17. Benign tumors of the brain and spinal cord (D32 – D33) – accumulation of body cells characterized by uncontrolled division, dislocation (push) of adjacent tissues:

24.4.17.1. The diagnosis is confirmed by an oncologist or neurosurgeon;

24.4.17.2. The diagnosis is confirmed by objective examinations (computed tomogram, magnetic resonance tomogram or brain biopsy).

24.4.18. Coronary heart bypass surgery – open coronary heart surgery, performed to correct the narrowing or occlusion of two or more coronary heart vessels, using the superficial leg vein, internal chest or other suitable artery as a graft:

24.4.18.1. For balloon angioplasty and stenting insurance benefits are not paid.

24.4.19. Deafness – complete loss of hearing in both ears due to a disease:

24.4.19.1. The diagnosis is confirmed by an otorhinolaryngologist;

24.4.19.2. The insurance benefit is paid only if total hearing loss in both ears persists 6 months after diagnosis.

24.4.20. Aphasia – the complete loss of the ability to speak as a result of a traumatic injury or disease. The benefit is also paid in cases where speech is lost due to surgical and medical treatment of the disease:

24.4.20.1. The diagnosis is confirmed by an otorhinolaryngologist;

24.4.20.2. The insurance benefit is paid only if the complete loss of speech persists 6 months after the diagnosis.

24.4.21. Sudden infant death syndrome (disease code – R95): – This is the sudden and unexpected death of a previously perfectly healthy baby between the ages of 1 month and 1 year, the cause of which remains unclear after a thorough post-mortem examination, including a full autopsy, investigation of the circumstances of death at the scene and medical history review:

24.4.21.1. The diagnosis is confirmed by a neonatologist or pediatrician.

24.4.21.2. Signs of sepsis identified during clinical and/or laboratory tests.

24.4.22. Severe burns:

24.4.22.1. The insurance benefit is paid if there are third-degree burns with scars that cover at least 20% of the body surface. The diagnosis and total area must be confirmed by a medical specialist based on clinically approved body surface area charts, and the Insured person must be treated in an inpatient facility.

24.4.23. End-stage liver failure (disease code – K72) – complete and irreversible failure of liver function.

24.4.23.1. The insurance benefit is paid when all the conditions listed below are met:

a) Incurable loss of liver function is confirmed by a gastroenterologist/hepatologist;

b) All of the following conditions occur: persistent jaundice, ascites, and hepatic encephalopathy;

24.4.23.2. The insurance benefit is not paid if the illness is caused by the use of alcohol, drugs or narcotic substances.

24.4.24. Brittle bone syndrome (Osteogenesis inperfecta (Q78.0)) – an inherited disease in which the bones are brittle and break easily. The insurance benefit is paid when all the conditions listed below are met:

24.4.24.1. Bone density (DEXA) examination confirms decreased bone density;

24.4.24.2. The diagnosis is confirmed after performing a histological (skin and bone tissue – altered collagen) sample or a genetic (blood, skin, bone tissue – altered gene) examination.

24.4.25. Amputation – the complete and irreversible loss of any 1 or more limbs due to spinal or brain injury or disease. Loss of a limb is defined as loss above the knee or elbow joint. A limb is defined as the whole arm or the whole leg.

24.4.25.1. The insurance benefit is not paid if the limb is lost due to self–harm or psychological disorders, due to Guillain–Barre syndrome or congenital limb loss.

24.4.26. Amyotrophic lateral sclerosis (G12.2) – an incurable, rapidly progressive disease of the nervous system that affects the motor neurons (nerve cells) of both the brain and the spinal cord. The insurance benefit is paid when all the conditions listed below are met:

24.4.26.1. The diagnosis is confirmed by a neurologist based on clinical, electrophysiological

(ENMG) and MRI examination data.

24.4.26.2. Permanent impairment of functions caused by the disease continues for at least 3 months after diagnosis.

24.4.27. Primary pulmonary arterial hypertension (I27.0) – a disease in which blood pressure in the pulmonary arteries increases due to changes in the pulmonary blood vessels for an unknown reason.

24.4.27.1. The insurance benefit is paid when all the conditions listed below are met:

a) The diagnosis was confirmed by a cardiologist and a pulmonologist based on the diagnostic criteria valid at the time of diagnosis, including catheterization of the right heart cavities, CT of the chest, echoscopy of the heart;

b) The average arterial blood pressure of the pulmonary artery at rest is at least 25 mm Hg (estimated during the catheterization of the right heart cavities);

c) NYHA functional class III–IV of heart failure is established (physical activity is severely limited or does not tolerate any physical exertion, signs of right ventricular failure are evident).

24.4.27.2. The insurance benefit is not paid when secondary pulmonary arterial hypertension is diagnosed, i.e. caused by other diseases or a reaction to toxic substances, or the insured has been infected with HIV.

25. IN WHICH CASES THE INSURANCE COVERAGE IS INVALID

An event is considered non-insured and insurance benefit is not paid for a Critical Disease:

25.1. The first symptoms of which appeared and the Final diagnosis of the disease was confirmed within the first 30 days from the beginning of the insurance contract period. This provision shall not apply where Critical Disease Insurance coverage is continued in the Renewed Contract;

25.2. The cause of which is the use of alcohol, drugs or toxic substances;

25.3. Which does not comply with conditions and criteria for Critical Diseases specified in clause 24.4.;

25.4. A Critical Disease that was already diagnosed before the conclusion of the insurance contract

25.5. A Critical Disease that its first symptoms appeared before the conclusion of the insurance contract;

25.6. A Critical Disease – Cancer (C00–C96) diagnosed when the Insured person is infected with HIV or has AIDS, except for cases where the Insured person provides proof (negative test for HIV conclusion) that he/she was not infected with HIV on the date of inclusion of the Critical Disease option in the insurance contract;

25.7. Critical Disease – AIDS (B20–B24), if the Insured person does not provide proof (negative HIV test results) that he/she was not infected with HIV at the time of inclusion of the Critical Disease option in the insurance contract;

25.8. If the Final diagnosis is not confirmed during the validity period of the insurance contract.

26. WHAT WE WILL PAY FOR AND IN WHAT WAY

26.1. For the risk of Critical Diseases, the insurance amount specified in the insurance policy may be paid to you no more than once during the insurance contract's validity period, regardless of the number of insured events, provided that the Final Diagnosis was confirmed in writing during the insurance contract's validity period.

26.2. Upon occurrence of an event that can be recognized as an insured event, you, the Policyholder or your authorized persons must submit to us all documents related to the event (with their translation into the national language) substantiating the fact and circumstances of the insured event, including:

26.2.1. Notification of the event online www.bta.lt;

26.2.2. Documents from a health care institution with a confirmed Critical Disease diagnosis, anamnesis data, examination and treatment description, from which it can be determined whether the diagnosed illness meets the criteria specified in clause 24.4. of these Terms and conditions;

26.2.3. Consent to the processing of personal data (upon our request).

ILLNESSES

27. WHAT IS INSURED

27.1. An insured event is considered to be your falling ill with the disease specified in clause 27.2 during the validity period of the insurance contract, except for the first 30 days from the beginning of the insurance contract period (if it is an initial contract).

27.2. The illness must meet the following criteria:

27.2.1. Lyme disease – an infectious disease caused by ingesting a borrelia–infected tick:

27.2.1.1. The diagnosis of Lyme disease is confirmed by clinical symptoms and the conclusion of a doctor's specialist;

27.2.1.2. Borrelia–specific immunoglobulin G or M is found in the blood. The diagnosis is based on the results of serological tests.

27.2.2. Tick–borne encephalitis, tick–borne myelitis, tick–borne acute meningoencephalitis – an infectious disease caused by ingesting a tick infected with a neurotropic virus:

27.2.2.1. The diagnosis is based on the results of serological tests.

27.2.3. Acute appendicitis – acute inflammation of the appendix:

27.2.3.1. An emergency surgery to remove the appendix (appendectomy) was performed.

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

27.2.4.1. The diagnosis is made and the disease is treated in a hospital;

27.2.4.2. The diagnosis is confirmed by microbiological examination.

27.2.5. Diphtheria – an infectious disease caused by the diphtheria bacillus (Corynebacterium diphtheriae and Corynebacterium ulcerans) entered through the respiratory tract or with saliva:

27.2.5.1. The diagnosis is made and the disease is treated in a hospital;

27.2.5.2. The diagnosis is confirmed by microbiological examination.

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

27.2.6.1. The diagnosis is made and the disease is treated in a hospital;

27.2.6.2. A form of meningococcal purulent meningitis, meningoencephalitis, meningococcal sepsis (meningococcemia) or fulminant meningococcal infection is diagnosed;

27.2.6.3. The diagnosis is confirmed by microbiological tests.

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

27.2.7.1. The diagnosis is made and the disease is treated in a hospital;

27.2.7.2. The diagnosis is confirmed by microbiological examination.

27.2.8. Perforated (ruptured) gastric (duodenal) ulcer – a complication of gastric (duodenal) ulcer, when the wall of the organ is punctured at the site of the ulcer and the contents of the stomach (duodenal) spill into the abdominal cavity, causing inflammation of the peritoneum (peritonitis):

27.2.8.1. The diagnosis is made and the disease is treated in a hospital;

27.2.8.2. Emergency surgery was performed.

27.2.9. Rabies – a viral disease that affects the central nervous system. It is caused by a neurotropic virus of the Rhabdoviridae family that entered the saliva of an animal after it was bitten:

27.2.9.1. The diagnosis is made and the disease is treated in a hospital;

27.2.9.2. The diagnosis is confirmed by microbiological tests.

27.2.10. Ectopic pregnancy – an acute condition in which pregnancy develops outside the uterine cavity. The fertilized egg implants and develops in the fallopian tube, abdominal cavity, ovary, rudimentary uterine horn.

27.2.11. Trichinellosis – a parasitic disease caused by the spiral trichina (Trichinella spiralis) and is contracted by eating raw or undercooked pork and wild animal meat:

27.2.11.1. The diagnosis is established and the disease is treated in the hospital for at least 3 days.

27.2.12. Botulism – an infectious disease of the nervous system caused by a very strong neurotoxin produced by the bacteria Clostridium botulinum, usually ingested with food:

27.2.12.1. The diagnosis is established and the disease is treated in the hospital for at least 3 days.

27.2.13. Malaria is a disease caused by blood protozoa of the genus Plasmodium:

27.2.13.1. The diagnosis is confirmed by microbiological tests.

27.2.14. Yellow fever is a disease caused by the yellow fever virus belonging to the Flaviviridae family:

27.2.14.1. The diagnosis is confirmed by microbiological tests.

27.2.15. Typhoid fever (A01) is an acute infectious disease caused by the bacterium Salmonella Typhi:

27.2.15.1. The diagnosis is confirmed by bacteriological tests.

27.2.16. Measles – an acute, contagious viral infection that spreads through airborne droplets and is manifested by fever, rash, and inflammation of the respiratory tract and conjunctiva of the eyes. The benefit is paid if all the following conditions are met:

27.2.16.1. The diagnosis is confirmed by serological tests;

27.2.16.2. The disease is treated in a hospital for at least 3 days.

27.2.17. Legionellosis v an infectious disease caused by bacteria of the genus Legionella:

27.2.17.1. The diagnosis is confirmed by microbiological tests.

27.2.18. Salmonellosis – an acute infectious disease caused by bacteria of the genus Salmonella:

27.2.18.1. The diagnosis is confirmed by microbiological tests;

27.2.18.2. The disease is treated on inpatient basis.

27.2.19. Peritonitis (K65) – an acute inflammation of the entire peritoneum or only part of it, resulting in the appearance of clear, and as the disease progresses, purulent inflammatory fluid in the abdominal cavity. The insurance benefit is paid when all of the following conditions are met:

27.2.19.1. The diagnosis is made and the disease is treated in a hospital for at least 5 days;

27.2.19.2. Inflammatory changes are detected in a blood test.

27.2.20. Bartonellosis (A28.1) – a disease caused by bacteria (Bartonella henselae) in the saliva of cats. The insurance benefit is paid when all of the following conditions are met:

27.2.20.1. A positive serological test for IgM antibodies against Bartonella henselae;

27.2.20.2. The disease is treated with antibiotics.

27.2.21. Dengue fever (A97) – a viral disease spread by the bite of mosquitoes infected with the dengue virus

27.2.21.1. The diagnosis is confirmed by serological tests.

28. IN WHICH CASES THE INSURANCE COVERAGE IS INVALID

An event is considered non-insured and insurance benefit is not paid for Illness:

28.1. If it is contracted or its first symptoms appeared before the beginning of the insurance contract period or within the first 30 days from the beginning of the insurance contract period.

28.2. Which does not comply with the conditions and criteria specified in clause 27.2. of the Terms and conditions;

28.3. If the diagnosis of the disease is not confirmed during the validity period of the insurance contract.

29. WHAT WE WILL PAY FOR AND IN WHAT WAY

29.1. The insurance amount specified in the insurance certificate for the risk of Illnesses may be paid to you no more than once (except for insured events when Lyme disease is confirmed) during the insurance contract's validity period, regardless of the number of insured events.

29.2. In case of an insured event – Lyme disease, no more than 50% of the insured amount is paid per event.

29.3. If the Illness risk insurance amount has been increased, then, after you are diagnosed with the disease specified in clause 27.2, within the first 30 days from the day of the increase of the insurance amount, the Illness risk insurance benefit is paid according to the Illness risk insurance amount valid before the increase of the insurance amount.

29.4. Upon occurrence of an event that may be recognized as an insured event, you, the Policyholder or your authorized persons must submit to us all documents related to the event (with their translation into the national language) substantiating the fact and circumstances of the insured event, including:

29.4.1. Notification of the event online www.bta.lt;

29.4.2. Documents from a health care institution with a confirmed diagnosis, anamnesis data, examination and treatment description, from which it can be determined whether the diagnosed illness meets the criteria specified in clause 27.2 of these Terms and conditions;

29.4.3. Consent to the processing of personal data (upon our request).

PLASTIC SURGERY

30. WHAT IS INSURED

Plastic surgery performed on you due to the consequences of injury specified in Annex 1 or 2 (depending on which annex is selected in the insurance policy) is considered an insured event no later than one year after the expiration of the insurance contract.

31. IN WHICH CASES THE INSURANCE COVERAGE IS INVALID

A non-insured event is considered if plastic surgery has been performed:

31.1. Due to the consequences of an Injury not recognized as an insured event;

31.2. Due to Injury, but you are not insured against the risk of Injury and it is not specified in your insurance policy;

31.3. Due to injuries that occurred before the beginning of the insurance contract period.

32. WHAT WE WILL PAY FOR AND IN WHAT WAY

32.1. If the plastic surgery performed on you is recognized as an insured event, an insurance benefit confirmed by financial documents will be paid, not exceeding the insurance amount indicated in the insurance certificate for this risk.

32.2. The insurance benefit for plastic surgery can be paid for one or more events, but not exceeding the insurance amount.

32.3. The insurance benefit for plastic surgery is paid if the plastic surgery was performed no later than 1 year after the expiry of the insurance contract.

32.4. Upon occurrence of an event, the Policyholder, You or the Beneficiary must provide us with all documents related to the event (with their translation into the national language) substantiating the fact of the insured event, the circumstances and the amount of the payment, including:

32.4.1. Notification of the event (in electronic form or by phone);

32.4.2. Documents from a health care institution with confirmed diagnosis, anamnesis data, examination and treatment description;

32.4.3. Financial documents confirming expenses (receipts, paid invoices, bank statements, etc.);

32.4.4. Consent to the processing of personal data (upon our request).

PSYCHOLOGICAL ASSISTANCE

33. WHAT IS INSURED

Psychological assistance provided to you for the reasons specified in clauses 33.1 – 33.4 is considered an insured event 33.1 is considered an insured event, but no later than within 6 months from the date of the events specified in clauses 33.1 - 33.4 and during the validity of the insurance contract in which the Psychological Assistance insurance option was selected:

33.1. Death of your family members (parents, brothers, sisters, children, spouse);

33.2. The use of physical violence (including rape, sexual assault) against you (the circumstances of the violence, including the date of the incident, must be confirmed by the authorities investigating the circumstances of the incident);

33.3. Due to the Loss of working capacity/disability due to an Injury determined for you, which would be recognized as an insured event according to the terms and conditions of these Terms and conditions;

33.4. Your Critical Disease, if the risk of Critical Disease is specified in your insurance policy and Critical Disease is recognized as an insured event.

34. IN WHICH CASES THE INSURANCE COVERAGE IS INVALID

A non-insured event is considered if psychological assistance is provided:

34.1. Due to Injuries that occurred before the start of the insurance contract period;

34.2. The reason for applying for psychological assistance is not specified in clause 33;

34.3. Psychological assistance provided to you by persons or institutions that do not have the right to engage in such activities;

34.4. You contacted the law enforcement authorities more than 1 day after the assault, physical violence, rape or sexual assault;

34.5. Psychological assistance was provided to you due to events that occurred during the validity of the contract, in which the Injuries, Loss of working capacity, Critical Disease and Psychological assistance insurance options were not selected.

35. WHAT WE WILL PAY FOR AND IN WHAT WAY

35.1. If the receipt of psychological assistance provided to you is recognized as an insured event, the part of the insurance amount confirmed by financial documents is paid out, not exceeding the insurance amount provided for this risk.

35.2. The insurance benefit for psychological assistance is paid for 10 visits for one event.

35.3. Upon occurrence of an event, the Insured, You or the Beneficiary must provide Us with all documents related to the event (with their translation into the national language) substantiating the fact of the insured event, the circumstances and the amount of the payment, including:

35.3.1. Notification of the event online www.bta.lt;

35.3.2. Documents from a health care institution with confirmed diagnosis, anamnesis data, examination and treatment description;

35.3.3. In case of the death of a family member – a copy of the death certificate and a document confirming the relationship;

35.3.4. If the incident was investigated by the police, a certificate from the police;

35.3.5. Financial documents confirming expenses (receipts, paid invoices, bank statements, etc.);

35.3.6. Consent to the processing of personal data (upon our request).

HELP

36. WHAT IS INSURED

36.1. The insured event is the expenses confirmed by financial documents, related to the burial and/or cremation of the Insured.

36.2. The event must be recognized as insurable under the Death Insured risk.

37. IN WHICH CASES THE INSURANCE COVERAGE IS INVALID

The insurance benefit is not paid if:

37.1. The Insured person did not choose and the insurance certificate does not specify the risk Death;

37.2. The event is recognized as non-insured according to the risk of Death;

37.3. Incurred losses are not substantiated by relevant financial documents;

37.4. Expenses related to mourners' lunches, accommodation, grave cleaning.

38. WHAT WE WILL PAY FOR AND IN WHAT WAY

38.1. In the event of an insured event:

38.1.1. In the event of the death of the insured due to an Accident, persons who organized a funeral in the Republic of Lithuania and incurred expenses as a result and submitted documents specified in clause 38.2., within the limit of the insurance amount specified in the insurance policy for this risk, we will pay the expenses for:

38.1.1.1. Purchase of a coffin;

38.1.1.2. Transportation of remains;

38.1.1.3. Cremation and/or burial services.

38.2. Upon occurrence of an event that can be recognized as an insured event, the Policyholder or the Beneficiary must provide us with all documents related to the event (with their translation into the national language) substantiating the fact, circumstances and amount of the indemnity of the insured event, including:

38.2.1. Notification of the event online www.bta.lt;

38.2.2. A copy of the Insured person's death certificate;

38.2.3. Documents issued by law enforcement authorities (if such an investigation was conducted);

38.2.4. Documents confirming the incurred financial losses related to the services/expenses specified in clause 38.1.1;

38.2.5. Consent to the processing of personal data (upon our request).

DRIVER AND PASSENGER ACCIDENT INSURANCE

39. WHAT IS INSURED

The insured event is considered to be an accident during a traffic event, during which the Driver and/or passengers traveling in the Vehicle specified in the insurance policy suffered Injury, Loss of working capacity or death.

40. IN WHICH CASES THE INSURANCE COVERAGE IS INVALID

40.1. The insurance coverage is not valid and the insurance benefit is not paid if the Accident occurred due to the circumstances specified in the General Terms and Conditions, and also if:

40.1.1. Injury not listed in Annex 1 or 2;

40.1.2. The cause of the Insured person's Loss of working capacity or death is not related to the Accident during the Traffic event;

40.1.3. The Accident occurred during the traffic event while the Insured person was performing official duties in a military unit, police, security, fire protection or ambulance service, unless otherwise specified in the insurance contract;

40.1.4. At the time of the Accident during the traffic event, there were more passengers in the Vehicle than provided by the Vehicle manufacturer or more than specified in the Vehicle's technical documents;

40.1.5. The Accident occurred during the traffic event while the Insured person was carrying out criminal actions that are subject to criminal liability;

40.1.6. Accident occurred during the traffic event while the Insured person was trying to cause damage to his/her health, life or physical condition;

40.1.7. Accident occurred during the traffic event while the Vehicle was used for the educational ride, training, participation in competitions, test drives or endurance races;

40.1.8. The police or an employee of another state law enforcement service was not urgently called to the scene of the Accident during the traffic event in accordance with the requirements of the regulatory acts of the country where the Accident occurred during the traffic event, and a protocol confirming the event (or other relevant document) was not drawn up;

40.1.9. It is Recurrent or Pathological bone fracture.

40.2. The insurance does not pay the insurance benefit to the Insured person driving the Vehicle if:

40.2.1. An accident during the traffic event occurred when the Insured person was driving the Vehicle being under the influence of alcohol, drugs, or in a state of toxic intoxication or without having a valid driver's license of the relevant category, as well as if being in the Vehicle knowing that the driver of the Vehicle is under the influence of alcohol, drugs, or in a state of toxic intoxication or does not have one a valid driver's license of the relevant category. This provision does not apply only if the concentration of alcohol in the blood of the person driving the Vehicle does not exceed the permitted norm for the driver of the Vehicle, established by the laws of the country where the incident occurred, and this is confirmed by breathalyzer testimony or medical documents;

40.2.2. The Insured person refused a medical examination, during which the concentration of alcohol or the effect of narcotic or other psychotropic substances is determined, if such examination was offered by a competent state institution or medical institution due to the traffic accident that occurred;

40.2.3. The traffic accident occurred as a result of the Insured person's epileptic seizure, loss of consciousness, emotions caused by mental injury, impaired coordination in the case of an affective state or chronic nervous diseases, or muscle weakness (including, but not limited to, Parkinson's disease, myopathy, multiple sclerosis); the Insured person was driving a vehicle for which the state technical inspection had expired at the time of the traffic accident and the cause of the traffic accident was a technical breakdown of the car;

40.2.4. The Insured person did not obey the request of a police officer (traffic regulator) to stop, tried to run away or was forcibly stopped, or left the scene of the incident arbitrarily;

40.2.5. The Insured person used the Vehicle as an instrument of crime or as a means of suicide;

40.2.6. The Insured person used the Vehicle in areas not designated for road traffic (drove through frozen bodies of water, forests, fields, meadows, etc.).

40.2.7. The Insured died during a Traffic Accident, but the cause of death is not related to the Trauma that occurred during the Traffic Accident, for example, the Insured suffered a stroke.

40.3. Events specified as non-insured under separate risks are also considered non-insured.

40.4. We have the right not to pay the insurance benefit if you did not go to a healthcare facility for treatment in time (within 72 hours from the moment of the Accident) or you reported the event to us late, and as a result we cannot verify the exact circumstances of such an event, and the medical documents do not confirm that the event occurred during the period of validity of the insurance contract.

41. WHAT WE WILL PAY FOR AND IN WHAT WAY

41.1. In the event of an insured event, we will pay the insurance benefit, according to the conditions specified in these Terms and conditions for each selected risk, but not exceeding the sums of insurance specified in the personal insured risk of the Driver and passengers, as follows:

41.1.1. If the insurance option based on seats or ticket turnover was selected, the insurance benefit will be paid to the injured driver and/or passengers, not exceeding the insurance amounts specified in the insurance policy for this risk;

41.1.2. If the insurance option Total insurance amount was selected, the insurance benefit will be paid as follows – for each victim – driver and/or passenger, the total insurance amount specified for this risk in the insurance certificate, divided by the number of persons present in the vehicle at the time of the accident and the resulting amount divided by the insured number of risks. The insurance benefit will be calculated from the amount received, as provided in these Terms and conditions for individual risks.

41.2. Only Legal heirs can be designated as Beneficiaries after choosing this risk.

41.3. Upon occurrence of an event that can be recognized as an insured event, the Insured or the Beneficiary must provide us with all documents related to the event (with their translation into the national language) substantiating the fact, circumstances and amount of the indemnified event, including:

41.3.1. Notification of the event online www.bta.lt;

41.3.2. Documents from a health care institution with a description of the fact, date, diagnosis, examinations and treatment of the injury;

41.3.3. In case of death of the Insured person, a copy of the death certificate;

41.3.4. Documents issued by law enforcement authorities;

41.3.5. Inheritance documents;

41.3.6. Consent to the processing of personal data (upon our request).

42. OTHER TERMS AND CONDITIONS

42.1. Upon learning of an increase in the Insured risk, you or the Policyholder must inform us thereof in writing within 5 calendar days.

42.2. If the Insured risk increases during the validity of the insurance contract, we have the right to demand a change in the terms and conditions of the insurance contract or an increase in the insurance premium.

42.3. If you or the Policyholder do not notify us of the increase in insured risk as stipulated in Clause 45.1 of these Terms and conditions, we have the right to demand the termination of the insurance contract and compensation for losses to the extent that they are not covered by the premiums received.

42.4. If the condition "Insurance only at work, to/from work" is specified in the insurance certificate, the selected insurance coverage is valid only when Accidents occur (the fact of the accident must be recorded in the act of accidents at work, on the way to work and from work):

42.4.1. While performing work assigned by the employer, other official tasks related to the work process and assigned by the employer or while on a business trip;

42.4.2. While the insured is in training or exercises organized by the employer;

42.4.3. During lunch, additional or special breaks on the Insured person's working days;

42.4.4. During the preparation or maintenance of the workplace by the Insured person during working hours, before or after work;

42.4.5. When the Insured person goes to or from work.

42.5. If the insurance condition states that the number of payments due to Death and/or Loss of working capacity is limited, the insurance against Death and/or Loss of working capacity is valid only for the number of deaths due to insured events specified in the insurance certificate. We only pay insurance benefits for the number of events of Death and/or Loss of working capacity specified in the insurance certificate in chronological order according to the date of the event. If as a result of the same accident, more people die or become disabled than are insured (the number of deaths and/or disabled people specified in the insurance policy is exceeded), the insurance amount payable is divided by agreement between us and the Policyholder.

42.6. When insuring legal entities by position, the chosen insurance coverage is valid for all employees of your company working under an employment contract. All newly hired employees of your company are automatically considered insured from the day of hiring. Insurance coverage for all dismissed employees of your company automatically ceases from the date of termination of employment. At the end of the validity of the insurance contract or at other times specified in the insurance contract, you provide us with data and, if we request it, supporting documents about the change in the number of employees of your company during the previous period. Based on this data, we recalculate the annual insurance premium, taking into account the change in the number of insured employees.

42.7. According to the insurance contract, unpaid insurance premiums whose payment term has expired on the day of the insured event are deducted from the calculated insurance benefit amount, unless otherwise agreed in the insurance contract.

42.8. After we have paid the insurance premium, in accordance with clauses 17.2.; 32.1.; 33.1.; 35.1.; 41.1., the right to demand the amount of the paid insurance benefit (subrogation right) is granted to the persons responsible for the damage caused to you.

42.9. These Terms and conditions are valid for all insurance contracts concluded from 27-02-2024, if the parties did not discuss other terms and conditions when concluding the insurance contract.

ANNEX 1 "TABLE FOR DETERMINING THE AMOUNT OF THE INSURANCE BENEFIT T1" "INJURIES TO BONES, SOFT TISSUES AND INTERNAL ORGANS"

Serial No.	Injury	Amount of the insurance benefit from the insurance amount, %
Central and peripheral nervous system		
1.1	**Bone fractures of the skull:**	
	a) fracture of the outer plate of vault bones, compression fracture;	3
	b) cranial vault fracture;	20
	c) fracture of the base of the skull;	25
	d) cranial vault and foundation fracture.	30
	Notes: 1. Only one clause of this article may apply for the same injury; 2. Fractures of several vault/base bones are considered as one fracture; 3. If, as a result of the injuries provided for in this article, the skull cavity was opened (trepanation, craniotomy) or a bone repositioning (repair) surgery was performed, an additional 5% of the insurance amount is paid.	
1.2	**Intracranial (inside the skull) traumatic blood effusions (hematomas), treated in an inpatient setting and confirmed by computed tomography or magnetic resonance imaging:**	
	a) subarachnoid (located under the arachnoid covering of the brain) hemorrhages;	8
	b) epidural (on the dura mater) hematoma;	10
	c) subdural (located under the dura mater) or (and) intracerebral (located in the brain tissue) hematoma.	12
	Notes: 1. Only one clause of this article may apply for the same injury; 2. If, as a result of the injuries provided for in this article, the skull cavity was opened (trepanation, craniotomy) or a bone repositioning (repair) surgery was performed, an additional 5% of the insurance amount is paid.	
1.3	**Brain injuries:**	
	a) brain concussion, bruise, treated on an outpatient basis for at least 10 days, or in an inpatient setting for at least 3 days;	4
	b) brain concussion, bruise or concussion syndrome, when there was continuous treatment for at least 4 days in an inpatient setting;	6
	c) brain injury (contusion) or contusion syndrome, compression, diagnosis based on CT or MR examinations;	10
	d) destruction of the structure of the brain: protrusion of the brain to the outside through a traumatic opening (prolapsus, fluxus, protrusio, fungus cerebri, etc.).	50
	Notes: 1. If article 1.2 applies, article 1.3 does not apply. Only one of these articles 1.2 or 1.3 may apply); 2. Only one clause of this article may apply for the same injury.	
1.4	**Injury to any part of the spinal cord and damage to nerve endings occurred due to:**	
	a) shock, concussion, treated in an inpatient setting for at least 5 days;	5
	b) bruise (contusion), compression, bleeding into the spinal cord, which is confirmed by a CT or MR examination performed in an inpatient setting;	12
	Notes: 1. For the same injury, articles 1.4 and 2.1 shall not apply together. When applying the clause of these articles, which provides for a higher percentage of the paid insurance benefit, the already paid amount is deducted, according to articles 1.4 or 2.1; 2. If a surgery was performed due to the injuries provided for in this article, an additional 5% of the insurance amount is paid once.	
1.5	**Neck, shoulder and lumbar nerve network injuries for which surgery was performed:**	
	a) traumatic plexitis (inflammation of the plexus) in case of functional injuries;	10

	b) partial rupture of the nerve network;	30
	c) complete breakdown of the nerve network.	50
1.6	**Complications of post-traumatic inflammations:**	
	a) osteomyelitis (osteitis) of the skull (bones);	15
	b) brain abscesses, purulent meningitis.	20
	Notes: 1. The insurance benefit according to article 1.6 is paid in addition to the insurance benefits paid according to articles 1.1 – 1.3; Due to the injuries provided for in this article, the insurance benefit for the surgery is not paid.	
Organs of vision		
1.7.	**Pulsating exophthalmia of one eye.**	15
1.8.	**Second-degree burn and spreading wound of the eyeball, third–degree burn, hemorrhage into the eyeball, keratitis, non–impairing iris of the eyeball, erosion of the iris, erosion of the cornea, penetrating injury of the eyeball.**	7
	Note: Due to a contusion of the eyeball, a foreign body in the eye according to article 1.8, the benefit is not paid. Article 2.8 shall apply if vision is impaired as a result of this injury.	
1.9.	**Orbital (eye socket) fracture.**	5
Hearing organs		
1.10	**Traumatic rupture of one ear drum.**	2
1.11	**Consequences of one ear cup injury (injury, burn, frostbite):**	
	a) Scars of 1 cm and larger on the front surface of the ear cup after suturing the wound;	1
	b) traumatic deformation of the cup due to scarring on the front surface of the cup or if less than 1/3 of the cup is lost;	2
	c) loss of 1/3 to 1/2 ear cup;	3
	d) loss of the ear cup or more than half of the cup.	5
Respiratory system		
1.12	**Dislocation of nasal cartilages, fractures of nose and forehead bones.**	3
	Note: The insurance benefit is not paid for surgery on the nasal bones or nasal septum.	
1.13	**Fractures of the front walls of the facial hollows: maxillary sinus (sinus frontalis), sinus (sinus ethmoidalis) or maxillary sinus (sinus maxillaris, sinus Haighmori).**	5
	Note: If several facial bones are broken, the percentages of the insurance benefit to be paid are added together, but the total amount of the insurance benefit cannot exceed 15%.	
1.14	**Lung injury, contusion, subcutaneous emphysema, hemothorax (bleeding from the lung), pneumothorax (air in the pleural cavity), traumatic pneumonia (inflammation of the lung), exudative pleuritis (wetting inflammation of the pleura), foreign body in the chest cavity:**	
	a) unilateral injury;	5
	b) bilateral injury.	8
	Notes: 1. The insurance benefit is paid if the specified effects are due to direct injury to the chest or its organs. If the cause of these effects (diseases) is different (e.g. cold, surgeries not related to chest injuries, or complications), the insurance benefit is not paid; 2. When acute pneumonia is caused by accidental acute poisoning with chemical substances that irritate the respiratory tract, pneumotoxic poisons – the insurance benefit is paid.	
1.15	**Fracture of sternum.**	5
1.16	**Rib fracture:**	
	a) 1–2 ribs;	2
	b) 3–5 ribs;	6
	c) 6 or more ribs.	10
	Notes: 1. A fracture of the cartilage of the rib or dislocation of the rib is equivalent to a broken rib; 2. If the received medical certificate indicates that the ribs were broken, but the number is not indicated, then the benefit is paid in accordance with clause a) of this article.	

1.17	**Damage to the larynx, fracture of the trachea, chin bones, tracheostomy performed after injury, brochoscopy, thoracotomy performed due to injury.**	5
Cardiovascular system		
1.18	**Injury to the heart, its coverings and large trunk vessels, which did not cause cardiovascular insufficiency.**	15
	Notes: 1. Large trunk blood vessels are the following: aorta, pulmonary, innominate, carotid arteries (trunks), internal jugular, upper and lower vena cava, portal vein, as well as trunks of blood vessels that ensure blood flow to internal organs; 2. If a surgery to restore blood circulation was performed due to the injury of large blood vessels, then 5% of the insurance amount is additionally paid (only once according to articles 1.18, 1.19 or 2.14).	
1.19	**Injury of large peripheral blood vessels that did not cause vascular insufficiency:**	
	a) both blood vessels are damaged in the wrist or ankle area;	3
	b) damaged blood vessels in the forearm or lower leg;	5
	c) damaged blood vessels in the upper arm or thigh.	10
	Notes 1. Large peripheral vessels include: subclavian, axillary, brachial, ulnar, radial, iliac, femoral, axillary, tibial arteries, subclavian, axillary, femoral, and axillary veins; 2. When blood vessels are damaged in the lower third of the forearm or lower leg, it is treated as if they are damaged in the wrist or ankle area, respectively.	
Digestive organs, facial bones		
1.20	**Jaw fractures:**	
	a) fractures of jaws, cheekbones, hyoid bone;	5
	b) dislocation of the lower and upper jaws.	3
	Notes: 1. Notes: When the jaw is broken, it is not taken into account whether the fractures are on one or both sides, i.e. the insurance benefit is paid once; 2. A fracture of the alveolar process is not considered a fracture of the jaw; 3. If the teeth are lost due to the fracture of the alveolar growth, then the insurance benefit due to fractures is not paid; 4. In the case of normal dislocation of the lower jaw, the insurance benefit is paid only if this complication is due to an injury that occurred during the insurance period (i.e. the primary dislocation due to injury was during the insurance period) and the diagnosis was made within a year from the date of the injury. Due to regular dislocation recurrences (recurrences), insurance benefits are not paid; 5. If facial bone surgery is performed due to jawbone or cheekbone fracture, an additional 3% of the insurance amount is paid once (regardless of the number of surgeries).	
1.21	**Traumatic damage to the teeth: fracture of the tooth or its root (at least ¼ of the tooth), submersion of the tooth (partial dislocation), including inclination (dentation of the tooth into the alveolus):**	
	a) partial avulsion of the tooth crown	2
	b) complete loss of 1 tooth, submersion or impaction into the alveolus;	3
	c) complete loss of 2-3 teeth, submersion or impaction into the alveolus;	5
	d) complete loss of 4-6 teeth, submersion or impaction into the alveolus;	8
	e) complete loss of 7-9 teeth, submersion or impaction into the alveolus;	10
	f) complete loss of 10 or more teeth, submersion or impaction into the alveolus.	12
	Notes: 1. The loss of a tooth crown or the entire tooth is defined as such loss, when re-implantation is not performed or when the tooth is treated for injury, it is removed within 1 year from the date of the injury; 2. If several teeth are chipped, the percentages are added up, but not more than 5%; 3. If teeth are damaged or lost while eating/biting – the insurance benefit is reduced by 50%; 4. In case of broken or damaged dental prostheses or prosthetic teeth due to injury, the insurance benefit is not paid.	
1.22	**An ulcer that appeared on the abdominal wall, diaphragm or at the site of a postoperative scar (if the surgery was performed due to injury).**	10
1.23	**Traumatic damage to the organs of the abdominal cavity, after which the following is performed:**	
	a) laparocentesis;	2
	b) laparoscopy, diagnostic laparotomy (if abdominal organs are suspected to be damaged);	7
	c) laparotomy (if the organs of the abdominal cavity are damaged);	10

1.24	**Hernia formed at the site of the postoperative scar of the anterior abdominal wall or diaphragm (if surgery was performed due to injury), regardless of whether this hernia was operated on.**	5
	Notes: 1. When paying the insurance benefit for clause 1.23, the insurance benefit according to items 1.24, 2.19 – 2.21 is not paid. 2. If several interventional procedures were performed after the event, the payment is paid only for the most complex one, except for re-laparotomy; 3. Insurance benefits are not paid for hernias (umbilical, white line, inguinal, inguinal scrotum) caused by physical stress (including weight lifting).	
Urinary and genital systems		
1.25	**Injuries to the organs of the urinary excretion system, as a result of which puncture (trocar) or surgical cystostomy, cystotomy, hemodialysis (one-time) were performed.**	10
Scars after injuries		
1.26	**Damage to the soft tissues of the face, front and side of the neck, submaxillary area, resulting in:**	
	a) a linear scar up to 3 cm;	1
	b) a linear scar from 3.1 cm to 5 cm;	3
	c) a linear scar from 5.1 cm to 8 cm, scar from 2 cm^2 to 5 cm^2 area;	5
	d) a linear scar longer than 8.1 cm; a scar with an area of more than 5.1 cm^2;	10
	e) a pigment spot up to 2 cm^2 remaining after a burn due to direct contact with hot liquids, devices, chemicals;	2
	f) a pigment spot from 2.1 cm^2 and more, remaining after a burn due to direct contact with hot liquids, devices, chemicals;	5
	g) disfigurement of one side of the face: massive contrasting spots of an unusual color for the face, ugly scars, disfigurement of the face (very significant change in the appearance of both sides of the face, there are no more or almost no intact areas of the face);	20
	h) disfigurement of the entire face: deformation of the soft tissues of the facial surface remains, massive contrasting spots of an unusual color for the face, ugly scars.	30
1.27	**Damage to the soft tissues of the hairy part of the head, torso, limbs, resulting in:**	
	a) a linear scar up to 5 cm (up to 2 cm inclusive for children under 6 years of age);	1
	b) a linear scar from 5.1 cm (for children up to 6 years of age inclusive from 2.1 cm to 5 cm) or a scar with an area of 2 cm^2;	5
	c) a linear scar longer than 10 cm (in children under 6 years of age longer than 5.1 cm inclusive) or a scar with an area of more than 5 cm^2.	7
1.28	**Damage to the soft tissues of the torso, limbs, which left pigment spots:**	
	a) I – II A degree burns up to 2% of the body surface area – pigment spot, or up to 1% of the body surface area – scar;	2
	b) II A – II B degree burns from 2% of the body surface area – pigment spot, or from 1% of the body surface area – scar;	4
	c) II B degree – and deeper burns from 2% of the body surface area – pigment spot, or from 2% of the body surface area – scar;	6
	Note. If the insurance benefit is paid according to clauses a); b) or c) of article 1.28 and as a result of that injury the insured person was treated in an inpatient setting for more than 2 days, an additional 2% of the Insurance amount is paid	
1.29	**Burn disease (burn shock, burn anuria, burn intoxication, acute burn toxemia, burn septicotoxemia), traumatic, posthemorrhagic, anaphylactic shock, fat embolism, if the diagnosis is based on hospitalization.**	10
1.30	**Open or closed soft tissue injury resulting in the following consequences: muscle hernia, post-traumatic periostitis (inflammation of the periosteum), non-resorbed hematoma (at least 5 cm^2), as well as, if the muscle is torn, damage to the integrity of the tendon (except for the foot and hand finger and shoulder joint tendons):**	
	a) one of the listed effects is present;	2

	b) two or more of the listed effects are present.	5
	Notes: 1. Scar – a skin formation formed by connective tissue and blood vessels after an injury, cut, or burn of the deeper layers of the skin (dermis). The insurance benefit for scars is paid only if the wound has been treated in a medical institution; 2. We do not pay insurance benefits for abrasions, scratches or other damages that did not require sewing or gluing of tissues. 3. Pigment spots and scars are measured after the end of healing and at least 1 month after the injury; 4. 1% of the body surface area is equal to the area of the palmar surface of the Insured person's hand (palm and II–V fingers together). This area is calculated in square centimeters: the length of the hand, measured from the distal fold of the wrist to the top of the rear phalanx of the third finger, multiplied by the width of the hand, measured in the line of the heads of the II–V metacarpals; 5. Insurance benefit for scars and/or partial loss of soft tissue resulting from open fractures, surgeries or amputations is not paid; 6. When calculating the insurance benefit due to scars formed during one event according to the relevant article of Annex No. 1, the measurements of the scars are added up; 7. If several muscles and/or tendons are damaged in one limb during one insured event, the insurance benefit due to the injury of individual muscles and tendons is not aggregated; 8. If several ligaments of one joint are damaged during one insured event, the insurance benefit due to the injury of individual ligaments is not aggregated. 9. If the size of the scar and/or pigment spot is not specified in the medical documents, 1% of the Insurance amount is paid.	
Spine		
1.31	**Fracture of the vertebral bodies or arches of the cervical, thoracic or lumbar spine (confirmed radiologically):**	
	a) 1–2 vertebrae;	10
	b) 3 or more vertebrae.	15
	Note: In the case of repeated dislocations (in the case of recurrence), the insurance benefit is not paid.	
1.32	**Fracture of the vertebral processes of the cervical, thoracic or lumbar spine, subsidence or dislocation of the vertebral bodies (confirmed X-ray):**	
	a) 1–2 vertebrae;	5
	b) 3 or more vertebrae.	8
	Note: In the case of repeated dislocations (in the case of recurrence), the insurance benefit is not paid.	
1.33	**Sprain or partial tear of vertebral ligaments for which treatment lasted for at least 14 days.**	5
1.34	**Fracture of the sacrum.**	10
1.35	**Coccyx fracture.**	8
	Notes: 1. If there were several injuries to the same vertebra during one injury (fracture of the body of the vertebra, fracture of its processes, damage to its ligaments), the insurance benefit is paid for the most serious injury;	
Arm		
1.36	**Fracture of the scapula.**	5
1.37	**Fracture of the clavicle.**	5
1.38	**Partial or complete rupture of the ligaments between the scapula and clavicle.**	5
1.39	**Tearing of the ligaments between the sternum and clavicle.**	10
Shoulder joint		
1.40	**Damage to the shoulder joint:**	
	a) sprained ligaments, when the treatment was at least 10 days	1
	b) rupture of ligaments, tendons, rupture of the articular lip, dislocation of the clavicle or dislocation of the humerus in the shoulder area, which has been treated for at least 14 days;	2
	c) the head of the humerus, the anatomical neck, the greater hump.	5

1.41	**Damage to the shoulder joints caused by ankylosis of the joint (not earlier than 3 months after the injury).**	10
	Notes: 1. When a surgery was performed due to an injury in the shoulder joint area, an additional 2% of the insurance amount is paid. Additional benefit is not paid for taking a transplant; 2. The insurance benefit for repeated (ordinary) dislocations is not paid; 3. If the original dislocation occurred before the conclusion of the insurance contract, repeated dislocations are not recognized as insured events and no insurance benefits are paid due to them; 4. Dislocations caused by physical exertion (e.g. weight lifting) are not recognized as insured events, and the insurance benefit for them is not paid; 5. A dislocation is recognized only if it was repaired in a medical facility; 6. For all injuries to one arm, the insurance contract pays no more than 80% of the sum insured; 7. If degenerative changes in the shoulder joint or injuries to ligaments/tendons are detected, 50% of the insurance benefit calculated according to Clause 8.1 of the Special Terms and Conditions is paid out.	
Upper arm		
1.42	**A fracture of the humerus in any part of its diaphysis, as well as a fracture of the surgical neck.**	8
	Note: 1. When a surgery was performed due to a fracture of the humerus, an additional 3% of the insurance amount is paid once, but if the insurance benefit is additionally paid due to shoulder or elbow joint surgery, then according to this note, the additional insurance benefit is not paid. Soft tissue management is not considered surgery.	
1.43	**False joint of the humerus (immature fracture, pseudarthrosis), present at least 9 months after the injury, when this is confirmed by a medical certificate.**	30
Elbow joint		
1.44	**Injury to the elbow joint area:**	
	a) elbow sprains after at least 10 days of treatment with immobilization	1
	b) partial ligament rupture of the elbow joint, rupture with immobilization, when the treatment lasts at least 10 days;	2
	c) rupture of the elbow joint (complete rupture of the ligaments, rupture of the elbow joint sac) with immobilization, when the treatment lasts at least 14 days;	3
	d) fracture of one epicondylus of the humerus, separation of the head (edge) of the radial bone, fracture of the coronal process (processus coronoideus) of the ulna, dislocation of one bone, fracture of the elbow process (olecranon) of the ulna, isolated dislocation of the head of the radial bone;	4
	e) supraclavicular fracture of the humerus, fracture of both metatarsals of the humerus, fracture of the neck (neck) of the radial bone, dislocation of both forearm bones (with or without articular fracture);	10
	f) articular fracture of the humerus (with or without dislocation), forearm articular fracture (with or without dislocation);	15
	g) articular fracture of the humerus with simultaneous fracture of the joints of two bones of the forearm (with or without dislocations).	20
	Note: 1. Due to one injury, only one clause of article 1.44 can be applied. When there were various injuries at the time of the injury, the clause corresponding to the most serious injury is applied; 2. When an injury to the elbow joint area was operated on, an additional 3% of the insurance amount is paid once; 3. When there is immobility of the elbow joint (ankylosis) together with immobility of the shoulder joint, 40% of the insurance amount is paid in accordance with clause b of article 1.45).	
1.45	**Consequences of an injury to the elbow joint, which have been present for at least 9 months after the injury, when this is confirmed by a certificate:**	
	a) joint dysfunction (limited mobility, contracture);	5
	b) joint immobility (ankylosis), pseudarthrosis confirmed by X-ray.	20
Forearm		
1.46	**Fractures of the diaphysis of the forearm bones, confirmed radiologically:**	
	a) single bone (without displacement);	5
	b) single bone (with displacement);	7
	c) Fracture of 2 bones, one bone or two bones with dislocation of another bone.	9
	Note: If it was necessary to operate on a broken forearm, an additional 3% of the insurance amount is paid once. However, if an additional benefit is paid for the elbow surgery, no additional benefit is paid under this note.	

1.47	**Malunion fractures of the forearm bones (false joints) occurring at least 9 months after the day of injury:**	
	a) one bone	5
	b) both bones	10
Radius and carpal joint		
1.48	**Traumatic damage to the integrity of the muscle, tendon, ligament (strain, partial tear, tear), dislocation of the wrist joint due to:**	
	a) treatment and/or incapacity for work lasted at least 7 days;	1
	b) treatment with a plaster cast or a special hard splint was applied for 14 days or longer.	2
1.49	**Separation of the epiphysis of the bone (epiphysiolysis), fracture of bony processes, including those of the radius (radius bone) or ulna (processus styloideus radii or ulnae), fracture of the ulnar head, fracture of the distal, lower end, fracture of the radius alone or both bones at a typical location:**	
	a) fracture of one or two bone spurs	2
	b) one bone	4
	c) two bones.	7
1.50	**Fracture of the radius in a typical location with dislocation or subluxation of the ulnar head, epiphysiolysis of two bones.**	6
1.51	**Consequences of an injury to the wrist joint area that have been present for at least 9 months after the day of the injury:**	
	a) joint dysfunction (limited mobility, contracture);	5
	b) joint immobility (ankylosis), confirmed by X-ray.	15
	Note: If it was necessary to operate on a fracture of the radial bone, an additional one-time payment of 2% of the insurance amount is made.	
Hand and palmar bone		
1.52	**Fracture or dislocation of the wrist bones, metacarpals, damage to the integrity of the muscle, tendon, or ligament of one hand:**	
	a) fracture or dislocation of one bone;	2
	b) fracture or dislocation of two bones, fracture or dislocation of the scaphoid (os scaphoid);	5
	c) fracture or dislocation of three or more bones;	10
	d) dislocation of the hand;	15
	e) traumatic damage of the integrity of the hand muscle, tendon, ligament (strain, partial rupture, rupture), nerve damage, which was treated with a plaster bandage or special with a hard splint and the treatment continued for at least 14 days.	2
	Note: 1) Due to one injury, only one clause of article 1.52 may be applied; 2) If it was necessary to operate on a fracture of the navicular bone (os scaphoideum), an additional 2% of the insurance amount is paid once.	
1.53	**Consequences of hand injury:**	
	a) nonunion fracture of one or several bones, except phalanges (false joint, pseudarthrosis), occurring at least 9 months after the injury, when this is confirmed by a medical certificate;	10
	b) loss of all fingers of the hand, amputation of the hand in the area of the metacarpal or wrist bones;	65
	c) amputation of the only hand the person had.	100
First finger (thumb)		
1.54	**Finger injuries:**	
	a) traumatic loss of the nail plate (nail), surgical removal, rupture of ligaments, damage to the ligaments of the joint capsule;	1
	b) bone fracture, tendon injury;	3
	c) finger dislocation.	2

1.55	**Damage to the finger that caused immobility:**	
	a) one joint;	5
	b) two joints.	10
Fingers (except the first finger)		
1.56	**Finger fracture, dislocation, tendon injury, joint capsule ligament tear, loss of nail plate (nail)**	1
Pelvic fractures		
1.57	**Fractures of pelvic bones (ilium, pubic bone, ischium):**	
	a) fracture of one bone, separation of the edge of the acetabulum;	7
	b) rupture of one ligament; bilateral fracture of one bone, fracture of two bones, fossa fracture;	12
	c) rupture of multiple ligaments, fracture of three or more bones, fracture of the hip with dislocation of the central femur.	15
	Note: When a surgery was performed due to the fracture of the pelvic bones or the rupture of the cartilaginous ligaments, an additional 3% of the insurance amount is paid once, regardless of the number of surgeries.	
LEG		
Hip joint		
1.58	**Injury to the hip joint area:**	
	a) damage of the integrity of the ligaments of the hip joint (strain, partial tear, rupture, rupture of the articular lip of the hip joint), when continuous treatment lasted for at least 14 days;	3
	b) fracture of the small and large ridges of the femur (trochanter minor et major), fractures through the ridges, supravertebral fracture;	10
	c) fracture of the head or neck of the femur, dislocation of the femur.	15
1.59	**The consequences of the hip joint injury, which have been present for at least 9 months after the date of the injury, and this is confirmed by a certificate:**	
	a) joint immobility (ankylosis), confirmed by X-ray;	15
	b) malunion fracture of the femoral neck (false joint, pseudarthrosis);	20
	c) femoral head, coccyx resection (surgical removal), endoprosthesis (internal joint replacement) due to injury.	35
	Notes: 1. When a surgery was performed due to an injury in the hip joint area, an additional 3% of the insurance amount is paid once, regardless of the number of surgeries. Soft tissue management is not considered surgery; 2. When several consequences of a single injury are provided for in several clauses of the article, the paid insurance benefit is determined according to the clause that stipulates the most severe consequences of that injury; 3. Due to an injury to one leg, the payment for all consequences cannot exceed 60% of the amount insured; 4. The immobility of the joint must be confirmed by a traumatologist, assessing and describing the range of motion of the affected joint in degrees.	
Thigh		
1.60	**Femur fracture**	
	a) diaphysis closed;	7
	b) diaphysis open;	10
	c) fracture of the distal end;	5
	d) articular fracture.	10
	Note: When a surgery was performed due to femur fracture, an additional 3% of the insurance amount is paid once, regardless of the number of surgeries, but if the insurance benefit is additionally paid due to hip or knee joint surgery, then according to this note, the additional insurance benefit is not paid. Soft tissue management is not considered surgery.	
1.61	**Malunion femur fracture (assessed at least 9 months after the injury), nonunion fracture (false joint, pseudarthrosis).**	30
1.62	**Dysfunction of one or more joints of the leg (restriction of mobility, contracture).**	5

Knee joint		
1.63	**Injury to the knee joint area:**	
	a) Damage of the integrity of the ligaments of the knee joint (strain, partial tear, rupture), when treatment and/or incapacity lasted for at least 10 days, hemarthrosis (confirmed puncture);	1
	b) Damage of the integrity of the knee ligaments (strain, partial tear, rupture) when treated with a plaster cast or special hard splint and the treatment lasted longer than 14 days, dislocation of the patella (rupture of the patellar ligaments);	1.5
	c) A knee meniscus tear or chipping confirmed by MRI or surgery;	2
	d) Fracture of the proximal end of the fibula.	4
	e) Fracture of patella. Tibia proximal end (lateral tooth, internal tooth articular fracture);	6
	Notes: 1. When a reconstructive surgery was performed due to damage to the integrity of the ligaments of the knee joint and/or the knee meniscus, an additional one-time payment of 1% of the insurance amount is made, regardless of the number of surgeries; 2. When paying the insurance benefit in accordance with clause e) of article 1.63 for the surgery, it is not paid additionally. In the event of a rupture of one knee joint during a single injury, the insurance benefit is paid as if it were due to a rupture of one meniscus; 3. If degenerative changes are detected in the knee joint, 50% of the insurance benefit calculated according to Clause 8.1 of the Special Conditions is paid.	
1.64	**Damage to the knee joint resulting in:**	
	a) block of the knee joint due to soft tissue damage;	10
	b) instability of the joint (due to resection of the bone surface in the knee joint).	20
Lower leg		
1.65	**Fracture of the diaphysis of the tibia:**	
	a) fibula;	5
	b) tibia.	8
1.66	**Fracture of one or both lower leg bones, resulting in the formation of a false joint (malunion fracture), not earlier than 9 months after the injury:**	
	a) fibula;	5
	b) tibia.	10
	Note: When paying the insurance benefit according to clause 1.65 b) for the surgery, an additional 2% of the insurance amount is paid once.	
Ankle joint		
1.67	**Injury to the ankle joint area:**	
	a) damage of the integrity of the ligaments (strain, partial tear, rupture), when treatment and/or incapacity for work lasted for at least 7 days;	1
	b) damage to the integrity of the ligaments (strain, partial tear, rupture) when it was treated with a plaster bandage or spec. with a hard splint and the treatment lasted longer than 14 days;	2
	c) fracture of one ankle, fracture of the posterior edge of the tibia, rupture of the tibia–fibula distal ligament connection (syndesmosis) (syndesmolysis);	3
	d) a fracture of both ankles, a fracture of one ankle and a fracture of the posterior edge of the tibia, a rupture of the tibia–fibula distal ligament (syndesmosis) and a submersion of the foot;	5
	e) fracture of both ankles with concomitant fracture of the posterior edge of the tibia, fracture of one ankle or both ankles with concomitant foot drop, complete dislocation of the foot with concomitant syndesmolysis (or without it);	10
	f) a fracture of both ankles and a fracture of the posterior edge of the tibia and subluxation (dislocation) of the foot and syndesmolysis.	20
1.68	**The consequences of an injury in the area of the ankle joint, which have been present for at least 9 months after the date of the injury, and this is confirmed by a certificate:**	
	a) joint immobility (ankylosis), confirmed by X-ray.	15

	Damage of Achilles integrity when treated conservatively (without surgery) and continuous treatment continued for at least 14 days;	5
1.69	**Note:** 1. When a surgery was performed due to damage to the bone of the Achilles tendon or ankle joint area, an additional 2% of the Insurance amount is paid once; 2. In case of a stress fracture in the area of the ankle, the insurance benefit is reduced by 50%. The payment for surgery due to a stress fracture is not paid. 3. 1% of the sum insured is paid out for the injury suffered, recognized as an insured event according to clause 1.67 b), which occurred within the first 90 days from the beginning of the validity of the initial insurance contract. This limitation does not apply where the Injury occurred during the term of the renewed contract.	
Foot		
1.70	**Traumatic damage to the integrity of the foot muscle, tendon, ligament (strain, partial tear, rupture), nerve damage due to:**	
	a) treatment and/or incapacity for work lasted longer than 7 days;	1
	b) was treated with a plaster bandage or special with a hard splint and the treatment lasted longer than 14 days;	2
	c) reconstructive surgery performed;	3
	d) fracture or dislocation of one or two bones (except the calcaneus or talus);	3
	e) fracture of the heel bone (calcaneus), fracture of the talus (talus), fracture or dislocation of three or more bones;	5
	f) dislocation of the talus, subtalar dislocation of the foot, dislocations of the transverse ankle joint (articulatio tarsi transversa, Chopar) or ankle plantar joint (articulatio tarsometatarseae, Lisfranco).	15
1.71	**Consequences of a foot injury:**	
	a) foot deformity caused by the result of the insured event – bone fracture with displacement;	5
	b) nonunion fracture or false joint of one or two metatarsals;	5
	c) nonunion fracture or false joint of three, four, or five metatarsals;	10
	d) nonunion fracture of the talus or calcaneus (pseudarthrosis), aseptic necrosis of the talus.	15
Toes		
1.72	**Injuries to the toes of one foot:**	
	a) damage of the integrity of the finger ligaments (strain, partial tear, rupture), loss of the finger nail plate (nail);	1
	b) fracture of one or two fingers (except the first);	1
	c) fracture or dislocation of the first finger;	2
	d) fracture or dislocation of the bones of three or four fingers (except the first) (regardless of the number of broken or dislocated phalanges), injury to the tendons of three, four or five fingers.	8
OTHER CONSEQUENCES OF INSURED EVENTS:		
1.73	**Consequences of various traumatic injuries (in the case of hand and toe injuries, the article does not apply):**	
	a) taking a bone autograft;	5
	b) post-traumatic osteomyelitis, hematogenous osteomyelitis.	10
1.74	**Traumatic, hemorrhagic (anemic, associated with blood loss), anaphylactic (due to hypersensitivity to some substances) shock, fat embolism.**	5
1.75	**Insured events, due to which the insured person was treated in an inpatient setting for more than 2 days (when the insurance benefit is not paid according to other articles of this table): traumatic asphyxia, acute poisoning by chemical (toxic) substances, injury by electric current (electrical networks, equipment, atmospheric electric discharges), snake bites, animal bites, insect bites, etc., if they required inpatient treatment:**	
	a) 3–7 days;	3
	b) 8–15 days;	7
	c) 16 days or more.	10

1.76	**Acute poisoning with food, mushrooms (except for poisoning with alcohol, narcotic substances, drugs used without a doctor's permission) for which the insured was treated:**	
	a) up to 3 days in an inpatient setting;	1
	b) 4–7 days in an inpatient setting;	3
	c) 8–14 days in an inpatient setting;	7
	d) 15 days or more in an inpatient setting.	10

ANNEX 2 "TABLE FOR DETERMINING THE AMOUNT OF THE INSURANCE BENEFIT T2" "LONG-TERM AND IRREVERSIBLE CONSEQUENCES OF INJURIES"

Serial No.	Injury	Amount of the insurance benefit from the insurance amount, %
Central and peripheral nervous system		
	Consequences of damage to the central nervous system caused by injury, acute accidental poisoning, mechanical asphyxia, determined at least 6 months after the injury:	
2.1	a) arachnoiditis, arachnoencephalitis or encephalopathy of traumatic (toxic) origin (encephalopathy – only for persons under 40 years of age);	10
	b) traumatic epilepsy, traumatic hydrocephalus, moderate mental impairment, paresis of one limb (monoparesis), remaining foreign body in the skull or brain (does not apply to foreign bodies remaining after brain surgeries), traumatic parkinsonism (the latter effect – in persons under 40 years of age);	15
	c) paresis of two or more limbs (hemiparesis, paraparesis);	30
	d) paralysis of one limb (monoplegia);	40
	e) unilateral (half-body) paralysis (hemiplegia); paralysis of the lower limbs (paraplegia);	50
	f) dementia (dementia); paraplegia with a marked impairment of the function of the pelvic organs (urination or defecation);	70
	g) paralysis of the upper and lower limbs (tetraplegia), decortication ("cortexless" brain).	100
	Notes: 1. When vision and/or hearing is reduced due to the injury referred to in article 2.1 and this is confirmed during inpatient treatment, the insurance benefit is additionally paid according to the corresponding articles in the table; 2. Due to one injury, only one payment can be made according to article 2.1.	
2.2	**Nerve damage (injuries) caused by:**	
	a) damage to the hand, radial bone (except finger nerve injury);	3
	b) lesions in the area of the forearm, wrist, calf, ankle;	10
	c) traumatic injuries of upper arm, elbow, thigh, knee joints.	15
	Notes: 1. If the injury of several nerves in one limb is considered as one injury; 2. The following nerve injuries are equated to traumatic peripheral nerve injury: nerve shock, contusion, compression, overstretching, rupture, uprooting; 3. The insurance benefit is not paid for finger nerve injury; 4. If the injuries of the peripheral nerves are in several limbs, then the lesions of each limb are evaluated separately; 5. If the injury to the peripheral nerve and/or nerve plexus is caused by a closed nerve injury, the insurance benefit is paid only if the signs of nerve injury persist for more than 6 months from the day of the injury and are confirmed by objective examination methods; 6. If a surgery was performed due to the damages listed in article 2.2 (separated nerves, plastic surgery, re-innervation of the plexus, etc.), then regardless of the number of surgeries, an additional 5% of the insurance amount is paid; 7. The insurance benefit for traumatic plexitis is paid if it persists for at least 3 months after the injury.	
2.3	**Peripheral cranial nerve injury**	10
	Notes: 1. The insurance benefit is paid once, regardless of the number of damaged nerves and regardless of whether the damage is unilateral or bilateral. If the insurance benefit is paid according to points b or c of article 1.1, then article 2.3 does not apply; 2. The insurance benefit is paid if the nerve damage clinic persists for 6 months with conservative treatment; 3. The insurance benefit is paid immediately if reconstructive surgery was performed due to traumatic nerve damage.	
Organs of vision		
2.4	**Accommodative paralysis of one eye.**	10
2.5	**Hemianopsia of one eye.**	10
2.6	**Narrowing of the visual field of one eye.**	7
2.7	**Unilateral impairment of the functions of the lacrimal canal: interruption or complete stenosis.**	5

2.8	**Loss of vision in one eye (without correction), determined no earlier than 3 months and no later than 1 year after the date of injury, comparing pre–injury vision with post-injury vision (see Table 1).**	

Table 1 "Amount of insurance benefit after traumatic visual impairment"

Vision		Amount of the insurance benefit from the insurance amount	Vision		Amount of the insurance benefit from the insurance amount
Before the injury	**After the injury**	**%**	**Before the injury**	**After the injury**	**%**
1.0	0.7 0.6 0.5 0.4 0.3 0.2 0.1 < 0.1 0.0	1 3 5 10 15 20 30 40 45	0.9	0.6 0.5 0.4 0.3 0.2 0.1 < 0.1 0.0	1 3 5 10 20 30 40 45
0.8	0.5 0.4 0.3 0.2 0.1 < 0.1 0.0	1 5 10 20 30 40 45	0.7	0.5 0.4 0.3 0.2 0.1 < 0.1 0.0	1 5 10 15 20 30 35
0.6	0.4 0.3 0.2 0.1 < 0.1 0.0	1 3 10 15 20 25	0.5	0.3 0.2 0.1 < 0.01 0.0	1 5 10 15 20
0.4	0.2 0.1 < 0.1 0.0	3 5 10 20	0.3	0.1 < 0.1 0.0	3 10 20
0.2	0.1 < 0.1 0.0	3 5 10	0.1	< 0.1 0.0	5 20
< 0.1	0.0	10	–	–	–

Notes:

1. If visual acuity is reduced due to retinal detachment, it must be based on evidence of injury to the eye that has just occurred/been suffered;
2. If the visual acuity of both eyes decreases due to an injury, each eye is evaluated separately, the obtained percentages are added and multiplied by a factor of 1.3;
3. When there is no data on the visual acuity before the injury in the documents of health care institutions, it is considered that the visual acuity was – 1.0, but was not higher than the visual acuity of the uninjured eye;
4. When an artificial lens is implanted or a corrective lens is used due to an injury, the insurance benefit payable is determined by the visual acuity before implantation or lens application;
5. The decrease in visual acuity is assessed no earlier than 3 months and no later than one year after the date of injury.

Hearing organs		
2.9	**Complete deafness in one ear**	15
2.10	**Complete deafness in both ears**	60
	Note: The consequences of the injury specified in articles 2.9 and 2.10 are assessed no earlier than 9 months from the date of the injury.	
Breathing system		
2.11	**Lung damage caused by:**	
	a) removal of 1 – 2 lung segments;	20
	b) removal of up to ½ of the lung;	30
	c) removal of ½ or the entire lung.	40
2.12	**Lung injury resulting in pulmonary insufficiency at least 9 months after the date of injury.**	20
2.13	**A functioning tracheostomy after the injury that has caused breathing problems, weakening or loss of voice and these effects persist for more than 9 months.**	20
Cardiovascular system		
2.14	**Injury to the heart, its coverings and large trunk vessels, causing cardiovascular insufficiency, occurring at least 3 months after the day of the injury and identified within a year of the day of the injury (when this is confirmed by a certificate or the conclusion of a cardiologist):**	
	a) I degree;	10
	b) II or II–III degree;	30
	c) III degree.	50
	Note: Large peripheral vessels include the subclavian, axillary, brachial, ulnar, radial, iliac, femoral, axillary, tibial arteries, subclavian, axillary, femoral, and axillary veins.	
Digestive organs, facial bones		
2.15	**Jaw injury caused by:**	
	a) loss of part of the jaw;	20
	b) complete loss of the jaw.	40
	Note: Loss of alveolar ridges is not considered loss of part of the jaw.	
2.16	**Damage to the tongue resulting in:**	
	a) loss of the tip of the tongue or the distal third of the tongue;	10
	b) loss of the middle third of the tongue;	30
	c) loss of the root of the tongue (the proximal third) or the entire tongue.	60
2.17	**Damage to the esophagus due to which:**	
	a) the esophagus narrowed and it became difficult to swallow liquid or soft food;	20
	b) the esophagus became impermeable, but not earlier than 6 months after the injury, and as a result a permanent gastrostomy (opening of the stomach to the outside through the abdominal wall) was formed.	80
2.18	**Damage to the digestive organs occurred as a result of severe poisoning, except for intentional (including alcoholic) poisoning, which resulted in:**	
	a) narrowing or deformation of the stomach, intestine, anus due to scarring);	20
	b) conjunctival disease developed after abdominal surgeries, functioning pancreatic fistula;	30
	c) intestinal fistula (ileostomy – opening of the ileum to the outside, enterostoma – opening of the small intestine to the outside), intestinal–vaginal fistula (enterovaginal, rectovaginal);	50
	d) colostomy (formation of an artificial anal opening).	80
	Notes: 1. When a single injury has several consequences specified in srticle 2.18, the insurance benefit is paid according to the clause that provides for the most severe consequences; 2. The insurance benefit according to clause b of article 2.18 is paid once, regardless of the number of surgeries.	

2.19	**Traumatic liver damage, severe poisoning caused by:**	
	a) suturing of the liver or removal of the gallbladder;	15
	b) suturing of the liver and removal of the gallbladder;	20
	c) removal of a part (lobe) of the liver;	25
	d) removal of part of the liver and gallbladder.	30
2.20	**Damage to the spleen resulting in:**	
	a) the rupture of the spleen;	5
	b) the removal of the spleen.	20
2.21	**Damage to the stomach, pancreas, intestines, peritoneum, which led to the removal of:**	
	a) 1/3 stomach, 1/3 intestine;	25
	b) ½ stomach, 1/3 pancreas, ½ pancreas;	35
	c) 2/3 stomach, 2/3 pancreas and 2/3 intestine;	60
	d) stomach, 2/3 pancreas and 2/3 intestine;	80
	e) the whole intestine, stomach and part of the pancreas.	100
Urinary and genital systems		
2.22	**Traumatic kidney injury resulting in:**	
	a) removal of part of a kidney/one kidney;	30
	b) removal of both kidneys.	60
2.23	**Damage to the urinary system due to injury:**	
	a) kidney failure;	30
	b) urinary tract obstruction.	40
2.24	**Traumatic injury to the genital system resulting in:**	
	a) removal of one ovary, one fallopian tube (fallopian tube) for women under the age of 40, both ovaries, both fallopian tubes for women over 40, one testicle (testis), part of the male genital organ (penis);	15
	b) removal of both ovaries, both fallopian tubes, for women under the age of 40, both testicles (testis) or a man's penis;	30
	c) hysterectomy of a woman under 40 years of age;	40
	d) hysterectomy of a woman aged 40 to 50;	30
	e) hysterectomy in a woman over 50 years old.	15
Upper arm		
2.25	**Traumatic amputation of the hand or severe injury resulting in amputation of the hand within a year of the injury:**	
	a) amputated arm with other bones of the shoulder girdle (scapula, clavicle or part thereof);	80
	b) amputated in any part of the upper arm or through the shoulder joint;	75
	c) amputated arm, which was the only one before the injury.	100
Forearm		
2.26	**Loss of an arm above the wrist joint or amputation of the forearm following injury due to severe damage.**	65
First finger (thumb)		
2.27	**Amputation during injury or severe injury resulting in finger amputation:**	
	a) partial loss of the nail phalanx (with bone loss);	3
	b) loss of the entire nail phalanx;	5
	c) at the level of the second and third phalanges (loss of a finger).	10
Fingers (except the first finger)		
2.28	**Amputation of a finger after injury or injury that caused this amputation:**	
	a) partial loss of the phalanx (with bone loss);	3

	b) loss of the entire phalanx;	5
	c) loss of the middle phalanx;	10
	d) loss of three phalanges (loss of a finger).	15
2.29	**Loss of all fingers due to injury or damage**	50
LEG		
Thigh		
2.30	**Traumatic leg amputation or severe injury resulting in amputation of the leg within one year from the date of injury:**	
	a) one leg;	70
	b) the only leg the person had.	100
Lower leg		
2.31	**Amputation of the lower leg due to injury or severe injury resulting in amputation of the lower leg within one year of the date of injury.**	60
Ankle joint		
2.32	**Ankle amputation due to injury or severe injury resulting in amputation of the leg at the ankle joint (exarticulation).**	50
Foot		
2.33	**Foot amputation:**	
	a) foot amputation in the area of the metatarsal joints (articulatio metatarsophalangeae);	25
	b) amputation in the metatarsal area;	35
	c) amputation in the metatarsal area;	45
Toes		
2.34	**Amputation of the toes of one foot due to injury or severe injury resulting in amputation of the toes within one year of the date of injury:**	
	a) first finger (thumb, big):	
	I. partial phalanx amputation;	2
	II. loss of the entire nail phalanx;	5
	III. amputated in the part of the basic (proximal, first) phalanx or in the area of the joint of the sole of the finger (loss of a finger);	10
	b) II–V toes:	
	I. amputation of phalanges of one or two fingers;	5
	II. amputation of three or more fingers in the part of the base phalanx or in the area of the joint of the sole of the finger;	10
	III. amputation of all fingers together with the metatarsal or part thereof.	25