HEALTH INSURANCE

Terms and Conditions No 52.3

Effective as of 01.02.2022

AAS "BTA Baltic Insurance Company" branch in Lithuania, Laisvės pr. 10, 04215 Vilnius, Lithuania. Phone: +370 5 2600 600, website bta.lt, e–mail: bta@bta.lt

VIENNA INSURANCE GROUP

BTA and Policyholders enter into Health Insurance Contracts in accordance with these Terms and Conditions.

CONTENTS

GENERAL REGULATIONS

1. DEFINITION OF AN INSURANCE CONTRACT

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.

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.

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 and entitled to receive insurance benefits.

Compensation principle – insurance principle, according to which insurance indemnity is calculated on the basis of the amount of loss sustained in an insured event.

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 deductibles in respect of the same risk, the largest of them shall always apply.

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 recover the respective part of the paid insurance benefit.

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

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.

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.

Insurance interest – the interest of the Insured not to incur losses upon occurrence of the insured risk.

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

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.

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.

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

Insured – 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.

Insurer – AAS BTA Baltic Insurance Company, represented by its Lithuanian Branch, hereinafter – BTA.

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

Parties to the insurance contract – the Policyholder and BTA.

Persons related to the Policyholder and/or the Insured, who are also bound by the fulfilment of obligations established for the Policyholder:

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

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.

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).

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.

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.

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 instalment 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 instalment;

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. When insurance contract regarding insurance of the same insurance object is concluded repeatedly immediately following the previous insurance contract and, the Policyholder or the Insured, when concluding the repeated insurance contract, do not specify that the information provided upon conclusion of the previous insurance contract has changed, BTA will assume that the previously provided information has not changed.

3.3. 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:

3.3.1. significant changes relating to the insurance object;

3.3.2. changes in the manner/ways of using the insurance object.

3.3.3. other significant circumstances due to which the insurance risk increases.

3.4. 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.

3.5. 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

4.1. 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. However, the total amount of the penalty may not exceed 10 % of the outstanding insurance premium amount. The above-indicated default interest shall not apply in the following cases:

4.3.1. the premium is paid as a lump sum;

4.3.2. 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 informs the Policyholder in writing that in the event of the failure to pay in the insurance premium or its part within 30 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 contract can be concluded by means of distance communication, i.e., by means of post, internet, electronic mail, telephone or other means of information exchange.

5.2. When insurance contract is concluded by a Policyholder, who is a consumer, then such insurance contract shall be subject to the Guidelines for the composition of non-life insurance contracts, which are publicly available on BTA's website www.bta.lt. Guidelines for the composition of non-life insurance contracts, among other things, describes the procedure of exercising the withdrawal rights, i.e., the rights to withdraw from the concluded insurance contract.

Consumer is a natural person, concluding an insurance contract for a purpose unrelated to its business or professional activity.

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 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 20 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 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. malicious acts by the Policyholder, Insured or Beneficiaries.

7.2. Irrespective of any terms of the concluded Insurance Contract, BTA has no obligation to provide insurance protection or perform any payments, or provide services, or provide benefits to persons or any third party insofar such insurance protection, payment, service, benefit and / or business or activity of the Policyholder, the Insured, the Beneficiary or a person claiming insurance indemnity, violates the enforceable sanctions, financial embargo and economic sanctions, laws and terms, which are directly to be enforced by BTA. The enforceable sanctions are national sanctions imposed by the Republic of Lithuania, European Union sanctions, United Nations Organization sanctions, United States of America sanctions and / or other sanctions, which are to be complied with and executed by BTA in accordance with regulatory enactments.

7.3. It shall not be considered an insured event and the losses shall not be indemnified, if occurred directly or indirectly related to:

7.3.1. Regulatory enactments issued by the state;

7.3.2. State of emergency or exceptional state announced, moreover, no losses or expenses shall be indemnified, directly or indirectly related to any measures intended to avert the state of emergency or the exceptional state;

7.3.3. Epidemics or pandemics.

8. INSURER'S OBLIGATIONS UPON OCCURRENCE OF THE INSURED RISK

8.1. In order to become eligible to the insurance benefit upon occurrence of an insured risk, the Policyholder or the Insured must:

8.1.1. immediately, but no later than within 3 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 notifies BTA of the occurrence of the insured risk with delay, the Policyholder or the Insured 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, 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 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 fulfil the requirements in paragraph 8.1.3 above;

8.1.7. if the insurance object cannot be preserved without changing its condition after the accident due to the fulfilment of the obligations referred to in paragraph 8.1.3 of these Terms and Conditions or other legal and justified reasons, to ensure that the pictures of the damaged insurance property are taken as soon as possible or the damaged insurance object is filmed so that its damages are registered and submit the pictures or the video recording to BTA by e-mail zalos@bta.lt or in another way approved by BTA.

8.2. Where the Policyholder, Insured or Beneficiary deliberately or by gross negligence fails to fulfil 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 is paid down within 15 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 theft or robbery of the insurance object has taken place, whereby the insurance indemnity is paid and then the insurance object is found, then BTA shall be entitled to request and be refunded the disbursed insurance indemnity or to acquire the property rights to the insurance object. If BTA has made a decision not to keep the found insurance object, but the found insurance object is damaged, then, when refunding the received insurance indemnity to BTA, the Insured shall deduct the expenses necessary for the repair of the found damaged insurance object in the amount agreed upon with BTA.

9.3. 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 pays 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.

9.4. 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. However, the total amount of the penalty may not exceed 10 % (ten per cent) of the outstanding insurance indemnity amount.

9.5. 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 be deducted.

9.6. In case BTA is or will be unable to make a recourse claim by subrogation due to malicious intent or gross negligence of the Insured, BTA may opt for not paying the insurance indemnity in the amount for which a claim is not or will not be possible to be brought, or, if insurance indemnity has already been disbursed, demand its refund from the Insured.

9.7. At the request of the person entitled to claim insurance indemnity, BTA will enable this person to study the documents, based on which BTA had made the decision of insurance indemnity payment or rejection, or issue copies of the documents for a fee not exceeding the costs of producing the document copies.

BTA does not enable this person, entitled to claim insurance indemnity, to study the documents or issue copies of the documents, if:

9.7.1. BTA has submitted documents to law enforcement institutions for criminal investigation of the insured risk occurrence circumstances;

9.7.2. the documents contain a trade secret of another person, which the person entitled to claim insurance indemnity is not entitled to obtain;

9.7.3. the documents contain a personal data, which the person entitled to claim insurance indemnity is not entitled to obtain.

10. COMPLAINT HANDLING AND DISPUTE SETTLEMENT PROCEDURE

10.1. Procedure how BTA handles a complaint for being dissatisfied with insurance contract or insurance services submitted by the submitter of insurance application, the Policyholder, the Insured, the Beneficiary and another person entitled to claim insurance indemnity, is publicly available on BTA's website www.bta.lt.

10.2. 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 Lithuanian branch.

11. PROCESSING OF PERSONAL DATA

11.1. BTA, as the personal data controller under, processes personal data of natural persons in compliance with personal data processing requirements defined in the 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 regulatory enactments.

11.2. The principles of processing of personal data conducted by BTA are published on BTA's privacy policy at www.bta.lt.

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 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. MISCELLANEOUS

14.1. 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:

14.1.1. 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;

14.1.2. sending as a postal item by registered mail;

14.1.3. 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

14.2. BTA is entitled to cede its rights and obligations to other insurance undertakings in the statutory procedure. 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.

14.3. Contractual insurance relations shall be governed by the law of the Republic of Lithuania.

14.4. 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.

14.5. The Policyholder, Insured, Beneficiary and other persons acquiring any rights on the basis of the insurance contract are required to fulfil the obligations stipulated in the Regulations.

14.6. 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.

14.7. In case of any differences or discrepancies between the languages, the wording in the Lithuanian language shall override.

14.8. The Regulations are available on BTA's web site at http://www.bta.lt.

SPECIAL TERMS AND CONDITIONS

1. DEFINITION OF AN INSURANCE CONTRACT

Acute disease – a sudden and short-term disorder of the body with Clinical symptoms of the Disease, which persist until the moment of contacting the Health Care Institution.

Check / repeat visit – Insured's visit to the doctor for the same Health condition 1 month. to evaluate the response to the prescribed studies and the effectiveness of the treatment prescribed.

CHIF – Compulsory Health Insurance Fund.

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.

Chronic disease monitoring – the Insured's visit to the doctor for a Disease that requires constant monitoring, examination and treatment control.

Clinical symptom of a Disease – a medical sign that indicates a disorder, pathological condition, or Disease of the body. Examples of symptoms are fever, nausea and vomiting, abdominal pain, dysuria, bleeding, and so on.

Day-Care Surgery Services – surgery services specified in the current version of the Order of the Minister of Health of the Republic of Lithuania and provided in the Day Hospital of the Health Care Institution, as well as Medical aids and medicines prescribed by a doctor for the treatment of a health disorder.

Deductible – the portion of loss (expenses) to be borne by the Policyholder or the Insured Person in respect of each event insured (risk covered).

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.

Disease – 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.

Exacerbation of a Chronic diseases – a condition of Chronic diseases with signs of Acute diseases confirmed by clear objective Clinical symptoms of the Disease.

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 – consultations of internal medicine doctor or a doctor's specialist, Diagnostic tests, diagnostic and therapeutic procedures aimed at diagnosing and treating Diseases and Health disorders.

Health disorder – an Acute disease, an Exacerbation of a Chronic disease or an Injury.

Hospital Day-Care Treatment – medical services lasting up to 24 hours and intended for the Insured who come to the Health Care Institution for a planned diagnostic, medical procedure and / or medical care. For example: suture removal, wound dressing, medication injections, ward infusion care, ward (excluding meals), and the like.

Implant – a medical device that is inserted/implanted in the human body to replace a dysfunctional or weakened organ or tissue, or to perform a function that the human body does not have at all. Artificial joint (endoprosthesis), heart valves, vascular stents, shunts, artificial pacemakers, pacemakers, lens of the eye, cochlear implants and similar devices.

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.

In-patient treatment – medical 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.

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.

Limits – Limits set in the Insurance Contract for specific insurance schemes, separate insurance periods, services, sums insured, etc.

Long-term nursing care – care of patients, including home-based services, in care settings, medical centres and/or social welfare settings.

Medical aids – Bandages, patches, syringes and needles, bats, catheters, urine bags, endotracheal tubes, spinal needles.

Medical devices – products that can be used to diagnose, treat and monitor the course of the disease. Hearing thermometers. aids, blood pressure monitors, glucometers and test strips therefor, inhalers, optical fibres, pulse oximeters.

Medical rehabilitation – no later than 30 days from the date of the last inpatient treatment (but not later than the end of the insurance contract) a complex application of medical rehabilitation measures (physiotherapy, physiotherapy, occupational therapy, massage) prescribed by an FMR (physical medicine and rehabilitation) doctor.

Medically justified – Is the Health Care Services prescribed to the Insured Physician according to his / her Clinical Symptoms of the Disease and described and justified as necessary in the medical documentation.

Non-traditional medicine – diagnostic, treatment or prevention of health disorders using medical methods not approved in the Republic of Lithuania, such as: food intolerance tests, acupuncture, endobiogenics, ozone therapy, leech therapy, bio resonance diagnostics, phytotherapy, hydrocollonotherapy, osteopathy, homeopathy, homeopathy, homeopathy detoxification, etc.

Orthopaedic goods – supinators, splints, corsets, sticks, crutches, apparatus for limiting joint movements, prostheses, construction or support apparatus, compression stockings purchased in specialized orthopaedics shops.

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.

Pharmacy (e-pharmacy) – legal entity that has a license to engage in pharmaceutical activities.

Rehabilitation – a complex of an integrated physical medicine and rehabilitation measures (physiotherapy, physiotherapy, occupational therapy, massage) prescribed by an FMR (physical medicine and rehabilitation) doctor in order to restore the patient's dysfunction in the presence of irreversible changes in the body or maintain the patient's functional capacity.

Renewed contract – means an insurance contract which enters into force on the next day following the day of expiry of the previous contract concluded with the BTA. A contract shall be considered to be renewed only where the Insured is the same person as in the expired contract. Where a new Insured is included in the renewed contract, the terms and conditions of the renewed contract shall not apply to such Insured. Where new insurance variants are chosen in the renewed contract, the terms and conditions of the renewed contract shall not apply to such insurance variants.

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. WHAT IS COVERED

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. FOR WHAT DO WE PAY

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 55 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.

OUT-PATIENT TREATMENT

4. WHAT IS COVERED

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;

4.1.4. Hospital Day-Care Treatment;

4.1.5. Health Care Services in connection with Health Disorders related to pregnancy and birth-giving;

4.1.6. Medical Rehabilitation services.

5. FOR WHAT DO WE PAY

5.1. Reimbursable Health Care Services provided to the Insured due to Acute Illness, Exacerbation of Chronic Illness or Injury.

5.2. Health Care Services shall be covered only if the Insured Person applies to a Health Care Institution with specific complaints and/or symptoms. 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.

5.3. Day-care surgery and Hospital Day-Care Treatment services shall be covered only if:

5.3.1. they are provided during the Insured Person's stay in an inpatient unit for up to 24 hours;

5.3.2. 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;

5.3.3. the reimbursable part of the CHIF is specified. BTA shall pay the non-reimbursable part of the CHIF. In cases where there is no CHIF compensation, the services are not reimbursed.

5.3.4. they are granted due to a Health Disorder that is Medically justified in the medical documentation;

5.3.5. 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.

5.4. Up to 10 sessions of psychotherapy (including treatment and consultations) performed by a psychiatrist or a psychiatrist-psychotherapist, medical psychologist in a health care institution are paid for.

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

5.5.1. prenatal complications;

5.5.2. forced abortion;

5.5.3. Health Disorders the development or exacerbation of which has been induced by pregnancy and/or birth-giving.

5.6. BTA shall compensate Medical Rehabilitation (appointed no later than 30 days after the last inpatient treatment) costs (up to 10% of the sum insured for Out-patient treatment program, but max. EUR 150) incurred in relation to:

5.6.1. 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);

5.6.2. individual and group kinesitherapy sessions in a gym and swimming pool and massage therapy (manual therapy) procedures.

6. WHEN DOES THIS INSURANCE NOT APPLY

6.1. BTA shall not reimburse the expenses provided for in section 56, as well as if:

6.1.1. 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;

6.1.2. Diagnostic Tests are carried out without any medical indications for them and doctor's referrals;

6.1.3. payment for day-care surgery services (surgeries) has not been agreed with BTA in writing in advance as set forth in paragraph 5.3.5 above;

6.1.4. the need for a ward (presence in a single or double ward) relates to a non-contributory event provided for in section 56, as well as to childbirth and post-natal care (except as specified in paragraph 5.5), also, placement of an accompanying person in a ward;

6.1.5. 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;

6.1.6. Psychotherapy sessions that were provided outside a Health care facility;

6.1.7. If the Insured has been diagnosed with Health Disorders during the Preventive Health Examination, such expenses are not reimbursed from the Out-patient treatment program.

OUT-PATIENT TREATMENT PLUS

7. WHAT IS COVERED

7.1. 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:

7.1.1. Health Care Services;

7.1.2. Diagnostic Tests;

7.1.3. Day-Care Surgery Services;

7.1.4. Hospital Day-Care Treatment;

7.1.5. Health Care Services in connection with Health Disorders related to pregnancy and birth-giving;

7.1.6. Medical Rehabilitation services;

7.1.7. Dental surgery services.

8. FOR WHAT DO WE PAY

8.1. 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:

8.2. Health Care Services shall be covered only if the Insured Person applies to a Health Care Institution with specific complaints and/or symptoms. 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.

8.3. Day-care surgery and Hospital Day-Care Treatment services shall be covered only if:

8.3.1. they are provided during the Insured Person's stay in an inpatient unit for up to 24 hours;

8.3.2. 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;

8.3.3. the reimbursable part of the CHIF is specified, BTA shall pay the non-reimbursable part of the CHIF. In cases where there is no CHIF compensation, the services are not reimbursed.

8.3.4. they are granted due to a Health Disorder that is Medically substantiated in the medical documentation, except for the events specified in Paragraph 56 of these Terms and Conditions;

8.3.5. 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.

8.4. Up to 10 sessions of psychotherapy (including treatment and consultations) performed by a psychiatrist or a psychiatrist-psychotherapist, medical psychologist in a health care institution are paid for.

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

8.5.1. prenatal complications;

8.5.2. forced abortion;

8.5.3. Health Disorders the development or exacerbation of which has been induced by pregnancy and/or birth-giving.

8.6. BTA shall compensate Medical Rehabilitation (appointed no later than 30 days after the last inpatient treatment) costs (up to 10% of the sum insured for Out-patient plus program, but max. EUR 150) incurred in relation to:

8.6.1. 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);

8.6.2. individual and group kinesitherapy sessions in a gym and swimming pool and massage therapy (manual therapy) procedures.

8.7. In the case of Dental surgery, BTA (up to 10% of the amount of Out-patient plus program insurance, but not more than EUR 150) for:

8.7.1. trauma and post-traumatic conditions of the face and jaw area (bone fractures, soft tissue injuries);

8.7.2. congenital anomalies of the development of the face, jaws, skull and neck;

8.7.3. neck cysts;

8.7.4. non-malignant tumors, cysts;

8.7.5. malignant tumors of the skin, soft tissues and bones;

8.7.6. Diseases of the salivary glands (stone disease, tumors, cysts);

8.7.7. pathology of the upper jaw ducks;

8.7.8. inflammation of the mouth, face and jaw and neck of various origins;

8.7.9. neurostomatological Diseases;

8.7.10. lymph node and vascular pathologies;

8.7.11. Diseases of the temporomandibular joint;

8.7.12. eye sockets pathology;

8.7.13. acquired facial deformities;

8.7.14. bone and soft tissue reconstruction surgery.

9. WHEN DOES THIS INSURANCE NOT APPLY

9.1. BTA shall not cover the costs listed in section 56. except for the services specified in paragraphs: 56.3.1.; 56.3.3.; 56.3.5.; 56.3.7.; 56.3.9.; 56.3.10.; 56.3.15.; 56.3.23.; 56.3.27.; 56.3.34.; 56.3.37.

9.2. In addition, BTA shall pay no compensation in the following cases:

9.2.1. 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;

9.2.2. Diagnostic Tests are carried out without any medical indications for them and doctor's referrals;

9.2.3. payment for day-care surgery services (surgeries) has not been agreed with BTA in writing in advance as set forth in paragraph 8.3.5 above;

9.2.4. the need for a ward (presence in a single or double ward) relates to a non-contributory event provided for in section 56, as well as to childbirth and post-natal care (except as specified in paragraph 8.5), also, placement of an accompanying person in a ward;

9.2.5. 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;

9.2.6. If Health disorders were found during the Preventive examination, Health care services related to these disorders are not reimbursed.

IN-PATIENT TREATMENT IN STATE HEALTH CARE INSTITUTION

10. WHAT IS COVERED

10.1. Insured Event – Expenses incurred by the Insured due to the therapeutic and / or surgical profile services provided to him / her in the inpatient State Health Care Institution, which were necessary due to the Health Disorder caused to the Insured during the term of the insurance coverage.

11. FOR WHAT DO WE PAY

11.1. BTA pays the costs for:

11.1.1. comfort services (treatment in a single or double ward);

11.1.2. premiums for medical care, nursing care and medicines during inpatient treatment;

11.1.3. inpatient therapeutic and surgical treatment, only if the reimbursable part of the CHIF is specified, BTA pays the non-reimbursable part of the CHIF.

IN-PATIENT TREATMENT PLUS

12. WHAT IS COVERED

12.1. Insured Event - Expenses incurred by the Insured due to the therapeutic and / or surgical profile services provided to him / her in the inpatient health care institution, which were necessary due to the Health Disorder caused to the Insured during the term of the insurance coverage.

13. FOR WHAT DO WE PAY

13.1. BTA pays the costs for:

13.1.1. comfort services (treatment in a single or double ward);

13.1.2. premiums for medical care, nursing care and medicines during inpatient treatment;

13.1.3. inpatient therapeutic and surgical treatment services (only if such services are paid for by the CHIF and by paying only the non-reimbursable part of the CHIF);

13.1.4. In case of Medical rehabilitation (appointed no later than 30 days after the last in-patient treatment), BTA pays (up to 10% of the sum insured of the In-patient treatment program, but not more than EUR 150) for:

13.1.4.1. physiotherapy procedures (light therapy, ultrasound, microwave, TENS, pulse therapy, dorsonvalization, electrophoresis, phonophoresis, halotherapy, induction thermotherapy, magnetotherapy, laser therapy, paraffin applications, low and medium frequency wave therapy);

13.1.4.2. individual and group physiotherapy classes in the hall and water, as well as therapeutic massage and manual therapy procedures.

MEDICINES, FOOD SUPPLEMENTS AND VITAMINS

14. WHAT IS COVERED

14.1. Insured event – Insured Person's costs incurred for purchase of the items specified in section 15 for the period of validity of the insurance cover.

15. FOR WHAT DO WE PAY

15.1. Expenses incurred by the insured due to:

15.1.1. Items, purchased in Pharmacies:

15.1.1.1. medicines;

15.1.1.2. food supplements;

15.1.1.3. vitamins;

15.1.1.4. Medical aids.

15.1.2. Items, assigned by a physician and purchased during the period of insurance coverage:

15.1.2.1. Medical aids for treatment;

15.1.2.2. Medical devices.

15.2. Orthopaedic goods (purchased at health care institutions or specialized orthopaedic stores) purchased during the term of the Insurance Coverage are covered.

16. WHEN DOES THIS INSURANCE NOT APPLY

16.1. Unpaid expenses for the purchase of medicines, food supplements and measures referred to in paragraph 55.4. except items, indicated in paragraphs 56.4.4.; 56.4.6. of the Terms and Conditions.

PRESCRIPTION MEDICINES, MEDICAL AIDS, MEDICAL DEVICES AND ORTHOPAEDIC APPLIANCES

17. WHAT IS COVERED

17.1. Insured event – Insured Person's costs incurred for purchase of the following prescribed items during the insurance period:

17.1.1. prescription medicines;

17.1.2. Medical Aids;

17.1.3. Orthopedic goods;

17.1.4. Medical Devices.

18. FOR WHAT DO WE PAY

18.1. Upon occurrence of the insured event BTA shall compensate the costs of purchase of the following:

18.1.1. prescription medicines in Pharmacies;

18.1.2. Expenditure on the purchase of Medical aid Medical devices and Orthopedic goods in health care establishments, specialized orthopedic shops and pharmacies, but only on prescription or by appointment of a doctor.

19. WHEN DOES THIS INSURANCE NOT APPLY

19.1. Unpaid expenses for the purchase of medicines, food supplements and devices specified in paragraph 56.4;

19.2. Costs are not paid if the items referred to in paragraph 17.1. have been purchased without a prescription or physician's appointment.

19.3. The expenses referred to in section 56 are not compensated, except expenses, indicated in paragraphs 56.4.4.; 56.4.6. of the Terms and Conditions.

FAMILY PLANING AND PRENATAL CARE

20. WHAT IS COVERED

20.1. Insured event – Insured Person's costs incurred with respect to medical services related to family planning and the insured's pregnancy and childbirth during the insurance period.

21. FOR WHAT DO WE PAY

21.1. Upon occurrence of the insured event BTA shall compensate the costs of the following:

21.1.1. 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;

21.1.2. pregnancy-related periodic visits of the Insured Person to a health care institution;

21.1.3. monitoring of a normal or increased-risk pregnancy in accordance with the procedure of prenatal medical checks approved by the Minister for Health;

21.1.4. diagnostics and treatment of prenatal health disorders diagnosed during the scheduled visits;

21.1.5. diagnostics and treatment of prenatal complications and forced abortion;

21.1.6. 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;

21.1.7. birth-giving and postnatal care, paid postnatal ward in public hospitals;

21.1.8. birth-giving and postnatal care in private health care institutions.

22. WHEN DOES THIS INSURANCE NOT APPLY

22.1. The expenses referred to in section 56 are not compensated, except expenses, indicated in paragraphs 56.3.4.; 56.3.6.; 56.3.13.; 56.3.15.; 56.3.17., of the Terms and Conditions, also placement of an accompanying person in a ward.

ODONTOLOGY

23. WHAT IS COVERED

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

24. FOR WHAT DO WE PAY

24.1. Upon occurrence of the insured event BTA shall compensate the costs of the following:

24.1.1. odontology: general endodontic, periodontal and surgical treatment of dental diseases, treatment of carious teeth and their complications, teeth filling, dental radiography;

24.1.2. oral hygiene: preventive consultation of a dentist, oral hygienist (hygiene education), removal of dental concrements, calculus, fluoride applications;

24.1.3. prosthodontics – dentist's consultations about prosthetics, implantation, construction, restoration and repair of removable and fixed dental prosthesis, implants.

25. WHEN DOES THIS INSURANCE NOT APPLY

25.1. BTA shall not compensate any costs referred to in section 56, as well as the costs for the following:

25.1.1. teeth whitening;

25.1.2. teeth laminating (veneering);

25.1.3. placement of dental sealants;

25.1.4. teeth cemetery (a protective grave, graves for athletes; a teeth whitening grave).

OPHTHALMOLOGY AND OPTICAL GOODS

26. WHAT IS COVERED

26.1. Insured event – Insured Person's costs incurred of visual impairments requiring the services or goods referred to in paragraph 27.1.

27. FOR WHAT DO WE PAY

27.1. Within the limits of the sum insured BTA shall compensate the following:

27.1.1. ophthalmologist's consultations and treatment;

27.1.2. costs of purchase of one pair of spectacle lenses prescribed by a doctor (during the insurance period);

27.1.3. costs of purchase of contact lenses;

27.1.4. vision correction surgery, including surgery performed using laser technology, corneal refractive therapy;

27.1.5. cataract surgery including the lens of the eye.

28. WHEN DOES THIS INSURANCE NOT APPLY

28.1. The costs referred to in section 56 are not compensated, as well as costs for the acquisition:

28.1.1. eyeglasses care products;

28.1.2. non-corrective eyeglass lenses and accessories (cleaners, napkins, chains for glasses and other similar goods);

28.1.3. sunglasses (excluding photochemical and corrective lenses);

28.1.4. optical goods not intended for the insured person.

28.2. The costs referred to in section 56 shall not be reimbursed, except for the costs referred to in paragraph 56.3.12.

PREVENTIVE MEDICAL CHECKS AND VACCINATION

29. WHAT IS COVERED

29.1. Insured event:

29.1.1. Insured Person's costs incurred in relation to Preventive medical checks undergone during the insurance period or Diagnostic 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;

29.1.2. Insured Person's costs incurred in relation to vaccination during the insurance period.

30. FOR WHAT DO WE PAY

30.1. Upon occurrence of the insured event BTA shall compensate the following:

30.1.1. specialized doctors' consultations, tests or procedures carried out in order to identify disease susceptibility or to prevent a potential illness;

30.1.2. consultations of psychotherapists, medical psychologists;

30.1.3. 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;

30.1.4. Diagnostic tests undergone by the Insured Person with no referral from the doctor;

30.1.5. examinations and consultations not related to the Clinical Symptoms of the Illness applied for by the Insured, as well as examinations and consultations appointed by a doctor regarding other health changes found during the examination, palpation, auscultation;

30.1.6. vaccines selected by the Insured Person or prescribed by a doctor and for the vaccination service;

30.1.7. Quick tests that are purchased at a health care facility or pharmacy;

30.1.8. Pregnancy care consultations and research.

31. WHEN DOES THIS INSURANCE NOT APPLY

31.1. The expenses specified in section 56 are not compensated, with the exception of the costs referred to in paragraphs: 56.3.1. – 56.3.15., 56.3.19., 56.3.23., 56.3.24., 56.3.28, 56.3.33., 56.3.34., 56.3.38., 56.3.39. of the Terms and Conditions.

WELLNESS SERVICES

32. WHAT IS COVERED

32.1. Insured Event – expenses incurred by the Insured due to health promotion services provided to him / her during the term of the insurance cover in SPA centres, sports clubs, medical institutions or sanatoriums (depending on the nature of services), such as physical education classes, physiotherapy classes, water treatments, massages.

33. FOR WHAT DO WE PAY

33.1. Expenses for purchased physical education subscriptions are paid only after their acquisition and only for the period that falls within the period of validity of the insurance coverage.

33.2. Expenses for services provided such as physiotherapy sessions, hydrotherapy procedures, manual therapy sessions and massages are paid only after the service / services have been provided, upon receipt of documents from the service provider or the Insured confirming the visit dates and the final provision of the service (s).

33.3. Expenses under this program are reimbursed only if they:

33.3.1. provided at a SPA center, wellness center or fitness club;

33.3.2. performed by persons engaged in individual activities on the basis of a certificate of individual activity and holding a valid seal (stamp number) of a masseur or physiotherapist, registered in accordance with the procedure provided for by legal acts.

34. WHEN DOES THIS INSURANCE NOT APPLY

34.1. BTA shall not compensate the expenses specified in section 56 and also do not pay the costs of accommodation and meals; visits to water (winter) amusement parks; gift coupons.

REHABILITATION SERVICES

35. WHAT IS COVERED

35.1. Insured Event - Expenses incurred by the Insured due to the Rehabilitation services provided to him / her during the term of the insurance coverage.

36. FOR WHAT DO WE PAY

36.1. BTA pays only for Medically justified consultations of a Physician of Physical Medicine and Rehabilitation, physiotherapist, occupational therapist, speech therapist and/or their prescribed Rehabilitation:

36.1.1. physiotherapy procedures (light therapy, ultrasound, microwave, TENS, pulse therapy, dorsonvalization, electrophoresis, phonophoresis, halotherapy, induction thermotherapy, magnetotherapy, laser therapy, paraffin applications, low and medium frequency wave therapy);

36.1.2. individual and group physiotherapy classes in the hall and in the water, as well as therapeutic massage (manual therapy) procedures;

36.1.3. speech therapist services in case of a doctor's referral when the Insured has been diagnosed with voice and speech disorders and communication, cognitive disability.

37. WHEN DOES THIS INSURANCE NOT APPLY

37.1. BTA shall not compensate the expenses specified in section 56, with the exception of the costs referred to in paragraph 56.3.8.

EMOTIONAL ASSISTANCE

38. WHAT IS COVERED

38.1. Insured Event Expenses incurred by the Insured due to the Emotional Assistance Services provided to him / her during the term of the insurance coverage.

39. FOR WHAT DO WE PAY

39.1. In case of emotional assistance, the following are paid:

39.1.1. psychotherapy sessions performed by a psychiatrist or a psychiatrist-psychotherapist. (Referral to a psychiatrist is not required, extracts are not required for reimbursement). Psychotherapy sessions are also paid for when they are issued to persons holding an individual activity certificate or business license;

39.1.2. medical psychologist sessions;

39.1.3. psychologist consultation sessions (medical education is not necessary, may be provided by a specialist according to the individual activity certificate).

39.2. Expenses under this program are reimbursed only if they:

39.2.1. provided in a health care institution by persons holding an individual activity certificate or business license;

39.2.2. The person providing the services has a valid stamp (stamp number) registered in accordance with the procedure provided for by legal acts.

40. WHEN DOES THIS INSURANCE NOT APPLY

40.1. The costs referred to in section 56 are not compensated, as well as costs for the group classes, various trainings, courses, etc.

TREATMENT OF CRITICAL ILLNESSES

41. WHAT IS COVERED

41.1. Insured event – Insured Person's costs incurred with respect to the treatment of a critical illness referred to in section 46 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 46 of the Terms and Conditions), and such illness had not been diagnosed before the conclusion of the insurance contract or within 30 days of its conclusion (except for Renewed contracts).

42. FOR WHAT DO WE PAY

42.1. BTA shall compensate:

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

42.1.2. prescription medicines prescribed by a specialized doctor, purchased in a pharmacy and necessary for the treatment of a critical illness referred to in section 46, unless such expenses are fully or partially compensated by the CHIF.

43. WHEN DOES THIS INSURANCE NOT APPLY

43.1. BTA shall not compensate the services referred to in section 56, except for the expenses specified in paragraph 56.3.10 of the Terms and Conditions.

CRITICAL ILLNESS INSURANCE

44. WHAT IS COVERED

44.1. Critical Illness – a final diagnosis of an Illness referred to in section 46 of the Terms and Conditions determining during the insurance period for the first time in the Insured Person's life.

44.2. 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.

44.3. 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 46 of the Terms and Conditions) and confirmed in writing by the specialized doctor.

44.4. 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.

44.5. 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. Unless the insurance contract specifies otherwise, the waiting period shall be 30 days. When insurance contract is concluded with the Policyholder without any interruption between the previous and the Renewed contract, the waiting period shall not apply.

44.6. 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.

44.7. 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.

45. WHEN DOES THIS INSURANCE NOT APPLY

45.1. The insurance benefit shall not be paid if:

45.1.1. 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;

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

45.1.3. a Critical Illness does not meet the conditions and criteria for Critical Illnesses set out in section 46;

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

45.1.5. 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;

45.1.6. 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.

45.1.7. The Final Diagnosis is not confirmed during the Policy period;

45.1.8. The costs referred to in item 56 shall not be reimbursed, except for the costs referred to in paragraphs 56.3.10.; 56.3.11.

46. LIST OF CRITICAL ILLNESSES

46.1. Myocardial infarction (I21) – irreversible damage to the heart muscle (necrosis) caused by lack of oxygen due to acute cardiac insufficiency. This diagnosis must be based on all of the following criteria that are consistent with the features of the first myocardial infarction:

46.1.1. new electrocardiogram changes, which confirm the acute myocardial infarction, in the presence of inherent complaints;

46.1.2. the increase in at least one of enzymes characteristic of infarction are found in blood serum (LD H (lactatdehydrogenase), KFK (creatine kinase), KKM B (MB isoenzyme of creatine kinase), troponine, etc.);

46.1.3. diagnosis of the illness with all the listed symptoms must be confirmed in writing by a cardiologist in hospital.

46.2. Stroke (I60–I64) – brain damage caused by acute cerebrovascular failure. This diagnosis must be based on all of the following criteria:

46.2.1. Stroke-specific clinical symptoms persist for more than 3 months after receiving the appropriate treatment;

46.2.2. the diagnosis is confirmed by a doctor's neurologist based on clinical symptoms and objective tests (MRI, CT scan or other).

46.3. Cancer (C00–C96) – uncontrolled reproduction of altered cells, and the ability of these cells to destroy surrounding tissues and spread to other parts of the body (metastases).

46.3.1. this diagnosis should be based on a conclusion confirmed by oncologist regarding the performed histological examination of the malignant tumour;

46.3.2. the diagnosis determined on the day of the histological examination is considered to be definitively confirmed;

46.3.3. the final diagnosis of the disease must be confirmed in writing by an oncologist;

46.3.4. the following illnesses shall not be considered risks covered:

46.3.4.1. benign or precancerous stage tumours;

46.3.4.2. pre-invasive tumours and in situ tumours (Tis*);

46.3.4.3. cervical dysplasia CIN I-III;

46.3.4.4. urinary bladder carcinoma in stage TA*;

46.3.4.5. all skin tumors;

46.3.4.6. all tumors with HIV infection or AIDS;

46.3.4.7. prostate cancer, histologically diagnosed as T1*.

*according to the international TNM classification.

46.4. Chronic renal failure (N00–N19) – unconscious loss of both kidney function when a continuous haemodialysis and / or kidney transplant operation is required:

46.4.1. an unconscious loss of kidney function is confirmed by a doctor's nephrologist;

46.4.2. 6 months of continuous haemodialysis or an Insured person entered the line for a kidney transplant operation or a kidney transplant operation.

46.5. Aortic aneurysm (I71) – abnormal enlargement of the vessel (aorta) with the risk of rupturing and causing severe bleeding:

46.5.1. The diagnosis must be based on objective examinations (ultrasound examination of the abdomen, aortography, CT scan, MRI, or other);

46.5.2. Emergency surgery must be performed or scheduled endovascular stent grafting must be prescribed.

46.6. Multiple or disseminated sclerosis (G35–G37) – Central nervous system autoimmune disease, in which the nerve fibres disappear (demyelinization):

46.6.1. the diagnosis of the illness must be confirmed in writing by a neurologist;

46.6.2. the disease-specific changes are determined by MRI;

46.6.3. an increase in the IgG index and an oligoclonal band in the cerebrospinal fluid is detected in brain fluid.

46.7. Intracranial aneurysm (I67.1) – unnatural dilation of the blood vessel of brain which can impact surrounding tissues or balloon out and lead to strong bleeding:

46.7.1. diagnosis is confirmed by objective tests (computed tomography, magnetic resonance imaging, brain angiography, cerebrospinal fluid testing, etc.);

46.7.2. an urgent surgery of brain aneurysm is performed or a planned surgery of brain aneurysm is assigned;

46.7.3. insurance indemnity shall not be paid with respect to brain aneurysm producing no symptoms which are only monitored by periodic tests.

46.8. AIDS (B20-B24) – immunodeficiency acquired by the human immunodeficiency virus (HIV):

46.8.1. the diagnosis of the illness must be confirmed in writing by the professionals from the Lithuanian Centre for Communicable Diseases and AIDS;

46.8.2. the result of a HIV test is positive;

46.8.3. Blood test reduces CD4 cell count (200 and less).

46.9. Blindness (H54.0- H54.4) – complete and irrecoverable vision loss due to disease:

46.9.1. irrecoverable vision loss is confirmed by ophthalmologist 3 months after diagnosing a disease or injury;

46.9.2. vision loss is confirmed by objective testing (sciascopy, refractometry, spectral compensation, etc.);

46.9.3. with respect to loss of vision in one eye a half of the specified insurance indemnity shall be paid;

46.9.4. with respect to loss of the eye(s) insurance indemnity may be disbursed without waiting for expiry of 3 months.

46.10. Cardiac, lung, liver, pancreas transplantation (Y83.0) – transplantation of organs taken from one person to another person for medical treatment purposes (due to a disease or injury):

46.10.1. the insured is the recipient of the organ;

46.10.2. performance of transplantation surgery or inclusion of the insured into the official waiting list for such surgery.

46.11. Muscular dystrophy (G71) – genetically inherited primary muscular conditions characterised by weakening and wasting (atrophies) of muscles:

46.11.1. disease is confirmed by the geneticist and neurologist;

46.11.2. diagnosis is confirmed by morphological muscle and/or electromyography test and specific muscular enzyme (creatine phosphokinase) tests.

46.12. Diabetes Type 1 (E10) – a disease that interferes with the production of insulin, which leads to an increase in blood glucose levels:

46.12.1. diagnosis is confirmed by the endocrinologist;

46.12.2. blood tests show an increase in glucose and / or an increase in glycated hemoglobin (HbA1c);

46.12.3. Continuous treatment with insulin injections.

46.13. Benign tumours of the brain and spinal cord (D32 - D33) – an accumulation of cells of the body, which are characterized by uncontrolled division, the deployment (pushing) of adjacent tissues:

46.13.1. the diagnosis of the illness must be confirmed in writing by the opinion of an oncologist or neurosurgeon;

46.13.2. the diagnosis is confirmed by objective examinations (CT scan, MRI, or brain biopsy).

46.14. Coronary artery bypass graft surgery – an open coronary artery bypass graft surgery performed to correct the narrowing or occlusion of two or more coronary arteries by transplanting the superficial vein of the leg, the internal thoracic artery or another suitable artery:

46.14.1. insurance benefit for Balloon angioplasty is not paid.

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

46.15.1. the diagnosis is confirmed by an otorhinolaryngologist;

46.15.2. the insurance benefit is paid only if complete hearing loss in both ears persists for 6 months after the diagnosis is made.

46.16. Speech loss – is the complete loss of hearing in both ears due to injury or illness:

46.16.1. the diagnosis is confirmed by an otorhinolaryngologist;

46.16.2. the insurance benefit is paid only if complete speech loss persists for 6 months after the diagnosis is made.

ILLNESS

47. WHAT IS COVERED

47.1. The insured event is Your illness specified in section 48 during the validity period of the insurance contract, except for the first 30 days from the beginning of the insurance contract period (except for Renewed contracts).

48. LIST OF DISEASES

48.1. Lyme disease – infection spread through the bite from a tick infected with Borrelia burgdorferi:

48.1.1. the diagnosis of Lyme disease is based on clinical symptoms and opinion of a specialised doctor;

48.1.2. presence in the blood of is Borrelia burgdorferi-specific IgG or IgM. The diagnosis is based on serological tests results.

48.2. Tick-borne encephalitis, tick-borne myelitis, tick-borne encephalomyelitis – infectious disease transmitted by the bite from a tick infected with neurotropic virus:

48.2.1. the disease is treated in a hospital;

48.2.2. the diagnosis is supported by serologic test results.

48.3. Acute appendicitis – acute inflammation of the vermiform appendix:

48.3.1. patient underwent emergency appendectomy.

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

48.4.1. the disease is diagnosed and treated in a hospital;

48.4.2. the diagnosis is supported by microbiologic testing.

48.5. Diphtheria – infectious disease caused by the bacteria Corynebacterium diphtheriae and Corynebacterium ulcerans through respiratory tract or saliva:

48.5.1. the disease is diagnosed and treated in a hospital;

48.5.2. the diagnosis is supported by microbiologic testing.

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

48.6.1. the disease is diagnosed and treated in a hospital;

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

48.6.3. the diagnosis is supported by microbiologic testing.

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

48.7.1. disease is diagnosed and treated by way of hospitalisation;

48.7.2. diagnosis is confirmed by microbiological testing.

48.8. Gastric (duodenal) ulcer perforation (rupture) – complication of a gastric (duodenal) ulcer when the wall of the organ gets perforated at the place of ulcer and the content of stomach (duodenum) effuses to the abdominal cavity causing inflammation of peritoneum (peritonitis):

48.8.1. disease is diagnosed and treated by way of hospitalisation;

48.8.2. performance of an urgent surgery.

48.9. Rabies – viral disease affecting the central nervous system caused by neurotropic Rhabdoviridae family virus which spreads with saliva when an infected animal bite:

48.9.1. disease is diagnosed and treated by way of hospitalisation;

48.9.2. diagnosis is confirmed by microbiological testing.

48.10. Ectopic pregnancy – an acute condition when in which the embryo attaches outside the uterus. An impregnate ovum gets implanted and develops in the uterine tube inside abdominal cavity, in the rudimental uterine horn.

48.11. Acute poisoning with toxic mushrooms, food:

48.11.1. disease is diagnosed and treated by way of hospitalisation for not less than 3 days;

48.11.2. insurance indemnity shall not be paid for poisoning with alcohol.

48.12. Trichinosis – is a parasite disease caused by a spiral trichina (Trichinella spiralis) which is spread when eating raw or undercooked pork and mead of wild animals.

48.12.1. Disease is diagnosed and treated by way of hospitalization for not less than 3 days.

48.13. Botulism – infectious nervous system disease mainly caused by extremely strong neurotoxin which spreads with food and is produced by Clostridium botulinum bacteria:

48.13.1. Disease is diagnosed and treated by way of hospitalisation for not less than 3 days.

49. FOR WHAT DO WE PAY

49.1. The sum insured specified in the insurance policy for Diseases program, in case of an insured event, shall be paid out once during the term of the insurance contract, regardless of the number of insured events. This amount shall be paid by providing the Insured with the Limit of Complementary Medical Services Insurance program (Basic Package), which the Insured may use as specified in section 52 of these Terms and Conditions.

50. WHEN DOES THIS INSURANCE NOT APPLY

50.1. This insurance does not apply to and no compensation is payable for Disease:

50.1.1. which occurs within the first 30 days from the entry into force of the insurance contract (except for Renewed contracts);

50.1.2. which does not meet the conditions and criteria laid down in paragraph 48 of the Terms and Conditions;

50.1.3. which diagnosis was not confirmed during the Policy period.

COMPLEMENTARY MEDICAL SERVICES

51. WHAT IS COVERED

51.1. Insured event – expenses of the Insured Person incurred in relation to her/his Health disorder or prophylaxis of Diseases for which she/he needs the goods and services specified in sections 52. and 54. of these Terms and Conditions.

51.2. The Policyholder may choose between two insurance risk options in the conclusion of the insurance contract:

51.2.1. Basic package;

51.2.2. Additional package.

52. FOR WHAT DO WE PAY

52.1. 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:

52.1.1. Out-patient treatment plus;

52.1.2. In-patient treatment plus;

52.1.3. Medicines, food supplements, vitamins, medical aids, prescribed medical devices and Orthopaedic goods;

52.1.4. Prescription medicines, prescribed medical aids, medical devices and Orthopaedic goods;

52.1.5. Family planning and Prenatal care;

52.1.6. Odontology;

52.1.7. Ophthalmology and optical goods;

52.1.8. Preventive medical checks and Vaccination;

52.1.9. Rehabilitation therapy;

52.1.10. Treatment of critical illnesses;

52.1.11. Emotional assistance.

53. WHEN DOES THIS INSURANCE NOT APPLY

53.1. In Basic package BTA shall not pay for:

53.1.1. the services referred in paragraph 56, except for the expenses specified in paragraphs 56.2.1.; 56.2.5.4.; 56.2.5.6; 56.3.1. – 56.3.28, 56.2.2., 56.3.32. – 56.3.39.; 56.4.6 of the Terms and Conditions;

53.1.2. accommodation and meals;

53.1.3. visits to water (winter) amusement parks;

53.1.4. gift coupons.

54. FOR WHAT DO WE PAY

54.1. 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:

54.1.1. Health services;

54.1.2. Hygienic preparations and medicated cosmetics purchased from pharmacies;

54.1.3. Sunglasses, safety glasses.

55. WHEN DOES THIS INSURANCE NOT APPLY

55.1. In Additional package BTA shall not pay for:

55.1.1. the services referred in paragraph 56, except for the expenses specified in paragraph 56.2.1.; 56.2.3.4.; 56.2.5.6; 56.3.1. – 56.3.39; 56.4.4. – 56.4.9. of the Terms and Conditions.

55.1.2. accommodation and meals;

55.1.3. visits to water (winter) amusement parks;

55.1.4. gift coupons.

56. UNINSURABLE RISKS

56.1. BTA shall pay no insurance benefit for Health Care Services provided in relation to Health Disorders:

56.1.1. caused to the Insured Person deliberately or as a result of an attempted suicide;

56.1.2. 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;

56.1.3. 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.

56.2. Insurance benefits shall not be paid for:

56.2.1. formalization of medical records and medical tests, entries and other information media provided as a separate service;

56.2.2. future services (paid up by but not yet provided to the Insured Person) and services delivered after the expiry of the insurance cover;

56.2.3. Health Care Services:

56.2.3.1. not specified in the Terms and Conditions or/and Insurance contract;

56.2.3.2. provided and paid for during a period when the insurance cover is not valid;

56.2.3.3. the date and circumstances of provision of which cannot be identified after the investigation of the event;

56.2.3.4. the need of which is not supported by medical documentation;

56.2.3.5. when the user of the insurance cover specified in the insurance contract is not the Insured Person;

56.2.3.6. attributed to non-traditional (alternative) medicine services (e.g. acupuncture, iridology, bio-magnetic resonance, electro-puncture, etc.);

56.2.3.7. granted for the same condition for which an insurance benefit has already been paid, unless a new condition has been diagnosed, another diagnosis of the disease has been made or no (unadjusted) treatment has been prescribed during that service.

56.2.4. costs related to the issue and submission of documents supporting the provided health care services shall be paid by the Insured Person.

56.3. The following costs shall not be eligible for compensation:

56.3.1. consultations of a reflexologist;

56.3.2. consultations and treatment of dependences on psychoactive substances (nicotine, drugs, alcohol,

psychotropic substances);

56.3.3. consultation with specialists such as homeopaths or endobiogenics;

56.3.4. diagnostics and treatment of infertility and potency disorders, artificial insemination;

56.3.5. diagnostics and treatment of congenital anomalies, diseases and their complications;

56.3.6. 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;

56.3.7. treatment and removal of moles, benign skin formations, vascular formations and warts, benign tumors;

56.3.8. costs related to general bodily diagnostics, polysomnography tests, tests or treatment of sleeping disorders;

56.3.9. diagnostics and treatment of eating disorders; (bulimia, anorexia, overeating, etc.) diagnosis and treatment;

56.3.10. diagnostics and treatment of oncologic illnesses;

56.3.11. cancer marker research;

56.3.12. treatment of refractive errors;

56.3.13. diagnostics and treatment of sexually transmitted diseases (syphilis, gonorrhoea, trichomoniasis, chlamydiosis, human papillomavirus, herpes genitalis, etc.), genital warts, AIDS and HIV;

56.3.14. the following diagnostic tests: allergen-specific IgE testing for food allergens, aeroallergens and mixed allergens (individual allergens or allergen mixes, molecular-based allergy testing);

56.3.15. sex hormone tests;

56.3.16. services provided according to the preventive health care programs fully subsidized from the CHIF;

56.3.17. abortion without medical indications and birth-giving not in a medical institution;

56.3.18. blood donorship and haemodialysis;

56.3.19. treatment of venous varicose using laser or any other similar method, when venous diseases are class C0–C3 according to the CEAP classification;

56.3.20. organ transplant surgeries, bone marrow transplantations;

56.3.21. elective surgeries when conservative treatment has not been applied and/or there is no exacerbation of a diseases;

56.3.22. purchase of joint endoprosthesis and joint endoprosthetic surgery;

56.3.23. laser therapy procedures;

56.3.24. intense light pulse therapy (phototherapy, photodynamic therapy, pulsed light therapy);

56.3.25. long-term care and palliative therapy;

56.3.26. services (procedures) for medicinal purposes: autologous cell therapy, hyaluronic acid injections, stem cell therapies, immunotherapy;

56.3.27. treatment of degenerative deformities of the foot bones, ligaments, tendons, joints and muscles (except for traumatic injuries);

56.3.28. preoperative tests and postoperative dressings when no compensation is paid for the surgery itself;

56.3.29. plastic aesthetic surgical treatment; procedures and operations performed for cosmetological, plastic and / or aesthetic purposes; dermatological treatment, including, but not limited to, laser aesthetic procedures (pigmentation, redness, dilated blood vessels, acne, stretch marks, scars, etc.); hair removal procedures; treatment with botulinum toxin injections;

56.3.30. services provided in cosmetology and beauty salons;

56.3.31. plastic and / or reconstructive surgical operations or procedures using different types of implants.

56.3.32. eyelid surgery (except for eyelid ptosis, where the eyelid covers more than half of the pupil area or prevents opening);

56.3.33. diagnosis and treatment of hair loss;

56.3.34. nail fungus treatment;

56.3.35. Health care services provided outside the Health Care Institution (eg preventive examinations performed in the workplace);

56.3.36. surgical treatment of obesity;

56.3.37. bone plates / nails / wires / screws used in surgical operations;

56.3.38. genetic testing;

56.3.39. consultations of dietician, drawing up a nutrition plan.

56.4. The costs incurred in relation to the following shall not be eligible for compensation:

56.4.1. 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;

56.4.2. articles of hygiene (except for the cases of postoperative treatment);

56.4.3. cosmetics, including decorative cosmetics (mascara, powder, eye-shadows, lipsticks, tanning lotions, anti-cellulite products, perfumes, etc.);

56.4.4. implants (including eye-lenses), prostheses and structures;

56.4.5. eye-glass frames, protective goggles, lens care products, eye-glass manufacturing services;

56.4.6. Medical Devices;

56.4.7. durable goods (inversion and massage tables and chairs, bodybuilding equipment and massagers, exercise mats and balls, orthopaedic pillows, footwear and mattresses, first-aid kits for cars and breathalysers);

56.4.8. lease of premises, equipment for undertaking sporting activities (sports halls (except for tennis, squash and badminton courts), deposits for wardrobe lockers);

56.4.9. leisure activities and entertainment: trampoline parks, wall climbing, skiing, water-skiing, etc.;

56.4.10. sweet prophylactic preparations (Hematogen, energy bars, juice extracts, etc.); nutritional supplements for athletes (BCC, Guarana, etc.); nutritional supplements for weight loss;

56.4.11. accommodation and meals;

56.4.12. food supplements that are purchased outside the pharmacy.

57. CASES WHEN BTA MAY REFUSE INSURANCE BENEFIT

57.1. BTA shall have the right to refuse payment of the insurance benefit in the following cases:

57.1.1. 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);

57.1.2. 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;

57.1.3. 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.

58. SUM INSURED

58.1. Sums insured and limits agreed upon by the parties to the insurance contract shall be specified in the insurance policy.

58.2. 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.

58.3. 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.

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

59.1. The Policyholder shall have the following obligations:

59.1.1. 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:

59.1.1.1. particulars and type of activities of the Policyholder;

59.1.1.2. data of the Insured Persons (full names, personal identification numbers);

59.1.1.3. information whether the Insured Person himself/herself pays the insurance premium or any part thereof;

59.1.1.4. consents of the Insured Persons with respect to processing of their personal data (including special personal data);

59.1.2. inform the Insured Persons on the conclusion or amendment of the insurance contract and expiration of the insurance cover;

59.1.3. 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;

59.1.4. pay the insurance premiums specified in the insurance policy;

59.1.5. 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;

59.1.6. 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.

59.2. The Policyholder shall have the right:

59.2.1. 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.

59.3. The Insured Person shall have the following obligations:

59.3.1. 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;

59.3.2. 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;

59.3.3. 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:

59.3.3.1. when services are provided not at the Service Providers' institution;

59.3.3.2. which are not compensated by BTA directly to the Service Provider under a mutual agreement.

59.3.4. The Insured Person is obliged to consider, and act in observance of, BTA's notices mentioned in paragraph 59.7.4.

59.4. The Insured Person shall have the right:

59.4.1. 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.

59.5. 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.

59.6. BTA shall have the following obligations:

59.6.1. 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;

59.6.2. fulfil other obligations of the Insurer provided for by legislative acts.

59.7. BTA shall have the right:

59.7.1. 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;

59.7.2. 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;

59.7.3. 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;

59.7.4. during the insurance contract period, unilaterally choose institutions which services, medicines, Medical Aids, Medical Products or Orthopaedic 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;

59.7.5. 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.

59.8. 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.

59.9. 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.

59.10. 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.

60. INSURANCE BENEFIT

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

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

60.2.1. 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 considering limitations (if any) set out in the insurance contract;

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

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

60.3. 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.

60.4. 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:

60.4.1. a request to compensate for the costs;

60.4.2. 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;

60.4.3. 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;

60.4.4. 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.

60.5. 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.

60.6. 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 59.3 of the Terms and Conditions.

61. MISCELLANEOUS

61.1. 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.

61.2. 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.

61.3. 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.

61.4. 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.

61.5. 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.

61.6. These Terms and Conditions shall apply to all insurance contracts concluded after 01 February 2021, unless otherwise agreed by the parties upon contracting for insurance.