HEALTH INSURANCE
Terms and Conditions No 52.2

APPROVED BY
BTA Baltic Insurance Company AAS Management Board decision
No LVB1_000202-03-03-2019-29 of 5th of March 2019

CONTENT **P.**

GENERAL INSURANCE TERMS AND CONDITION

1. DEFINITIONS AS USED IN THE INSURANCE CONTRACT

1.1. **The Insurer** – AAS BTA Baltic Insurance Company, represented by its Lithuanian Branch, hereinafter – BTA.
1.2. **The Policyholder** – a person who has applied to BTA to contract for insurance or to whom BTA has offered to enter into an insurance contract, or who has signed an insurance contract with BTA for own benefit or for benefit of other persons.
1.2.1. Persons related to the Policyholder and/or the Insured Person, who are also bound by the fulfilment of obligations established for the Policyholder:
Persons associated with the Policyholder and/or Insured Person to whom Policyholder's obligations are also binding:
a) Persons living together with the Policyholder or the Insured Person;

b) Persons responsible for insurance object pursuant to an agreement with the Policyholder or the Insured Person;
c) Persons sharing insurance interests together with the Policyholder or the Insured Person, or other persons named in the insurance contract;
d) Persons related to the Policyholder or the Insured Persons under employment, service delivery or other legal relationships and bound to act in conformity with the safety requirements.

1.3. **The Insured Person** – a person whose interests shall be covered:
a) In case of property insurance – the owner of property covered by the insurance contract or other person named in writing in the contract;
b) In case of third party liability insurance – a person whose property interests arising from third party liability are covered;
c) In case of person's insurance – a natural person indicated in the insurance contract, whose health, life or physical condition is covered under the insurance contract.

1.4. **The Beneficiary** – a person named in the insurance contract or a person appointed by the Policyholder or, in cases stipulated in the insurance contract, by the Insured Person and entitled to receive insurance benefits

1.5. **Third party** – in the case of civil liability insurance – a person who has suffered losses due to the Policyholder's or/and Insurer's acts or omissions and who is eligible to receive the insurance benefit in accordance with the terms and conditions of the insurance contract.

1.6. **The parties to the insurance contract** – the Policyholder and BTA.

1.7. **Insurance object** – property interests relating to human life and/or health, property or third party liability.

1.8. **Application to contract for insurance** – a document in the form established by BTA for the Policyholder to provide with information required for the entering into the insurance contract. The application shall not be required, if the Policyholder provides BTA with information which BTA considers sufficient to assess insurance risks. Acceptance of the application to contract for insurance does not obligate BTA to sign the insurance contract.

1.9. **Insurance contract** – an agreement between BTA and the Policyholder according to which the Policyholder undertakes to pay the insurance premium of the agreed by the time limit fixed in the insurance contract and to fulfil other obligations stipulated in the insurance contract, and BTA undertakes to pay the benefit upon occurrence of the insured event in accordance with the terms and conditions of the insurance contract.

1.10. **Insurance policy** – a document confirming the entering into insurance contract and covering the terms and conditions of the insurance contract agreed by BTA and the Policyholder.

1.11. **Sum insured** – a sum of money specified in the insurance contract or a sum of money calculated in the procedure described in the insurance contract which is the limit of indemnity (insurance benefit).

1.12. **Underinsurance** – cases when the established sum insured is less than the value of insurance. In such cases, upon occurrence of the event insured BTA shall indemnify a portion of the benefit in proportion to the ratio of the sum insured and the value of insurance.

1.13. **Insurance exceeding the value of insurance** – cases when the sum insured exceeds the value of insurance as of the date of contracting for insurance. In such cases, the benefit shall be paid down within the limits of the loss suffered.

1.14. **Double insurance** – cases when the Policyholder signs several insurance contracts with different insurance undertakings to cover the same risks. In such case, the Policyholder must notify BTA in writing of other insurance contract concluded by him and to specify the sums insured and other contractual terms and conditions. Otherwise, the Insurer, having paid the insurance benefit, shall become entitled to recoved the respective part of the paid insurance benefit.

1.15. **Additional insurance** – cases when only a portion of the value of property or risk is insured. In such cases the Policyholder shall be entitled to enter into an additional insurance contract with the same or any other insurer. However, the total sum insured under all insurance agreements shall not exceed the value of insurance.

1.16. **Deductible** – a portion of insurance benefit stipulated in the insurance contract and not indemnified by BTA. The deductible shall be defined as a specific amount of money and/or as percentage unless the insurance policy specifies otherwise. Where the insurance contract provides for several types of deductible in respect of the same risk, the largest of them shall always apply.

1.17. **Insurance premium** – an amount of money set in the insurance contract which is payable by the Policyholder to BTA under the terms and conditions of the insurance contract for the insurance cover.

1.18. **Event insured (risk covered)** – incidents stipulated in the insurance contract upon occurrence of which BTA is obliged to pay the insurance benefit.

1.19. **Non-insured event** – an occurrence in respect of which BTA does not pay the insurance benefit.

1.20. **Insurance risk** – a probability for the event insured to occur in future beyond control of the Policyholder and/or Insured Person.

1.21. **Insurance benefit** – an amount of money payable upon occurrence of the event insured or delivery of services if so is stipulated in the insurance contract.

1.22. **A written document:**
a) A document executed in writing and containing all necessary particulars, including signature affixed in accordance with valid legislation of the Republic of Lithuania;
b) transmitted by telegraph, facsimile or other telecommunications terminal equipment, provided that the protection of the text is ensured and it is possible to identify the signature, including an e-message.

2. VALIDITY OF INSURANCE COVER

2.1. A period of insurance means a period when insurance cover is in force.
2.2. The insurance cover shall come into force at 00:00 o'clock on the date indicated in the insurance contract, but not earlier than the premium or its first installment is paid down, if:
2.2.1. the date of payment of the insurance premium or its first instalment is not indicated in the insurance contract;
2.2.2. the beginning of the insurance period coincides with the date of payment of the premium or its first installment;
2.2.3. the time limit for paying the premium or its first instalment precedes the beginning of the insurance period.
2.3. Where the coming into force of the insurance cover is linked to the payment of the insurance premium or its first instalment, the insurance cover shall come into force on the next day at 00:00 following the receipt of payment, but not earlier than specified in the insurance contract.
2.4. The insurance benefit shall not be paid if the event occurs before the entry into force of the insurance cover.
2.5. Where the insurance contract stipulates that the premium should be paid after the first day of the insurance period, the cover shall come into force at 00:00 on the first day of the insurance period.
2.6. The insurance contract shall expire at 24:00 o'clock on the last day of the insurance period specified in the insurance contract unless terminated earlier for other reasons.

3. POLICYHOLDER'S DUTY TO DISCLOSE

3.1. Prior to signing the insurance contract, the Policyholder undertakes to provide BTA with true and complete information requested by BTA in relation to the insurance object and necessary for the assessment of insurance risks. Where the Policyholder knowingly conceals information necessary for the assessment of the insurance risk or knowingly provides incorrect or incomplete information, BTA shall be entitled to claim nullification of the insurance contract and retain the paid down insurance premium.
3.2. The Policyholder is required to promptly notify of any changes which occur during the period of validity of the insurance contract and which are likely to increase the insurance risk. The changes required to be disclosed include:
a) significant changes relating to the insurance object;
b) changes in the manner/ways of using the insurance object.
c) other significant circumstances due to which the insurance risk increases.
3.3. Where information provided to BTA about the insurance object and risks covered changes and this results in insurance risk increase, as well as in case BTA is misled by minor misrepresentations of the Policyholder, BTA shall be entitled to offer the Policyholder, within a period of 1 month from the date of getting aware, to amend the terms and conditions of the insurance contract, including the amount of the insurance premium.
Where the Policyholder disagrees to the amendment of the terms and conditions of the insurance contract or fails to give any answer to BTA within 1 (one) month from the date of dispatch of the notice of the proposed amendments, BTA shall be entitled to terminate the insurance contract upon expiration of the time limit stipulated in this paragraph without any further notice.
Where BTA proves that, being aware of the risk increase, it would have not entered into the insurance contract, BTA shall be entitled to claim termination of the insurance contract within 2 (two) months from getting aware of the risk increase.
3.4. Violation of the Policyholder's duty to disclose information shall also incur other legal consequences entrenched in the legislation of the Republic of Lithuania.

4. INSURANCE PREMIUM AND PAYMENT PROCEDURE

The Policyholder must pay insurance premium to BTA in the amount and by the time limit set in the insurance contract.
4.2. The premium shall be deemed paid:
4.2.1. if the insurance premium is paid by bank transfer – from the moment of receiving the relevant amount to the bank account of BTA or its authorized insurance intermediary.
4.2.2. if the insurance premium is paid using other payment methods – from the date specified in the particular document supporting the fact of payment. For obtaining the list of payment methods please visit internet website www.bta.lt, or call us by phone (8 5) 2600 600;
4.3. In case of failure to pay the premium by the time limit set in the insurance contract, the Policyholder shall pay BTA a default interest in the amount of 0.02% for each day overdue. The above-indicated default interest shall not apply in the following cases:
a) the premium is paid as a lump sum;
b) in respect of the first payment, if the premium is paid in instalments.
4.4. Should the Policyholder fail to pay the premium or any part thereof by the deadline fixed in the insurance contract (with the exception of case when the coming into force of the insurance contract is linked to payment of the insurance premium or its part), BTA must inform the Policyholder in writing that in the event of the failure to pay in the insurance premium or its part within 15 days of receipt of the notice, the insurance contract will be terminated.

5. CONTRACTING FOR INSURANCE BY MEANS OF TELECOMMUNICATION TERMINAL EQUIPMENT

5.1. Insurance contracts concluded between the Policyholder and BTA by post, internet, e-mail, telephone and other means of exchange of information will be considered as shall be deemed to be properly concluded and binding.
5.2. An insurance contract made by means of telecommunications terminal equipment:

a) shall come into force on the next day following payment of the full amount of the insurance premium or its first instalment specified by BTA;

b) by paying the insurance premium the Policyholder confirms that he agrees with all terms and conditions of the insurance contract;

c) the absence of a written policy does not affect validity of the insurance contract.

6. EXPIRATION AND AMENDMENT OF THE INSURANCE CONTRACT

6.1. The insurance contract shall expire at 24:00 on the last day of the insurance period unless otherwise agreed by the Policyholder and BTA.
6.2. The Policyholder shall be entitled to terminate the insurance contract at any time giving a 15 days' notice to BTA in writing. In this case, the insurance contract shall be deemed terminated as of the date indicated in the notice, but not earlier than on the 15th (fifteenth) day after receipt of the notice of termination.
Such being the case:

6.2.1. Where there was no payment of insurance benefit effected and no claims were lodged within the period of validity of the insurance contract, the Policyholder shall be repaid, within 15 (fifteen) calendar days from the receipt of the Policyholder's notice, the insurance premium, less costs of conclusion and performance of the insurance contract (30% of the sum to be repaid).

6.2.2. If during the period of validity of the insurance contract the insurance benefit was paid and/or reserved or claims were filed, within 20 (twenty) calendar days of receipt of the Policyholder's notice, BTA shall repay to the Policyholder the part of the premium which is equal to the difference between the unused portion of the premium for the remaining period of the contract and the insurance benefit paid, having deducted the costs of conclusion and performance of the insurance contract (30% of the repayable amount).

6.3. The terms and conditions of the insurance contract may be modified or amended only upon a written agreement between BTA and the Policyholder.
6.4. The insurance contract may be terminated on other grounds stipulated in the insurance legislation of the Republic of Lithuania governing legal relationships in insurance contracts.

7. GENERAL EXCLUSION CLAUSE

7.1. Unless the insurance contract stipulates otherwise, BTA shall not pay insurance benefits for:

7.1.1. Terrorist acts (the acts involving the use of, or threatening to use, force or violence, committed by a group of persons acting independently or on behalf of any organization or government, committed for political, religious, ideological or ethnic ends for the purpose of putting in fear or exerting influence on the government, public or any section of the public); losses incurred in relation to the prevention of terrorist acts shall not be compensated either.

7.1.2. War, invasion, hostile acts of foreign countries or other operations attaining the same level, such as civil war (whether or not the war is declared), riots, strikes, rebels, commotions, revolution, military situations, marauding, vandalism, sabotage; strike, lockout, public disorder attaining the level of a coup or riot, seizure of property, nationalization, when this is caused or authorized, whether legally or not, by the public authorities; other political risks and any other losses or costs directly or indirectly sustained in relation to the prevention of such acts shall not be compensated either;

7.1.3. Direct or indirect nuclear explosion, nuclear power or impact of radioactive substances; direct or indirect radioactive contamination;

7.1.4. other circumstances which by virtue of legal acts of the Republic of Lithuania are considered to be *force majeure* circumstances;

7.1.5. malicious acts by the Policyholder, Insured Person or Beneficiaries.

8. INSURER'S OBLIGATIONS UPON OCCURRENCE OF A POTENTIAL INSURED EVENT

8.1. In order to become eligible to the insurance benefit upon occurrence of a potential insured event, the Policyholder or the Insured Person must:

8.1.1. immediately, but no later than within 3 (three) working days (unless specified otherwise in the special terms and conditions of the Regulations) notify BTA of the occurrence of a potential insured event in accordance with the procedure laid down in the special terms and conditions of the Regulations. If the Policyholder or the Insured Person notifies BTA of the occurrence of a potential insured event with delay, the Policyholder or the Insured Person must prove that it was impossible to notify in good time;

8.1.2. To immediately report to competent authorities (e.g., medical establishments, the Fire and Rescue Department, the police, emergency services, etc.);

8.1.3. To follow all instructions given by BTA and to take all and any measures to mitigate the damage and prevent its occurrence or increase;

8.1.4. To make it available for BTA to inspect the scene of the event likely to be recognized as the risk covered, to investigate it and examine witnesses so that BTA would be able to identify the causes and size of damages;
8.1.5. To provide with any information and documents requested by BTA, including commercial secrets, if any, known to the Policyholder or the Insured Person so that BTA would be able to identify the causes and size of damages;
8.1.6. Unless instructed by BTA otherwise, to preserve, where possible, the scene unchanged while waiting for BTA's representative. This paragraph shall not apply in as much as it is necessary to fulfill the requirements in paragraph 8.1.3 above.
8.2. Where the Policyholder or Beneficiary deliberately or by gross negligence fails to fulfill the obligations stipulated in the Regulations, BTA shall be entitled to reduce or disallow payment of the insurance benefit.

9. INSURANCE BENEFITS

9.1. The insurance indemnity must be paid down within 30 days after receipt of all information required for the establishment of the fact, circumstances and consequences of the event insured as well as for the identification of the amount of insurance benefit.
9.2. If the event is the risk covered, but the Policyholder and BTA fail to agree as to the amount of benefit, on the Policyholder's request BTA must pay down an amount equal to the benefit indisputable by the parties, if definite establishment of the amount of damage lasts for a period exceeding 3 months.
9.3. Where BTA delays payment of the benefit for its own fault, BTA shall pay a default interest in the amount of 0.02% of the outstanding benefit for each day overdue.
9.4. For the purpose of paying insurance benefits, all insurance premiums (for a current insurance year), which are mature on the date of paying the benefit, shall be accounted. Pending premiums can be also accounted if so agreed by the Policyholder. If the insurance object is killed, destroyed or lost as a result of the event insured, all premiums pending in accordance with the insurance contract shall de deducted.

10. DISPUTE SETTLEMENT PROCEDURE

10.1. Any disputes arising between the parties to the insurance contract shall be settled by way of negotiations. In case of failure to reach agreement by way of negotiations, all disputes arising from and in relation to the violation, termination or invalidity of from the insurance contract shall be settled in compliance with legal acts of the Republic of Lithuania before courts of the Republic of Lithuania according to the place of registered office of BTA.

11. MANAGEMENT OF PERSONAL DATA

11.1. By entering into the insurance contract, the Policyholder and/or the Insured Person expresses his consent that BTA would manage, as a data controller, personal data of the Policyholder (except for special categories of personal data) in accordance with the provisions of the Law on Legal Protection of Personal Data to an extent it is necessary for the assessment of risks, solvency and debt management as well as for the purpose of direct marketing and statistics. The Policyholder further agrees that BTA would disclose data on debtors, including personal identification numbers, to other data controllers who process consolidated debtor files. In addition, the Policyholder agrees that BTA would receive information from data controllers processing personal data, when such information is necessary for BTA for the aforementioned purposes and requirements of legal acts of the Republic of Lithuania are not violated. BTA must process personal data accurately, fairly and lawfully as well as take measures to ensure protection of personal data. BTA shall be liable for violations of the Law on Legal Protection of Personal Data in compliance with legislation of the Republic of Lithuania.

12. SUBROGATION AND RIGHT OF RECOURSE

12.1. Upon disbursement of the insurance benefit, the Insurer shall acquire the right of claim to the amounts paid from the person responsible for the inflicted damage (subrogation or right of recourse). The Policyholder, the Insured person or the Beneficiary must communicate to BTA all requested information necessary for the Insurer in order to be able to properly implement the right of claim transferred to him.

13. CONFIDENTIALITY

13.1. The parties undertake not to disclose any confidential information received on the basis of contractual or pre-contractual legal relationships to any third parties, and not to use such information in the manner which would infringe the interests of the other party to the insurance contract. BTA shall have the right to provide to independent experts and reinsurers all necessary information received on the basis of the contractual or pre-contractual relationships, and to store such information in BTA's databases. This duty shall not apply when the parties must disclose the information to competent public authorities in compliance with requirements of legal acts of the Republic of Lithuania.

14. PROCEDURE OF CEDING THE INSURER'S RIGHTS AND OBLIGATIONS UNDER INSURANCE CONTRACT TO OTHER INSURERS

14.1. BTA is entitled to cede its rights and obligations to other insurance undertakings in the statutory procedure.
14.2 If the Policyholder disagrees with the Insurer's intention to transfer its rights and obligations under the insurance contract, the Policyholder is entitled to terminate the insurance contract within one month from the cession of the rights and obligations. In this case the Policyholder shall be refunded the paid in premiums for the remaining period of the insurance contract validity.

15. NOTICE GIVING PROCEDURE

15.1. Any notice to be communicated by the Policyholder or BTA to each other shall be delivered by the time limits set in the Regulations using one of the below specified methods:
15.1.1. delivering to the Policyholder to the addresses specified in the insurance policy or other written documents or in the notifications of the parties on the change of addresses of their registered offices;
15.1.2. sending as a postal item by registered mail;
15.1.3. sending by e-mail, when this method of notification is provided for by the parties in the contract or when they express their consent to exchange the information in this manner by actions;
15.1.4. By a facsimile transmission.

16. MISCELLANEOUS

16.1. Unless specified by the Policyholder otherwise upon signing the insurance contract, the Policyholder agrees that BTA would send him insurance offers concerning:
a) extension of existing insurance contracts;
b) entering into new insurance contracts in whatsoever class of insurance.
16.2. Contractual insurance relations shall be governed by the law of the Republic of Lithuania.
16.3 The insurance contract shall be signed on the basis of the general and special terms and conditions. In case of any differences between the special and/or individual insurance terms and conditions, as stipulated in the insurance contract (policy), and the general terms and conditions herein, the special and/or individual insurance terms and conditions shall take precedence.
16.4. The Policyholder, Insured Person, Beneficiary and other persons acquiring any rights on the basis of the insurance contract are required to fulfill the obligations stipulated in the Regulations.
16.5. The Regulations are effective from the date of being approved by the BTA board unless it provides for another date for the Regulations to come into effect.
16.6. In case of any differences or discrepancies between the languages, the wording in the Lithuanian language shall override.
16.7. The Regulations are available on BTA's web site at http://www.bta.lt.

SPECIALIOSIOS SĄLYGOS

1. DEFINITIONS AS USED IN THE INSURANCE CONTRACT

Insurance contract – A health Insurance Contract made by and between BTA and the Policyholder on the basis of these Terms and Conditions. The conclusion of the contract is confirmed by the issue of a policy. Any agreements between the Parties, annexes and/or amendments thereto constitute integral parts of the health Insurance Contract.
Insurance scheme – Services chosen by the Policyholder upon contracting for insurance and set out the Insurance Contract to be covered when provided in relation to an event insured.
Deductible – The portion of loss (expenses) to be borne by the Policyholder or the Insured Person in respect of each event insured (risk covered).
Chronic disease – A gradually starting dysfunction of a human organism manifesting in the symptoms of illness and lasting more than 3 months weeks, accompanied by improvements and exacerbations of the health condition.
Exacerbation of a chronic disease – A condition of a chronic disease with acute disease symptoms. An exacerbation of the chronic disease is manifested in distinct, objective and medically justified factors.
Illness – A dysfunction of the human organism manifesting in typical symptoms, confirmed by examination results and requiring application of the medicinally justified diagnostics and treatment necessary to eliminate the disorder.
Limits – Limits set in the Insurance Contract for specific insurance schemes, separate insurance periods, services, sums insured, etc.
Medical aids – Bandages, patches, syringes and needles, bats, catheters, urine bags, endotracheal tubes, spinal needles.
Partner – An institution, enterprise or organization which is a party to a cooperation agreement with BTA and

provides services/sells goods to the Insured Person on the basis of the cooperation agreement.
CHIF – Compulsory Health Insurance Fund.
Health care institution – An institution or entity authorized in accordance with legislation of the Republic of Lithuania to provide Health Care, Health Promotion and pharmaceutical services.
Health care services – Qualified consultations of a doctor or a specialized doctor, diagnostic tests, diagnostic and therapeutic procedures after detection of illness.
Long-term nursing care – Care of patients, including home-based services, in care settings, medical centres and/or social welfare settings.
Implant – A medical device that is grown in the human body to replace inactive or strengthen the weakly functioning organ or tissue or to perform a function that the human body does not have at all.
Diagnostic tests – Medicinally justified tests exclusively prescribed by the doctor (doctor's referral issued in accordance with the requirements of the Ministry of Health must be provided) and necessary for the diagnosis and treatment of a Health Disorder and related to the Health Disorder with respect to which the Insured Person has applied.
Day-care surgery services, hospital day-care – Day-care surgery services that are included in the list of services approved by a valid version of the order of the Minister for Health of the Republic of Lithuania and provided in an inpatient day-care unit of a Health Care Institution, including medical aids and medicines prescribed by the doctor and necessary for the treatment of the Health Disorder.
Inpatient treatment – Services provided to the Insured Person in an inpatient Health Care Institution for at least 24 hours, which were necessary because of a Health Disorder occurring to the Insured Person during the insurance period.
Health disorder – An Acute Disease, an Exacerbation of a Chronic Disease or an Injury.
Medical rehabilitation – Medical rehabilitation services prescribed by a specialized doctor as a complex medical aid (physiotherapy, kinesitherapy, ergotherapy, massages), applicable after ineffective or insufficiently effective treatment of the Insured Person's Health Disorder in an inpatient Health Care Institution for at least 72 hours and not later than 30 days after the last day of the hospitalization (but not later than the end of the insurance contract). Illnesses and conditions when medical rehabilitation services may be provided on an inpatient basis must be confirmed by the order of the Minister for Health.
Rehabilitation – A complex of physical medicine and rehabilitation measures (physiotherapy, kinesitherapy, ergotherapy, massages) prescribed by a specialized doctor and applicable after ineffective or insufficiently effective treatment of the Insured Person's Health Disorder.
Injury – Damage of tissue integrity resulting from a sudden impact of external forces out of control of the Insured Person, causing a dysfunction of the Insured Person's organism.
Acute illness – A sudden dysfunction of the organism persisting for up to 2–3 weeks with distinct disease symptoms in respect of which the Insured Person applies to a Health Care Institution within 2 weeks of the day of occurrence of the first complaints.
Pharmacy (e-pharmacy) – legal entity that has a license to engage in pharmaceutical activities.
Water (winter) amusement park – an enterprise that performs other entertainment and recreation activities according to Classification of Economic Activities (hereinafter EVRK) (code 93.29 by EVRK).
Sports club – an enterprise which according to EVRK carries out one of the following activities: operation of sports facilities (code 93.11 by EVRK), sports club activities (code 93.12 by EVRK) or physical well-being activities (code 96.04 by EVRK).
SPA center – an enterprise which according to the EVRK carries out one of the following activities: hotels and similar temporary holding activities (code 55.10 by EVRK) or physical well-being activities (code 96.04 by EVRK).

2. INSURANCE OBJECT

2.1. Insurance object – property interests of the Insured Person related to the payment for the insured events provided for in the Insurance Contract.

3. INSURANCE COVER

3.1. Insured event – an occurrence specified in the Insurance Contract in the case of which BTA is obliged to pay the insurance benefit. Insured events are described in sections 4 to 15 of these Terms and Conditions.
3.2. Geographic limitations of the insurance cover – unless the insurance policy specifies otherwise, the insurance cover shall apply only within the limits of the territory of the Republic of Lithuania.

4. IN-PATIENT AND OUT-PATIENT TREATMENT

Insured event
4.1. Insured Person's costs incurred in relation to Health Disorders suffered by the Insured person during the insurance period and the following services related thereto:

4.1.1. Health Care Services;
4.1.2. Diagnostic Tests;
4.1.3. Day-Care Surgery Services (Hospital Day-Care Treatment);
4.1.4. Inpatient Treatment;
4.1.5. Health Care Services in connection with Health Disorders related to pregnancy and birth-giving;
4.1.6. Medical Rehabilitation.

Eligible costs

4.2. Health Care Services shall be covered only if the Insured Person applies to a Health Care Institution with specific complaints and/or symptoms (pain, fever, extrasystoles, jaundice, etc.). Health Care Services and Diagnostic Tests have to be prescribed only in respect of the specific complaint for which the Insured Person applies and/or for the purpose of examining the existing symptoms and/or formulating a differential diagnosis.

4.3. Day-care surgery services, hospital day-care treatment shall be covered only if:

4.3.1. they are provided during the Insured Person's stay in an inpatient unit for up to 24 hours (excluding meals costs);
4.3.2. they are on the list of services approved by a valid version of the order of the Minister for Health of the Republic of Lithuania;
4.3.3. they are granted due to the exacerbation of Acute Illness or Chronic Disease and are based on medical documentation, except for the events specified in paragraph 16 of these Rules;
4.3.4. expenses exceeding EUR 250 which are agreed with BTA in writing in advance. BTA shall be provided with complete medical information (diagnosis of a Health Disorder and/or illness with respect to which a surgery is planned, anamnesis of the illness, performed tests, justification of the need for surgery, etc.) and a detailed list of manipulations planned to be carried out during a surgery and of used aids with their prices.

4.4. In the event of inpatient treatment, BTA shall pay for the following:

4.4.1. paid Health Care Services provided at an inpatient personal health care institutions;
4.4.2. comfort services (placement in a single-bed or two-bed ward);
4.4.3. surcharges for Medical aids.

4.5. BTA shall compensate Diagnostics and Health Care costs (up to 10% of the sum insured for Health Care Services, but max. EUR 150) incurred by the pregnant Insured Person in relation to:

4.5.1. prenatal complications;
4.5.2. forced abortion;
4.5.3. Health Disorders the development or exacerbation of which has been induced by pregnancy and/or birth-giving.

4.6. BTA shall compensate Medical Rehabilitation costs (up to 10% of the sum insured for Health Care Services, but max. EUR 150) incurred in relation to:

4.6.1. physiotherapy procedures (light therapy, ultrasound, microwaves, TENS, pulsed therapy, dorsonvalization, electrophoresis, phonophoresis, halotherapy, inductothermy, magnetotherapy, laser therapy, paraffin applications, low-frequency and medium-frequency wave therapy);
4.6.2. individual and group kinesitherapy sessions in a gym and swimming pool and massage therapy (manual therapy) procedures.

4.7. BTA shall cover the costs only to the extent not covered by the CHIF.

Non-eligible costs

4.8. BTA shall not cover the costs listed in section 16. In addition, BTA shall pay no compensation in the following cases:

4.8.1. Health Care Services are provided to the Insured Person when s/he has no specific complaints and/or symptoms and/or seeks to undergo a medical examination/testing which is considered a preventive medical check;
4.8.2. Diagnostic Tests are carried out without any medical indications for them and doctor's referrals;
4.8.3. payment for day-care surgery services (surgeries) has not been agreed with BTA in writing in advance as set forth in paragraph 4.3.3 above;
4.8.4. the need for a ward (presence in a single or double ward) relates to a non-contributory event provided for in clause 16, as well as to childbirth and post-natal care (except as specified in clause 4.5), also, placement of an accompanying person in a ward;
4.8.5. Medical Rehabilitation is received in relation to Health Disorders caused by degenerative changes, treatment of osteochondrosis and services related thereto which are not considered Medical Rehabilitation within the meaning of the Terms and Conditions.

5. MEDICINES, FOOD SUPPLEMENTS, VITAMINS, MEDICAL AIDS, MEDICAL DEVICES AND ORTHOPAEDIC APPLIANCES

Insured event

5.1. Insured event – Insured Person's costs incurred for purchase of the items specified in clause 5.2 for the period of validity of the insurance cover.

Eligible costs

5.2. Expenses incurred by the insured due to:

5.2.1. Items, purchased in Pharmacies:

a) medicines;
b) food supplements;
c) vitamins;
d) Medical Aids.

5.2.2. Items, assigned by a physician and purchased during the period of insurance coverage:
a) Orthopedic appliances;
b) Medical devices.

Non-eligible costs

5.3. Unpaid expenses for the purchase of medicines, food supplements and measures referred to in point 16.4, except items, indicated in paragraph 16.4.6 of the Terms and Conditions.

6. PRESCRIPTION MEDICINES, PRESCRIBED MEDICAL AIDS, MEDICAL DEVICES AND ORTHOPAEDIC APPLIANCES

Insured event

6.1. Insured event – Insured Person's costs incurred for purchase of the following prescribed items during the insurance period:
6.1.1. prescription medicines;
6.1.2. Medical Aids;
6.1.3. Orthopedic Appliances;
6.1.4. Medical Devices.

Eligible costs

6.2. Upon occurrence of the insured event BTA shall compensate the costs of purchase of the following:
6.2.1. prescription medicines in Pharmacies;
6.2.2. medicines and/or Medical Aids not subsidized from the CHIF that are used for the Insured Person's at health care institutions providing inpatient treatment services;
6.2.3. Medical Aids and Orthopedic Appliances, but only upon submission of the prescription or physician's referral.

Non-eligible costs

6.3. Costs are not paid if the items referred to in point 6.1. have been purchased without a prescription or physician's appointment.
6.4. This scheme shall be excluded from the scope of application of paragraph 16.4.6 of the Terms and Conditions.

7. PRENATAL CARE

Insured event

7.1. Insured event – Insured Person's costs incurred with respect to medical services related to her pregnancy and birth-giving and provided during the insurance period.

Eligible costs

7.2. Upon occurrence of the insured event BTA shall compensate the costs of the following:
7.2.1. pregnancy-related periodic visits of the Insured Person to a health care institution;
7.2.2. monitoring of a normal or increased-risk pregnancy in accordance with the procedure of prenatal medical checks approved by the Minister for Health;
7.2.3. diagnostics and treatment of prenatal health disorders diagnosed during the scheduled visits;
7.2.4. diagnostics and treatment of prenatal complications and forced abortion;
7.2.5. diagnostics and treatment of illnesses or health conditions the development or exacerbation of which has been induced by the pregnancy condition and/or birth-giving;
7.2.6. birth-giving and postnatal care, paid postnatal ward in public hospitals;
7.2.7. birth-giving and postnatal care in private health care institutions.

Non-eligible costs

7.3. The expenses referred to in point 16 are not compensated, also placement of an accompanying person in a ward.

8. DENTISTRY, ORAL HYGIENE, PROSTHODONTICS

Insured event

8.1. Insured event – Insured Person's costs incurred with respect to dental services provided to the Insured Person during the insurance period.

Eligible costs

8.2. Upon occurrence of the insured event BTA shall compensate the costs of the following:
8.2.1. dentistry: general endodontic, periodontal and surgical treatment of dental diseases, treatment of carious teeth and their complications, teeth filling, dental radiography;

8.2.2. oral hygiene: preventive consultation of a dentist, oral hygienist (hygiene education), removal of dental concrements, calculus, fluoride applications;
8.2.3. prosthodontics – dentist's consultations about prosthetics, implantation, construction, restoration and repair of removable and fixed dental prosthesis, implants.

Non-eligible costs

8.3. BTA shall not compensate any costs for the following:
8.3.1. teeth whitening;
8.3.2. teeth laminating (veneering);
8.3.3. placement of dental sealants;
8.3.4. teeth cemetery (a protective graves for athletes; a graves for dental croaking; a teeth whitening grave; a miorelaxation grave).

9. OPHTHALMOLOGY AND OPTICAL GOODS

Insured event

9.1. Insured event – Insured Person's costs incurred of visual impairments requiring the services or goods referred to in point 9.2.

Eligible costs

9.2. Within the limits of the sum insured BTA shall compensate the following:
9.2.1. ophthalmologist's consultations and treatment;
9.2.2. costs of purchase of one pair of spectacle lenses prescribed by a doctor (during the insurance period);
9.2.3. costs of purchase of contact lenses;
9.2.4. vision correction surgery, including surgery performed using laser technology, corneal refractive therapy.

Non-eligible costs

9.3. The costs referred to in point 16 are not compensated, as well as costs for the acquisition:
9.3.1. eyeglasses care products;
9.3.2. non-corrective eyeglass lenses and accessories (cleaners, napkins, chains for glasses and other similar goods);
9.3.3. sunglasses (excluding photochemical and corrective lenses);
9.3.4. optical goods not intended for the insured person.

10. PREVENTIVE MEDICAL CHECKS AND VACCINATION

Insured event

10.1. Insured event:
10.1.1. Insured Person's costs incurred in relation to preventive medical checks undergone during the insurance period or medical tests selected by the Insured Person performed at a Health Care Institution or specialized doctors' consultations aimed at assessing the health condition of the Insured Person;
10.1.2. Insured Person's costs incurred in relation to vaccination during the insurance period.

Eligible costs

10.2. Upon occurrence of the insured event BTA shall compensate the following:
10.2.1. specialized doctors' consultations, tests or procedures carried out in order to identify disease susceptibility or to prevent a potential illness;
10.2.2. preventive doctor's consultations and tests necessary for regular monitoring of the health condition of the Insured Person who suffers from a chronic disease or after surgery, when it is necessary to monitor the health condition and medication-based treatment is not prescribed;
10.2.3. diagnostic tests undergone by the Insured Person with no referral from the doctor;
10.2.4. tests and consultations unrelated to the Health Disorder in respect of which the Insured Person sought medical advice, but prescribed by the doctor on the basis of other health changes identified during examination, palpation and/or auscultation provided that the results of the testing performed are within the limits of normal;
10.2.5. vaccines selected by the Insured Person or prescribed by a doctor and for the vaccination service;
10.2.6. BTA shall cover the costs only to the extent not covered by the CHIF.

Non-eligible costs

10.3. The expenses specified in point 16 are not compensated, with the exception of the costs referred to in paragraphs: 16.3.1 to 16.3.3, 16.3.6, 16.3.9, 16.3.10, 16.3.12, 16.3.13, 16.3.16, 16.3.17, and 16.3.22 of the Terms and Conditions.

11. REHABILITATION THERAPY AND WELLNESS SERVICES

Insured event

11.1. Insured event – expenses suffered by the Insured Person in relation to the following:
11.1.1. rehabilitation services provided to the Insured Person;

11.1.2. Wellness services provided to the Insured Person in the State health care institutions (these services do not require a physician's appointment).

Non-eligible costs

11.2. BTA shall not compensate the costs of the following:

11.2.1. if a long-terms Healthcare subscription is acquired and its duration is longer than the end date of the insurance contract;

11.2.2. the services referred to in point 16, except for the expenses specified in paragraphs 16.2.3(f), 16.3.1 and 16.3.16 of these Terms and Conditions;

11.2.3. services specified in 11.1.1. point if:

a) there is no clear pathology or clinic and diagnosis with the indicated ICD-10 code and a justification for the necessary rehabilitation treatment;

b) a health condition in accordance with these Terms and Conditions is considered a non-insurance event. In this case, the costs of complications of the health disorder and the relapse of rehabilitation treatment is not paid;

c) long-term health disorders were caused by degenerative changes and osteochondrosis;

11.2.4. accommodation and meals;

11.2.5. visits to Water (winter) amusement parks;

11.2.6. gift coupons.

12. TREATMENT OF CRITICAL ILLNESSES

Insured event

12.1. Insured event – Insured Person's costs incurred with respect to the treatment of a critical illness referred to in section 14 of the Terms and Conditions, provided that the diagnosis of the illness has been proved by the respective laboratory, histological and instrumental tests (according to the criteria specified in section 14 of the Terms and Conditions), and such illness had not been diagnosed before the conclusion of the insurance contract or within 60 days of its conclusion (except for contracts renewed without interruption).

Eligible costs

12.2. BTA shall compensate:

12.2.1. medicinally justified costs of the Insured Person incurred during the insurance period in a health care institution as a result of the event insured;

12.2.2. prescription medicines prescribed by a specialized doctor, purchased in a pharmacy and necessary for the treatment of a critical illness referred to in section 14, unless such expenses are fully or partially compensated by the CHIF.

Non-eligible costs

12.3. BTA shall not compensate the services referred to in point 16, except for the expenses specified in paragraph 16.3.13 of the Terms and Conditions.

13. CRITICAL ILLNESS INSURANCE

Critical illness

13.1. Critical Illness – a final diagnosis of an illness referred to in section 14 of the Terms and Conditions determining during the insurance period for the first time in the Insured Person's life.

Initial diagnosis of an illness

13.2. Initial Diagnosis of an illness – a temporary diagnosis of a Critical Illness registered in the Insured Person's medical records on the basis of characteristic symptoms and anamnesis data of the illness.

Final diagnosis of an illness

13.3. Final Diagnosis of an illness – a Critical Illness diagnosis proven by respective laboratory, histological and instrumental medical tests (in observance of the criteria specified for such Critical Illness in section 14 of the Terms and Conditions) and confirmed in writing by the specialized doctor.

Starting day of an illness

13.4. Starting day of an illness – a date of determining the Final Diagnosis. The date of registration of the Initial Diagnosis of a Critical Illness may also be considered to be the starting day of the illness, provided that the Final Diagnosis of the illness is confirmed in writing no later than within one month after expiration of the Insurance Contract.

Waiting period

13.5. Waiting period – a period calculated from the day of entry into force of the Insurance Contract during which the insurance benefit is not disbursed after determining the Final Diagnosis for the Insured Person or after the Insured Person's death caused by the Critical Illness. Unless the insurance contract specifies otherwise, the waiting period shall be ninety days. When insurance contract is concluded with the Policyholder without any interruption between the previous and the newly concluded insurance contract (renewed contract), the waiting period shall not apply.

Survival period

13.6. Survival period – a period calculated from the starting day of a Critical Illness. The insurance benefit shall be paid if the Insured Person survives during the survival period. Unless the insurance contract specifies otherwise, the

survival period shall be twenty-eight days.

Insured event

13.7. The insured event shall be the fact of the Final Diagnosis of an illness, provided that the Critical Illness is not a consequence or a complication of other health disorders, or a concomitant disease, and also provided that such illness has not been diagnosed prior to concluding the insurance contract.

13.8. The Initial Diagnosis of an illness determined during the insurance contract shall be considered the insured event, if the Initial Diagnosis is confirmed as the Final Diagnosis of the illness after expiration of the insurance contract, but no later than within one month of the day of registration of the Initial Diagnosis.

13.9. If the Insured dies from any of the illnesses specified in section 15 of the Terms and Conditions after expiration of the survival period, BTA shall pay the insurance benefit if the Final Diagnosis of the illness was determined and confirmed in writing before the Insured Person's death.

Cases of refusal of insurance benefit

13.10. The insurance benefit shall not be paid if:

13.10.1. the first symptoms of a Critical Illness manifest and/or the Final Diagnosis is confirmed during the first ninety days of the commencement of the insurance contract. This provision shall not apply when the insurance cover for Critical Illnesses is continued in the renewed contract;

13.10.2. the cause of a Critical Illness is alcohol, drug or toxic substance abuse;

13.10.3. a Critical Illness does not meet the conditions and criteria for Critical Illnesses set out in section 14;

13.10.4. a Critical Illness has been diagnosed prior to entering into the insurance contract;

13.10.5. Critical Illness Cancer (C00–C96) is diagnosed for the Insured Person with HIV or AIDS, unless the Insured Person produces evidence (HIV-negative test result) of being not HIV infected on the date of inclusion of the Critical Illness option into the insurance contract;

13.10.6. Critical Illness AIDS (B20–B24), unless the Insured Person produces evidence (HIV-negative test result) of being not HIV infected on the date of inclusion of the Critical Illness option into the insurance contract.

13.10.7. The Final Diagnosis is not confirmed during the insurance contract and while the Insured Person is alive.

14. LIST OF CRITICAL ILLNESSES

Myocardial infarction (heart attack) (I21)

14.1. Irrecoverable damage to the myocardium (necrosis) as a result of oxygen deprivation, which in turn is caused by acute obstruction of the blood supply. This diagnosis must be based on all of the below-listed criteria corresponding to the symptoms of the first myocardial infarction:

14.1.1. presence of typical complaints and development of new changes in the electrocardiogram confirming the myocardial infarction;

14.1.2. increase of at least one of the enzymes typical to myocardial infarction found in the blood serum (LDH (lactate dehydrogenase), CPK (creatine kinase), KKM B (creatine kinase MB isoenzyme), troponin, etc.);

14.1.3. the diagnosis is confirmed by a cardiologist in the course of inpatient treatment.

Stroke (I60-I64)

14.2. Brain damage caused by a sudden disturbance in the blood supply. The diagnosis must be substantiated by all of the following criteria:

14.2.1. stroke-specific clinical symptoms are persistent after the applied therapy for more than three months after the occurrence;

14.2.2. the diagnosis is confirmed by a neurologist on the basis of clinical symptoms and objective examinations (e.g. magnetic resonance image, computed tomography or other).

Cancer (C00–C96)

14.3. Malignant cells with uncontrolled proliferous growth resulting in invasion and destruction of adjacent tissues or distant metastases in other organs. This diagnosis must be based on a conclusion drawn from the performed histological tests of a malignant tumor confirmed by an oncologist or a specialized pathologist. The diagnosis determined on the date of receiving the histological test result shall be considered finally confirmed.

14.4. The Final Diagnosis of an illness must be confirmed in writing by an oncologist.

14.5. The following diseases shall not be considered to be insured events:

14.5.1. benign or precancerous tumors;

14.5.2. pre-invasive tumors and in situ tumors (in situ) (Tis*);

14.5.3. cervical dysplasia CIN I-III;

14.5.4. urinary bladder carcinoma in stage TA*;

14.5.5. any skin tumors;

14.5.6. any tumors in the presence of HIV or AIDS;

14.5.7. prostate cancer, histologically diagnosed as T1*.

* according to the international TNM classification.

Chronic renal failure (N00–N19)

14.6. Irreversible failure of both kidneys requiring regular hemodialysis and/or renal transplantation:

14.6.1. irreversible failure of kidneys is confirmed by a nephrologist;

14.6.2. regular dialyses for 6 months or the Insured Person is put on the waiting list for a kidney transplant, or has

had kidney transplantation.
Aortic aneurysm (I71)
14.7. Abnormal enlargement of the vessel (aorta) with the risk of rupturing and causing severe bleeding:
14.7.1. diagnosis is based on objective examinations (ultrasound examination of the abdomen, aortography, CT, MRI, or other);
14.7.2. emergency endovascular stent-grafting is performed or elective surgery is scheduled.
Multiple or disseminated sclerosis (G35–G37)
14.8. An autoimmune disease of the central nervous system damaging the Insured Person's myelin sheath around nerves (demyelination):
14.8.1. diagnosis is confirmed by a neurologist;
14.8.2. illness-specific changes are diagnosed on the basis of magnetic resonance imaging;
14.8.3. cerebrospinal fluid analysis shows elevation of IgG levels and oligoclonal IgG bands in the cerebrospinal fluid.

Cerebral aneurysm (I67.1)

14.9. Abnormally dilated blood vessel in the brain that has the potential to press on the adjacent tissues or rupturing and causing severe bleeding:
14.9.1. diagnosis must be based on objective examinations (CT, MRI scan, cerebral angiography, cerebrospinal fluid analysis or other);
14.9.2. emergency cerebral aneurysm surgery is performed or elective surgery is scheduled;
14.9.3. insurance benefit is not paid for asymptomatic cerebral aneurysms that only need periodic examinations and monitoring.

AIDS (B20-B24)

14.10. Acquired immunodeficiency syndrome caused by the human immunodeficiency virus (HIV):
14.10.1. diagnosis must be confirmed by communicable diseases and/or AIDS professionals;
14.10.2. testing for HIV is positive;
14.10.3. a CD4 count in blood is low (≤ 200).

15. COMPLEMENTARY MEDICAL SERVICES

Insured event

15.1. Insured event – expenses of the Insured Person incurred in relation to s/his Health disorder or prophylaxis of diseases for which s/he needs the goods and services specified in clause 15.2 of these Terms and Conditions.
15.2. The Policyholder may choose between two insurance risk options in the conclusion of the insurance contract:
15.2.1. Basic package;
15.2.2. Additional package.

Eligible costs for Basic package

15.3. When choosing the Basic Package, the costs of these medical and health services carried out with or without the physician's delivery or without all the medical documentation are paid:
15.3.1. In-patient and Out-patient treatment;
15.3.2. Medicines, food supplements, vitamins, medical aids, prescribed medical devices and orthopedic appliances;
15.3.3. Prescription medicines, prescribed medical aids, medical devices and orthopedic appliances;
15.3.4. Dentistry, oral hygiene, prosthodontics;
15.3.5. Rehabilitation therapy and wellness services;
15.3.6. Prenatal care;
15.3.7. Ophthalmology and optical goods;
15.3.8. Preventive medical checks and vaccination;
15.3.9. Treatment of critical illnesses.

Non-eligible costs for Basic package

15.4. In Basic package BTA shall not pay for:
15.4.1. the services referred in paragraph 16, except for the expenses specified in paragraph 16.2.1, 16.2.3(d), 16.2.3(f), 16.3.1 to 16.3.24 of the Terms and Conditions;
15.4.2. accommodation and meals;
15.4.3. visits to Water (winter) amusement parks;
15.4.4. gift coupons.

Eligible costs for Additional package

15.5. When choosing the Additional Package, the costs of these medical and health services carried out with or without the physician's delivery or without all the medical documentation are paid:
15.5.1. sports activities in Sports clubs;
15.5.2. Health services and non-state health care facilities;
15.5.3. untreated massages and other SPA services;
15.5.4. the cost of transporting ambulance to / from the hospital (only in cases of acute illness or injury).

Non-eligible costs for Additional package

15.6. In Additional package BTA shall not pay for:
15.6.1. the services referred in paragraph 16, except for the expenses specified in paragraph 16.1.4, 16.2.3(d), 16.2.3(f),

16.3.1 to 16.3.24; 16.4.4.; 16.4.6. – 16.4.9. of the Terms and Conditions.
15.6.2. accommodation and meals;
15.6.3. visits to Water (winter) amusement parks;
15.6.4. gift coupons.

16. UNINSURABLE RISKS

General clauses

16.1. BTA shall pay no insurance benefit for Health Care Services provided in relation to Health Disorders:
16.1.1. caused to the Insured Person deliberately or as a result of an attempted suicide;
16.1.2.caused by criminal acts committed or attempted by the Insured Person, as well as a result of other illegal acts carried out by the Insured Person;
16.1.3. resulting from pandemics;
16.1.4. caused to the Insured Person as a result of the use of alcohol, drugs or other toxic substances, or non-prescribed medicines used for the purpose of intoxication.

16.2. Insurance benefits shall not be paid for:
16.2.1. formalization of medical records and medical tests, entries and other information media provided as a separate service;
16.2.2. future services (paid up by but not yet provided to the Insured Person) and services delivered after the expiry of the insurance cover;
16.2.3. Health Care Services:
a) not specified in the insurance contract;
b) provided and paid for during a period when the insurance cover is not valid;
c) the date and circumstances of provision of which cannot be identified after the investigation of the event;
d) the need of which is not supported by medical documentation;
e) when the user of the insurance cover specified in the insurance contract is not the Insured Person;
f) attributed to non-traditional (alternative) medicine services (e.g. acupuncture, iridology, bio-magnetic resonance, electro-puncture, etc.);
16.2.4. Costs related to the issue and submission of documents supporting the provided health care services shall be paid by the Insured Person.

Non-eligible costs, unless otherwise specified in the policy

16.3. The following costs shall not be eligible for compensation:
16.3.1. consultations of a reflexologist, dietician, homeopath;
16.3.2. consultations and treatment of dependences on psychoactive substances (nicotine, drugs, alcohol, psychotropic substances);
16.3.3. psychotherapy consisting of more than 10 sessions and/or conducted not by a psychotherapist/psychiatrist;
16.3.4. services provided according to the preventive health care programs fully subsidized from the CHIF;
16.3.5. abortion without medical indications and birth-giving not in a medical institution;
16.3.6. diagnostics and treatment of infertility and potency disorders, artificial insemination;
16.3.7. blood donorship and hemodialysis;
16.3.8. consultations on family planning matters and contraception, implantation, control and removal of contraceptive devices, diagnostic tests prior to initiating a contraceptive method, tests for avoiding complications caused by their use, and treatment of complications resulting from the use of such methods;
16.3.9. diagnostics and treatment of congenital anomalies, diseases and their complications;
16.3.10. diagnostics and treatment of sexually transmitted diseases (syphilis, gonorrhea, trichomoniasis, chlamydiosis, human papillomavirus, herpes genitalis, etc.), genital warts, AIDS and HIV;
16.3.11. treatment of venous varicose using laser or any other similar method, when venous diseases are class C0–C3 according to the CEAP classification;
16.3.12. treatment and removal of moles, benign skin formations, vascular formations and warts, benign tumors;
16.3.13. diagnostics and treatment of oncologic illnesses;
16.3.14. organ transplant surgeries, bone marrow transplantations;
16.3.15. elective surgeries when conservative treatment has not been applied and/or there is no exacerbation of a diseases;
16.3.16. costs related to general bodily diagnostics, polysomnography tests, tests or treatment of sleeping disorders;
16.3.17. diagnostics and treatment of eating disorders;
16.3.18. purchase of joint endoprosthesis and joint endoprosthetic surgery;
16.3.19. laser therapy procedures and intense pulsed light therapy;
16.3.20. long-term care and palliative therapy;
16.3.21. services (procedures) for medicinal purposes: autologous cell therapy, hyaluronic acid injections, stem cell therapies, immunotherapy;
16.3.22. the following diagnostic tests: allergen-specific IgE testing for food allergens, aeroallergens and mixed allergens (individual allergens or allergen mixes, molecular-based allergy testing); sex hormone tests; food intolerance tests;

16.3.23. treatment of degenerative deformities of the foot bones, ligaments, tendons, joints and muscles (except for traumatic injuries);
16.3.24. preoperative tests and postoperative dressings when no compensation is paid for the surgery itself;
16.3.25. cosmetic and cosmetology (beauty) services, as well as services provided in beauty salons or beauty-aesthetics salons, beauty studios, etc., botulinum injections;
16.3.26. plastic and / or reconstructive surgical operations or procedures using different types of implants.

16.4. The costs incurred in relation to the following shall not be eligible for compensation:
16.4.1. purchase of medicines not registered by the State Medicines Control Agency in Lithuania or other Member States of the European Union, as well as anabolic steroids, preparations reducing weight, increasing potency, contraceptives, medicines for treating various addictions;
16.4.2. articles of hygiene (except for the cases of postoperative treatment);
16.4.3. cosmetics, including decorative cosmetics (mascara, powder, eye-shadows, lipsticks, tanning lotions, anti-cellulite products, perfumes, etc.);
16.4.4. implants (including eye-lenses), prostheses and structures;
16.4.5. eye-glass frames, protective goggles, lens care products, eye-glass manufacturing services;
16.4.6. Medical Devices;
16.4.7. durable goods (inversion and massage tables and chairs, bodybuilding equipment and massagers, exercise mats and balls, orthopedic pillows, footwear and mattresses, first-aid kits for cars and breathalyzers);
16.4.8. lease of premises, equipment for undertaking sporting activities (sports halls (except for tennis, squash and badminton courts), deposits for wardrobe lockers);
16.4.9. leisure activities and entertainment: trampoline parks, wall climbing, skiing, water-skiing, etc.;
16.4.10. sweet prophylactic preparations (Hematogen, energy bars, juice estractas, etc.); nutritional supplements for athletes (BCC, Guarana, etc.); nutritional supplements for weight loss.

Recurrently provided services

16.5. If the insurance benefit has already been paid for a Health Care Service provided in respect of the same Health Disorder, the insurance benefit for the analogous service shall not be paid repeatedly unless a new Health Disorder is diagnosed, another diagnosis is determined and/or different (adjusted) therapy is prescribed.

Cases when BTA may refuse insurance benefit

16.6. BTA shall have the right to refuse payment of the insurance benefit in the following cases:
16.6.1. the Insured Person refuses to undergo medical checks which are required by BTA in order to determine whether the event should be recognized as risk covered (event insured);
16.6.2. the Insured Person and/or institution providing services fail(s) or refuse(s) to provide BTA with all documents necessary for the assessment of circumstances of the event and/or calculation of the insurance benefit;
16.6.3. the Insured Person pays for the received services or medicines/medical products not directly to the entity which has provided the services or sold the medicines/medical products (purchase of coupons, etc), unless the Insured Person uses the services thereafter and produces supporting documents to BTA.

17. SUM INSURED

Sums insured and limits

17.1. Sums insured and limits agreed upon by the parties to the insurance contract shall be specified in the insurance policy.
17.2. Sums insured shall not be restored, i.e. upon payment of the insurance benefit the obligation of BTA to pay insurance benefits shall only apply in respect of the remaining part of the sum insured.

Consequences of exceeding sums insured or limits

17.3. BTA shall pay no insurance benefit, if the Insured Person exceeds the limit(s) of the sums insured specified for a service in the insurance policy, the quantity of services and/or the sum insured specified in the insurance policy, or when the Insured Person should have not been eligible to the insurance cover.

18. RIGHTS AND OBLIGATIONS OF THE POLICYHOLDER, INSURED PERSON AND BTA

18.1. The Policyholder shall have the following obligations:
18.1.1. upon contracting for insurance, provide BTA with full, complete and correct information necessary for the assessment of the insurance risk and for the conclusion and implementation of the insurance contract, including the following data:
a) particulars and type of activities of the Policyholder;
b) data of the Insured Persons (full names, personal identification numbers);
c) information whether the Insured Person himself/herself pays the insurance premium or any part thereof;
d) consents of the Insured Persons with respect to processing of their personal data (including special personal data);
18.1.2. inform the Insured Persons on the conclusion or amendment of the insurance contract and expiration of the insurance cover;
18.1.3. familiarize the Insured Person with the conditions of these Terms and Conditions and the Terms s and conditions of the insurance contract applicable or related to the Insured Person;

18.1.4. pay the insurance premiums specified in the insurance policy;
18.1.5. during the insurance contract period, notify BTA in writing within five working days of any changes in the information about the Policyholder or Insured Person specified upon contracting for insurance;
18.1.6. immediately, but no later than within three working days, notify BTA in writing about termination of employment or other contractual relationships between the Insured Person and the Policyholder. Upon termination of employment or other contractual relationships with the Insured Person, the insurance cover shall cease with respect to such Insured Person from the date of termination of employment/other contractual relationships with the Policyholder, unless the insurance contract provides for otherwise. The Policyholder shall be held liable for all losses caused by inadequate fulfilment or non-fulfilment of the obligation under this paragraph, including, but not limited to, the losses arising during the period when the insurance cover is de facto invalid.

Policyholder's rights

18.2. The Policyholder shall have the right:
18.2.1. during the period of the contract, modify the list of the Insured Persons (delete the existing Insured Persons and include new ones), having notified BTA to the effect in advance and having obtained its approval. Such modifications shall be made by signing a new endorsement to the policy or any other document and, where appropriate, paying an additional insurance premium.

Insured Person's obligations

18.3. The Insured Person shall have the following obligations:
18.3.1. provide BTA with all available documents and information on the circumstances and consequences of the insured event necessary for determining the amount of the insurance benefit;
18.3.2. take all available measures to reduce the damage to health and avoid and refrain from any actions that may impair the course of treatment or his/her health;
18.3.3. pay, on his/her own account, for health care and other services or medical products specified in the Terms and Conditions and provide BTA with documents for compensation of costs:
a) when services are provided not at the Service Providers' institution;
b) which are not compensated by BTA directly to the Service Provider under a mutual agreement.
18.3.4. The Insured Person is obliged to take into account, and act in observance of, BTA's notices mentioned in paragraph 18.7.4.

Insured Person's rights

18.4. The Insured Person shall have the right:
18.4.1. choose, at his/her own discretion, a Health Care Institution in Lithuania, except for those which services, medicaments and/or medical products are not compensated by BTA.

Duty to notify of the insured event in a timely manner

18.5. The Policyholder or the Insured Person must notify of the insured event in writing immediately, but no later than within thirty calendar days of the day of the event (paragraph 8.1.1 of the General Terms s and Conditions of the Terms and Conditions shall not apply). Late notification of the event is to be considered a material breach of the contract entitling BTA to refuse the insurance benefit. If the Insured Person uses Health Care Services of the Partner, the Policyholder and/or the Insured Person are released from the duty to notify BTA of the insured event.

BTA's obligations

18.6. BTA shall have the following obligations:
18.6.1. refrain from disclosing the information about the Policyholder or the Insured Person obtained when concluding the insurance contract, except for the cases and/or exclusions specified in the insurance contract or laws;
18.6.2. fulfil other obligations of the Insurer provided for by legislative acts.

BTA's rights

18.7. BTA shall have the right:
18.7.1. prior to concluding the contract and/or amending the Terms s and conditions thereof, request additional information about the health condition, lifestyle and preferences of the Insured Persons, as well as other information which may have any impact on the risks covered and which the Policyholder undertakes to provide within the time limits specified by BTA;
18.7.2. request the Insured Person to undergo a medical check in a Health Care Institution specified by BTA and to provide BTA with the results of the medical check prior to concluding the contract and/or amending the Terms s and conditions thereof;
18.7.3. during the insurance contract period, unilaterally change the list of the Partners, choose the services the payment for which is directly made to the Partners, the volumes of such services, and apply service limitations;
18.7.4. during the insurance contract period, unilaterally choose institutions which services, medicines, Medical Aids, Medical Products or Orthopedic Appliances shall not be compensated by BTA by giving the Policyholders at least a thirty-days' notice to this effect prior to the coming into force of such amendments;
18.7.5. in order to determine whether insurance benefits are due, request additional evidence and information from the Policyholder, Insured Person or other persons in relation to the assessment of the insured event, provided Health Care Services or other services set forth in the insurance contract and/or the determination of the insurance benefit, or carry out necessary investigation at its own account or appoint a medical expert.

18.8. Where BTA pays down the insurance benefit to the Partner for services, medicaments and/or Medical Products provided or sold to the Insured Person during invalidity of the insurance cover or in excess of the sums insured under the policy, BTA acquires the right to claim damages caused to BTA from the Insured Person.

18.9. Where Policyholder's or Insured Person's failure to perform the Contract or defective performance thereof increases, to any extent, the likelihood of the insured event to occur or higher losses/expenses to be sustained in relation thereto, BTA shall be entitled to disallow payment of the insurance benefit.

Consequences of failure to perform the duty to disclose

18.10. If after conclusion of the insurance contract it is found that the Policyholder or the Insured Person failed, whether when concluding the insurance contract or during its validity period, to fulfil their duty to disclose information and deliberately or by negligence supplied BTA with incomplete and/or false information about the Policyholder, the Insured Person or circumstances that are likely to have essential impact on the assessment of the insurance risk, the likelihood of occurrence of the insured event, determination of the amounts of payments under the insurance contract, insurance premiums and sum insured of the insurance contract, or of other circumstances important to the insurance contract, BTA shall have the right to terminate the insurance contract or to refuse the insurance benefit.

19. INSURANCE BENEFIT

Insurance benefit

19.1. Insurance benefits shall be paid within the limits of the insurance cover specified in the insurance contract.

Insurance benefit calculation and payment procedure

19.2. Insurance benefits shall be calculated and paid by BTA as follows:

19.2.1. to the Partners – upon submission of documents attesting to the provision of services in accordance with the procedure, to the extent, and according to the rates specified in cooperation agreements with the Partners, and taking into account limitations (if any) set out in the insurance contract;

19.2.2. Health Care Services provided not by the Partners shall be paid for in accordance with the insurance provisions specified in the insurance contract;

19.2.3. where the policy sets price limits for certain services, the insurance benefit may not exceed the established limits.

Mandatory documents to be submitted upon arrival to the Partner

19.3. Upon arrival to the Partner, the Insured Person must have with him/her and produce to the Partner a personal identity document with his/her photo and documentary proof of the validity of insurance cover. If the Insured Person cannot produce the Partner a valid personal identity document (passport, personal identity card or a driving license) and/or document confirming the validity of the insurance cover, the Insured Person shall pay for the services himself/herself.

Mandatory documents to be submitted to BTA upon occurrence of a potential insured event

19.4. If the Insured Person pays for the provided Health Care Services or products himself/herself, then the insurance benefit in the case of the insured event shall be paid by BTA to the Insured Person upon submission of the following documents, or copies thereof, attesting to the provision of the Health Care Service, purchase of medicines/Medical Products and payment for them:

19.4.1. a request to compensate for the costs;

19.4.2. a financial document evidencing the payment for the provided Health Care Services – pay slip, cash receipt or payment order and invoice bearing the particulars of the institution which has provided the services and/or sold medicines/medical products, the payer's details and indicating to whom and what services have been provided or medicines/medical products sold, their quantities and prices;

19.4.3. an extract from medical records or its copy (e.g. Form 027) bearing the doctor's signature and containing information about the type of a Health Disorder, diagnosis, prescribed and/or conducted tests, treatment and procedures, and/or a copy of personal health card;

19.4.4. in the cases of purchase of medicines, Medical Aids or optics – a prescription (or its copy) or doctor's referral, order sheet for the purchase of such medicines, Medical Aids or optics.

Double insurance

19.5. If the Insured Person is covered under several insurance contracts by different Insurers, then the insurance benefit paid by BTA upon occurrence of the insured event shall be reduced proportionately to the ratio of the insurance value and sums insured under all insurance contracts.

Cases when BTA has the right to refuse insurance benefit

19.6. BTA may refuse payment of the insurance benefit, if the Policyholder or the Insured Person has provided incorrect data or deliberately misleading information on the provided services and/or purchased medicines/medical products, or if the Insured Person has failed to comply with the requirements specified in paragraph 18.3 of the Terms and Conditions.

20. MISCELLANEOUS

Primacy of documents

20.1. If the insurance Terms s and conditions specified in the insurance policy differ from those laid down in the Terms and Conditions, the Terms s and conditions of the insurance policy shall prevail.

Communication and entry into force of notices

20.2. Any notices relating to the insurance contract shall be communicated exclusively in writing. Such notices for BTA shall enter into force from the moment of their receipt.

Amendments to the Terms and conditions of the Insurance Contract

20.3. The Policyholder willing to amend the Terms s and conditions of the insurance contract shall submit a written application with BTA on the requested amendments to the insurance contract no later than one month in advance of the envisaged date of amendment of the insurance contract. If the Policyholder delays, or does not specify, this time limit, BTA shall amend the insurance contract no later than within one month of the day of receipt of the Policyholder's application. Having assessed the consequences of an injury and changes in the circumstances, BTA may refuse to amend the Terms s and conditions of the insurance contract. Any amendments shall be made by signing a new endorsement to the insurance policy or any other document and, where appropriate, by paying an additional insurance premium.

20.4. When amending the Terms s and conditions of the insurance contract, BTA may request information on the health condition, hobbies of the persons to be covered and other risk factors.

Liability for the violation of the Terms s and conditions of the insurance contract

20.5. BTA and the Policyholder undertake to fulfil all obligations provided for in the contract in due and timely manner and to indemnify the other for the loss arising from failure to perform or improper performance of the obligations.

Application of the Terms and Conditions to contracts

20.6. These Terms and Conditions shall apply to all insurance contracts concluded after 01 April 2019, unless otherwise agreed by the parties upon contracting for insurance.