Seesam
VIENNA INSURANCE GROUP

Health insurance terms and conditions No. VA 17/1

Approved by the Decree No. 2017/9-pa of Seesam Insurance AS Latvian Branch
Valid from April 1, 2017.

Seesam Insurance AS Latvian branch (hereinafter – the insurer) shall enter into insurance contracts with legal persons in accordance with these Conditions.

1. Rights and Duties under the Insurance Contract

Rights and duties under the insurance contract shall apply to the insurer, the insured person and the policyholder – a legal person, who enters into a health insurance contract for the benefit of a natural person.

2. Insurance Object

Insured person is an individual who has an insured interest and for the benefit of whom a health insurance contract is concluded. Insured person is the policyholder's employee, who has entered into an employment contract with the policyholder. Insured person, according to an employment contract on performance of his/her job duties, receives work remuneration, and policyholder makes tax payments.

The insured person can also be a relative of the policyholder's employee – spouse, parent, child, foster child, adopted child, brother, sister, foster parent. Relatives may be included in the insurance contract only in agreement with the insurer.

3. Insurance Territory

Insurance contract is in effect in the territory of the Republic of Latvia 24 hours a day.

4. Insurance Period

Insurance period is the term of validity of an insurance contract.

For new employees, who are added to an insurance agreement, the insurance period begins on the date specified in the Annex to the insurance contract and expires at the end of the insurance period.

5. Procedure of Conclusion of the Insurance Contract

5.1. Insurance contract is entered into on the basis of the offer provided by the insurer and the risk information presented by the policyholder for receipt for a health insurance offer.

5.2. Any corrections of the health insurance offer are made or an appendix on amendments to the insurance contract is concluded only upon receipt of a written application of the policyholder.

6. Payments of Insurance Premium

6.1. Amount of insurance premium is determined by the insurer on the basis of the insurance application provided by the policyholder. Amount and procedure of payment of insurance premium is specified in the insurance policy.

7. Coming into Effect of Insurance Contract

7.1. The insurance contract is considered concluded and comes into effect on the date specified in the insurance policy if the insurer or an authorized representative of the insurer has received the insurance premium or first instalment of the insurance premium. If payment of the insurance premium or first instalment thereof is made by bank transfer, the date when the relevant amount is credited to the account of the insurer or his authorized representative shall be considered the payment date.

7.2. From the date of conclusion of the insurance contract it shall be deemed that the policyholder, acting on behalf of himself and on behalf of the insured persons, has authorized the insurer as the personal data processing system controller and the personal data operator to process data of the policyholder and personal data of the insured person as well as sensitive personal data, ensuring performance of the insurance contract in accordance with requirements set out in the Personal Data Protection Law and other laws and regulations.

7.3. From the moment of commencement of use of the health insurance card, the insured person confirms and attests that according to the Personal Data Protection Law and other laws and regulations of the Republic of Latvia, he/she authorizes the insurer as the system controller and the personal data operator to process his/her data, including any sensitive personal data and the personal identity number, with the purpose to ensure performance and inspection of the insurance contract. The insured person authorizes the insurer to obtain his/her personal data, including any sensitive personal data and the personal identity number, medical and other documentation from third parties (both legal persons and individuals), for insurance contract performance purposes.

8. Termination of Insurance Contract

8.1. The insurer and/or the policyholder may terminate the insurance contract in accordance with requirements set out in the laws and regulations of the Republic of Latvia.

8.2. Termination of the insurance contract shall not prejudice the right of the insurer to demand from the policyholder any payment of the insurance premium or any part thereof due for the period of time when the insurance contract was in effect.

8.3. In the case of termination of the insurance contract or in the case when the insurance contract has not come into effect, the policyholder shall be obliged to return all the issued health insurance cards back to the insurer by the date of termination of the insurance contract, or within 5 (five) days upon the insurer's request. If an insured event has occurred after termination of the contract or after the date when the insurance contract became ineffective, any insurance indemnity paid by the insurer shall be repaid by the policyholder.

8.4. In the case when the insurance contract is terminated prematurely in respect to a particular insured person, the policyholder shall inform the insurer in written about this insured person. The insurance contract shall be terminated in respect to this insured person as of the date when the policyholder submitted information on the person to be excluded from the list of insured persons to the insurer. The insurer shall have the right not to include repeatedly this insured person in this insurance contract.

9. Duties and Rights of the Policyholder

9.1. Present true and complete information for risk assessment.

9.2. Inform the insurer in written promptly and not later than in 3 working days on any changes of the information provided in the health insurance application.

9.3. Fulfil the terms and conditions of the insurance contract.

9.4. Pay the insurance premium in the amount and within the term specified in the insurance policy, and according to the time schedule specified in the invoice.

9.5. Inform the insured person about insurance of him/her and acquaint him/her with insurance programs, insurance conditions and health insurance terms and conditions, instructions and obligations towards the insurer arising therefrom. Deliver the health insurance card to the insured person as well as all and any information provided by the insurer that is intended for the insured person.

9.6. Explain to the insured person his/her rights and duties.

9.7. Submit any information and/or requests in written form.

9.8. Inform the insured person that the list of contractual organisations and any amendments thereto made during the insurance period are published on the insurer's website www.seesam.lv.

9.9. Inform the insured person that in the case if the health insurance card is lost or stolen, or in the case of any change in the personal data of the insured person or discovery of any error in the personal data, he/she must immediately inform the insurer by calling to the 24-hour information line or sending an application to the insurer's e-mail on issue of a duplicate of the health insurance card.

9.10. Upon the insurer's request, to present a health declaration regarding the insured person/the person to be insured.

9.11. Return back a health insurance card to the insurer in the case when the insurance contract has not come into effect or when the insurance contract has been terminated before its expiration date, or when the insurance contract has been terminated prematurely in respect to an insured person, or when a new health insurance card has been made due to any change of personal information of the insured person or due to any error in the personal data.

9.12. Repay to the insurer any insurance indemnity having been paid according to these Conditions if the insured person has failed to repay such indemnity to the insurer and if the insurer has demanded such repayment from the policyholder.

9.13. The policyholder is obliged to inform the insurer if the insurance premiums for the company employees included in the health insurance policy are not paid solely from the funds of the company.

9.14. Comply with and fulfil requirements of the Law "On Insurance Contract" and other laws and regulations.

9.15. Upon the insurer's request, submit to the latter copies of reports presented to the State Revenue Service regarding dates of commencement of employment relationships with employees specified in the relevant request and approved in accordance with the Latvian laws and regulations.

9.16. The policyholder is obliged, if required by the nature of the insured risk, to notify law enforcement authorities and/or emergency services, and/or other competent authorities of the Republic of Latvia on occurrence of a risk.

10. Duties and Rights of the Insured Person

10.1. Present true and complete information for risk assessment.

10.2. Inform the insurer on any other valid insurance contracts relating to the health of the insured person.

10.3. Take care of maintenance of his/her health state.

10.4. Prior to commencement of use of health insurance services, to review the insurance program and terms and conditions of the health insurance contract.

10.5. Read, comply with and meet all the requirements contained in the conditions of the insurance contract and set by the insurer as well as to comply with and meet additional requirements set by the insurer in written in respect to certain conditions of the contract.

10.6. In the case of occurrence of an insured event, to comply with all instructions given by the attending doctor.

10.7. Upon occurrence of an insured event, if the insured person has paid for the received services by using his/her private money, immediately and as soon as practicable, but not later than within ninety (90) days from receipt of the service, when it became possible, to submit to the insurer a health insurance claim and other documents requested by the insurer. All the documents requested by the insurer and the health insurance claim may be sent electronically, by claiming the indemnity on the insurer's website at www.seesam.lv or sending the claim and documents to the insurer's e-mail address: veseliba@seesam.lv.

10.8. Within 15 days after the date of reception of a written claim of the insurer to repay the insurance indemnity:

10.8.1. which has been paid to the insured person or a contractual organisation for services or cases which are defined as exceptions in the present conditions or which are not included in the insurance program;

10.8.2. which has been paid to a contractual organisation if the insured person has exceeded the insurance limit specified in the insurance program or the insurance amount;

10.8.3. which has been paid for an insured event which had occurred during the period of invalidity of the insurance contract or when the insurance contract had been suspended, or after discontinuation of validity of the insurance contract, or after premature termination of the insurance contract in relation to the insured person.

10.9. Verify whether the medical institution which is not a contractual organisation of the insurer and which will be visited, is registered in the Register of Health Care Institutions, Enterprises, Practices and Certification of the RL.

10.10. When receiving services from contractual organizations, to present the health insurance card only together with a personal identification document, and not to transfer the health insurance card to another person.

10.11. The insured person is liable for any loss resulting from untimely reported cases of loss or theft of the health insurance card or cases of change in the personal data of the insured person, or cases of discovery of errors in the personal data of the insured person.

10.12. The insured person shall pay for issue of a health insurance card duplicate. If the insured person presents a certificate issued by the State Police of the Ministry of the Interior of the RL confirming fact of theft or robbery of the health insurance card, or if the error in the personal data of the insured person had been caused through the insurer's fault, a new health insurance card shall be issued by the insurer free of charge.

10.13. The insured person is responsible for supervising that the insurance sum and the limits specified in the insurance programs are not exceeded.

10.14. The insured person must return back the health insurance card if the health insurance contract in respect of the insured person has been terminated prematurely.

10.15. The insured person is obliged to submit all and any documents requested by the insurer which are necessary for examination of the claim and making the insurer's decision.

10.16. The insured person shall have the right to get information on recourse amounts recovered by the insurer from the person who is responsible for the damage caused to the insured person.

10.17. The insured person shall have the right to require that the decision made by the insurer and transmitted electronically, should be issued in the form of an original document.

10.18. The insured person is obliged to keep any original documents submitted electronically for up to 3 (three) years, to be able to submit them to the insurer in the case of necessity, if requested by the insurer.

10.19. The insured person shall have the right to submit a complaint to the insurer regarding decision made in his/her claim case, within 30 (thirty) days following the date of receipt of the decision.

11. Rights and Duties of the Insurer

11.1. In accordance with the insurance contract, in the case of occurrence of an insured event, to make decision on payment or refusal of payment of the insurance indemnity to the insured person or his/her authorized representative, or to a contractual organisation.

11.2. In the case of entering into the insurance contract, to deliver to the policyholder the set of documents that constitute an integral part of the contract, namely: the insurance policy, the health insurance cards, the health insurance conditions, annexes to the insurance policy, and the description of insurance programs.

11.3. Upon request of the policyholder, to send the health insurance conditions and/or the list of contractual organisations in electronic format to an e-mail address specified by the policyholder.

11.4. To renew health insurance cards within 5 (five) working days following the date of receipt of the application.

11.5. To provide the insured person with information confirming the amount of money is paid for the received services.

11.6. The insurer shall be obliged, upon the insured person's request, to provide information on the spent insurance amount and the balance of the insurance amount under the insurance programs.

11.7. Verify correctness of information provided by the insured person, occurrence of an insured event and reasonability of payment of insurance indemnity by reviewing medical records of the insured person maintained by medical treatment institutions and medical persons, and/or in the case of any uncertainty, to engage an independent licensed physician (medical expert) selected by the insurer in order to have examined the health state of the insured person in connection with the insured event.

11.8. Request the policyholder and/or the insured person to repay the insurance indemnity referred to in these Conditions, in accordance with the Law "On Insurance Contract".

11.9. If the insured person has failed to make repayment of the amount claimed by and due to the insurer according to these Conditions, the insurer may reduce the sums of insurance indemnity payable to the insured person in the future by an amount equivalent to the claimed but not received amount.

11.10. If it is established that the insured person has exceeded a limit specified in the insurance program in regard to an insured risk included in the insurance program, the insurer may reduce the sums of insurance indemnity payable in the future to the insured person in respect of other risks insured by the amount equivalent to the amount in excess of the said limit.

11.11. Determine the cost of issue of a duplicate of the health insurance card according to the insurance conditions.

11.12. To process personal data of the policyholder and the insured person, including sensitive personal data. Data processing shall be carried out in accordance with the Personal Data Protection Law. The insurer shall provide for safe storage of the personal data of the insured person.

11.13. The insurer shall have the right, during the period of validity of the insurance contract, to make changes in the list of contractual organisations and services provided by those organisations, without notifying the insured person. The insurer ensures availability of the current list of contractual organisations on the insurer's website www.seesam.lv.

11.14. The insurer shall have the right to pay indemnity according to a price list established by the insurer for services received in institutions other than contractual organizations, as well as in cases when a service is unavailable at contractual organizations or when full payment for services can not be made and the insured person must make payment from his/her private funds. The insurer shall ensure availability of the current price list on the insurer's web site www.seesam.lv.

11.15. The insurer shall have the right to send electronically the adopted decision in the insurance claim case, to the electronic address specified by the insured person.

11.16. The insurer shall have the right, during the period of validity of the insurance contract, to request payment of additional insurance premium, if during the period of validity of the insurance contract there have been made any amendments to the legislation affecting payment of services in the health care sphere.

11.17. The insurer shall have the right, according to the procedures of recourse, to recover from the guilty party damages resulting from the reimbursement of medical expenses to insured persons, who have suffered damage in the result of an unlawful act or omission of a natural or legal person. If in the result of acts or omissions of the insured person or the policyholder recovery of the damages is not possible for the benefit of the insurer, the insurer may require the insured person to return the paid insurance indemnity to the extent it is impossible to recover the actual damage. The insurer takes over the claim against the person who is responsible for the loss to the extent of the paid insurance indemnity.

11.18. If the insurer has recovered, according to the procedures of recourse, full claimed amount during the insurance period, the respective limits under the insurance program shall be increased by this amount, less the administrative expenses of the insurer relating to recovery of the claimed amount and amounting to 25 % of the amount recovered.

11.19. The insurer shall give a written response to the claim submitted by the insured person or the authorized person or the mediator within 30 working days from the date of receipt of the application.

12. Insurance Program

12.1. Insurance program consists of insured risks which are included in the insurance contract and which may be received in the form of services solely in medical treatment institutions registered in the Register of Health Care Institutions, Enterprises, Practices and Certification of the RL and/or the Commercial Register of the Register of Enterprises of the RL where the services are being provided according to procedures established in the laws and regulations.

12.2. The insurer shall pay insurance indemnity for services provided by a medical practitioner who has received a certificate of the right to practice in a particular specialty and to apply medical technology utilized in medical treatment and approved according to the requirements of laws and regulations of the RL before the insurance contract effective date.

12.3. Risks insured:

12.3.1. In the country of the patient's contribution there is established a unified direct payment of the patient for a medical service to the medical institution, and this payment is collected by the medical institution within the framework of the state health care program and the minimum of health care services.

12.3.2. The insured risk "Patient's contribution" covers:

12.3.2.1. portion to be paid by the patient when receiving the state-guaranteed medical treatment in a medical treatment institution or from a physician who has an agreement with the state on payment of services from the state budget;

12.3.2.2. co-payment for surgical operations carried out at a hospital at a time.

The amount of the patient's contribution and the co-payment shall be established in accordance with requirements of laws and regulations of the Republic of Latvia.

12.3.2.3. Instruction:

To enable the insured person to receive the state-guaranteed medical treatment:

- 12.3.2.3.1. the insured person must be registered at a primary care medical practitioner;
- 12.3.2.3.2. the insured person must have a referral issued by a physician, who has an agreement with the state on payment of services from the state budget.

12.3.2.4. The insured risk "Patient's contribution" does not cover:

- 12.3.2.4.1. medical services for pay (services not covered from the state budget);
- 12.3.2.4.2. expenses if the insured person is exempted from the patient's contribution in accordance with requirements of laws and regulations of the Republic of Latvia.

12.3.3. Outpatient services for pay:

12.3.3.1. Patient's contribution to a medical institution for a medical service not covered from the state budget.

12.3.3.2. The insured risk "Outpatient services for pay" covers:

- 12.3.3.2.1. medical advice and medical treatment;
- 12.3.3.2.2. prescribed lab and diagnostic tests;
- 12.3.3.2.3. vaccination;
- 12.3.3.2.4. medical certificates;
- 12.3.3.2.5. mandatory health examinations associated with specific job requirements;
- 12.3.3.2.6. emergency help.

12.3.3.3. The insured risk "Outpatient services for pay" does not cover:

- 12.3.3.3.1. non-reimbursable services specified in the insurance program and the Conditions.

12.3.4. Inpatient services for pay:

12.3.4.1. Patient's contribution to a medical institution for a medical service not covered from the state budget.

12.3.4.2. The insured risk "Inpatient services for pay" covers:

- 12.3.4.2.1. stay at a 24-hours and day hospital;
- 12.3.4.2.2. surgical operations;
- 12.3.4.2.3. prescribed lab and diagnostic tests, and manipulations.

12.3.4.3. The insured risk "Inpatient services for pay" does not cover:

- 12.3.4.3.1. extra payment for choice of attending doctor or other medical personnel during a medical treatment episode;
- 12.3.4.3.2. surgical operations for pay having been received by the insured person as emergency help;
- 12.3.4.3.3. non-reimbursable services specified in the insurance program and the Conditions.

12.3.5. Purchase of medicines:

12.3.5.1. The insured risk "Medicines" covers the following provided that they are purchased at a pharmacy:

- 12.3.5.1.1. medicines;
- 12.3.5.1.2. vitamins;
- 12.3.5.1.3. food supplements.

12.3.5.2. The insured risk "Medicines" does not cover:

- 12.3.5.2.1. expenditure on the purchase of medicines, which are incurred in connection with cases referred to in the health insurance conditions and the relevant insurance program or which are intended for treatment of non-reimbursable sicknesses referred to in the said documents;
- 12.3.5.2.2. costs of medicines not purchased in a pharmacy.

12.3.6. Dentistry services:

12.3.6.1. The insured risk "Dentistry services" covers:

- 12.3.6.1.1. advice, diagnostics and treatment;
- 12.3.6.1.2. oral hygiene services.

12.3.6.2. The insured risk "Dentistry services" does not cover:

- 12.3.6.2.1. non-reimbursable services specified in the insurance program.

12.3.7. Sports services:

12.3.7.1. The insured risk "Sports services" covers:

- 12.3.7.1.1. sports (visits to fitness centre, swimming pool, tennis, squash, aerobics).

12.3.7.2. The insured risk "Sports services" does not cover:

- 12.3.7.2.1. non-reimbursable services specified in the insurance program.

12.3.8. Purchase of optics:

12.3.8.1. The insured risk "Purchase of optics" covers:

- 12.3.8.1.1. purchase of contact lenses, spectacle lenses and spectacle frame, based on prescription issued by the attending doctor.

12.3.8.2. The insured risk "Purchase of optics" does not cover:

- 12.3.8.2.1. non-reimbursable services specified in the insurance program.

13. Compensation Principle

13.1. When the compensation principle is applied, both the insurance indemnity to be paid and the insurance indemnity paid shall not exceed the amount of loss caused in the result of the insured event.

13.2. Only proved losses shall be compensated.

13.3. Any loss incurred before/after the insurance period shall not be compensated.

14. Procedure of Payment of Insurance Indemnity

14.1. The insurer shall pay an insurance indemnity in accordance with the insurance program specified in the insurance policy, not in excess of the insurance amount and/or the insurance limit specified in the insurance policy:

14.1.1. To a contractual organisation, according to a mutual contract.

14.1.2. To the insured person, who has paid for the services received by using own funds, according to the insurance program, or to an authorised representative of the insured person.

14.2. If the insured person has received any service included in the insurance program from an institution other than a contractual organisation of the insurer and if the insurance program of the insured person does not set any restrictions to reception of services from that institution, the insured person shall present all the necessary documents to the insurer according to the procedure set out in these Conditions.

14.3. If the insurer needs any additional documents for establishment of an insured event, the documents shall be requested from the insured person. The insured person shall present the documents requested within 30 (thirty) days as of the date of reception of the request. If the insured person has failed to present the documents requested within the term specified above in this Article, the insurer shall be entitled not to pay the insurance indemnity. In examination of the claim case and decision-making the insurer shall apply the provisions of the Law "On Insurance Contract" and other laws and regulations, which provide for reduction of insurance indemnity in cases when the policyholder has not performed or has partially performed requirements set out in the insurance contract and laws and regulations.

14.4. Upon reception of all the documents required, the insurer shall adopt decision on payment of the insurance indemnity and pay the insurance indemnity in accordance with the existing insurance contract.

14.5. If there is adopted decision on refusal of payment of insurance indemnity, the insurer shall send a motivated written notice to the insured person on the decision adopted.

14.6. For services received in institutions other than contractual organizations, as well as in cases when a service is unavailable at contractual organizations or when full payment for services can not be made, the insured person must make payment from his/her private funds. If the price of medical services received by the insured person exceeds the price of the same services provided by the insurer's contractual organisation, the insurance indemnity shall be paid according to the pricelist approved by the insurer. The price list is applicable also to insurance programs, containing services for which a certain limit is set. The insurer shall ensure availability of the pricelist on the insurer's website www.seesam.lv.

14.7. If the cooperation contract between the insurer and the contractual organisation, as well as the conditions of the insurance contract, envisages payment for services provided, the insured person shall have the right not to pay for the services received, upon presentation of the health insurance card along with a personal identification document. If the insurance program of the insured person envisages a partial payment for the services received, the insured person shall cover the difference between the price specified in the pricelist of the contractual organisation and the part of the price covered by the insurer. If the insurance program of the insured person envisages a deductible for the services received, the amount of the deductible shall be covered by the insured person at his/her own expense

14.8. If the insured person has submitted electronically to the insurer the documents required for receipt of indemnity and if the insured person has failed to submit the original documents upon the insurer's request within the time limit set by the insurer, the insurer shall have the right to require return of the paid indemnity by transferring it within 5 (five) working days to a bank account specified by the insurer.

15. Exceptions

15.1. The insurer shall not be liable to indemnify any losses incurred in the event if the losses have been caused in the result of any exceptions specified in the laws and regulations of the Republic of Latvia or in the insurance contract.

15.2. The insurer shall not pay insurance indemnity for:

15.2.1. Services, upon reception of which provisions and instructions of the Insurance Conditions and the insurance program have not been complied with.

15.2.2. Costs of issue of documents, fees and other similar additional costs.

15.2.3. Medical, health promotion or sports services that are identical by their nature and that have been received by the insured person repeatedly during 24 hours.

15.2.4 Purchase of subscription certificates with payment in arrears

15.2.5. Occasions when the insured has deceived the insurer deliberately by providing false data about his/her health condition.

15.2.6. Expenses associated with departure from the Republic of Latvia or stay abroad.

15.2.7. Expenses incurred in the result of treatment of a disease diagnosed before the effective date of the insurance contract or a chronic disease.

15.2.8. Medical treatment of health problems arisen in the result of professional sports activities.

15.2.9. Treatment of illnesses, traumas and bodily injuries arisen to the insured person when being in the state of intoxication or because of influence of intoxication.

15.2.10. Unconventional methods of medical treatment and diagnostics.

15.2.11. Medical treatment methods which are not registered in the State Register of Medical Technologies.

15.2.12. Social and home care.

15.2.13. Medical transport services upon the patient's request.

15.3. If the insured person before buying an insurance policy was aware of the need for elective surgery or inpatient stay at a hospital, the insurer has the right to refuse to reimburse out-patient and/or hospital costs related to the operation or treatment.

15.4. When entering into the insurance contract, the insurer and the policyholder may agree upon additional exceptions or restrictions as well as upon deletion of any exceptions specified in these Conditions and insurance programs.

16. Procedure of Settlement of Disagreements

16.1. All and any disagreements shall be settled by negotiations.

16.2. If the disagreement has arisen due to the fact that the particular issue is not regulated by the insurance conditions, the particular issue shall be settled in accordance with laws and regulations of the Republic of Latvia.

16.3. If the parties have not settled the dispute by negotiations, the dispute shall be referred to a court of justice of the Republic of Latvia and settled in accordance with the laws of the Republic of Latvia.

16.4. The division of the insurance contract in paragraphs, sub-paragraphs and headings thereof shall not affect legal interpretation of the text.

17. Confidentiality

17.1. Unless the law provides otherwise, the insurer, the insured persons and the policyholder undertake not to disclose, without written consent, to any third parties any information that has become known during the period of validity of the insurance contract or after its expiration. The period of validity of the confidentiality provision shall be unlimited regardless of the validity of this contract. Any information that is publicly available and that has not become publicly available due to any violation of provisions of law or the contract shall not be considered confidential information.

18. Definitions

18.1. **Insurance contract** – an agreement between the insurer and a policyholder according to which the policyholder undertakes the obligation to pay an insurance premium in the form, on the date and in the amounts specified in the contract as well as perform other obligations specified in the contract, but the insurer undertakes the obligation to pay, in the case of occurrence of an insured event, an insurance indemnity to the person specified in the contract according to the conditions of the insurance contract.

18.2. **Insurance policy** – a document certifying conclusion of an insurance contract; it includes the terms and conditions of the insurance contract, the insurance program as well as all and any amendments and supplements to this contract, agreed upon by the insurer and the policyholder during the period of validity of the insurance contract; the insurance policy shall be considered to be an integral part of the contract.

18.3. **Risk insured** – an event envisaged in the insurance contract, the occurrence of which is not dependant on the will of the insured and occurrence of which is possible in the future, when the insured person may incur costs for medical services and/or health promotion services and/or optical products and/or medicines.

18.4. **Insured event** – an event which has a causal relationship with a risk insured and upon occurrence of which the insurance indemnity is due in compliance with the insurance contract.

18.5. **Insurance amount** – an amount of money specified in the insurance policy, which, in the case of occurrence of an insured event during the insurance period, shall be paid out in accordance with the insurance program.

18.6. **Insurance limit** – an amount of money and/or a number of medical services and/or visits specified in the insurance program, up to which the costs of health care services provided to the insured person will be covered in the case of occurrence of an insured event.

18.7. **Insurance premium** – a payment for insurance as stated in the insurance contract.

18.8. **Insurance indemnity** – the insurance amount, a part thereof or any other sum payable for an insured event, or health services to be reimbursed according to the insurance contract.

18.9. **Insurance claim** – a claim for payment of health insurance indemnity; a set of documents established by the insurer, which is to be submitted by the insured person to the insurer in order to receive an insurance indemnity as stated in the insurance contract concluded.

18.10. **Health insurance application** – a set of documents established by the insurer which is to be submitted by the policyholder to the insurer for risk assessment in order to enter into an insurance contract. An insurance application shall not oblige the insurer to enter into an insurance contract.

18.11. **Insurance offer** – a document informing the policyholder on terms and conditions of the insurance contract and/or amendments thereto. The insurer shall prepare insurance contract on the basis of the offer presented.

18.12. **Health insurance card** – a document attesting the fact of insurance and constituting an integral part of the insurance contract. When beginning to use the health insurance card, the insured person undertakes the obligations under the insurance contract.

18.13. E**lectronically prepared invoice** – an invoice for payment of insurance premium; valid without signature and impression of the seal. If the insurance contract envisages a number of payments, the invoice shall contain a payment schedule. New invoice for each payment shall not be issued.

18.14. **Medical institution** – a medical institution or medical practice registered in the Commercial Register of the Register of Enterprises of the Republic of Latvia and/or in the Register of Health Care Institutions, Enterprises, Practices and Certification of the RL, which is engaged in provision of therapeutic and preventive, medical treatment or rehabilitation services.

18.15. **Contractual organisation** – an institution, which provides services to the insured person according to the procedures set out in the laws and regulations of the Republic of Latvia and which has entered into a cooperation agreement with the insurer on provision of services under an insurance program.

18.16. **Deductible** – a part of loss specified in the insurance policy, which is expressed as an amount of money or a percentage and which in the case of occurrence of an insured event shall be covered by the policyholder or the insured person.

18.17. **Sudden illness** – previously not present, unpredictable, sudden and sharp deterioration of health state during the insurance period, is not continuation or a consequence of the health state as it was prior to commencement of the insurance period.

18.18. **Chronic disease** – state of health opposite to sudden illness - progressing deterioration of the body's physiological processes and functions having been formed internally and in a longer period of time, which is characterized by more frequent or less frequent rapid changes of the health state (exacerbation of the disease), regardless of whether such a medical condition has or has not been diagnosed before the commencement of the insurance period.

18.19. Exacerbation of chronic disease – sudden appearance of symptoms which are typical for a chronic disease and which did not appear before commencement of the insurance period, and which have resulted in necessity of medical assistance to the insured person.

18.20. **Emergency medical assistance** – medical services, which must be urgently provided to the insured person due to acute deterioration of his/her state of health in connection with a sudden illness or accident, in order to prevent further sharp deterioration of the insured person's health and / or a threat to the life of the insured person.

18.21. **Emergency surgery** – an operation to be carried out no later than 24 hours after occurrence of a sudden illness or an injury caused in the result of an accident.

18.22 **Additional conditions** – conditions agreed upon individually by and between the insurer and a policyholder that are binding upon the insurance contract concluded and specified in the insurance policy.

18.23. **Duplicate card** – issue of a new health insurance card upon request of the insured person.

18.24. **Initial medical consultation** – a visit to a physician in connection with a sudden illness.

18.25. **Repeated medical consultation** – a repeated visit to the physician in the course of one and the same illness, in connection with one and the same diagnosis.

18.26. **Professor or a highly qualified specialist** – a physician who has obtained additional qualifications in his/her medical activities and who is practising as a profesor, associate profesor or department head in the particular medical institution.