These insurance terms and conditions are subject to the law of the Republic of Latvia. Only the Latvian wording is binding. This translation is provided for information purposes only.

Health Insurance Conditions for Legal Entities

I Terms Used in the Conditions

1.1. EMPLOYEE – an employee of the policy holder who the policy holder has entered into an employment contract with and who the policy holder pays taxes on.
1.2. INSURED – a natural person with the insured interest and for the benefit of whom a health insurance agreement is entered into by and between the insurer and the policyholder, under which costs of medical services are covered upon occurrence of the insured event within the framework of the insurance program specified in the agreement.
1.3. INSURANCE APPLICATION - a set of documents specified by the insurer that the policy holder shall submit to the insurer for the purposes of advising on facts necessary for the risk assessment.
1.4. INSURANCE PROGRAM – a set of insurance services intended for the insured risk indicated in the insurance policy and/or a percentage of the medical service costs covered by the insurer in the case of the insured event.
1.5. SUM INSURED – an amount of money specified in the insurance policy for which the health of each insured person has been insured in line with the insured risk specified in the policy and within the limits of which the indemnity is disbursed upon occurrence of the insured event.
1.6. LIMIT – an amount of money set either within the insurance program or equal to the payable amount, or the number of medical services according to the risk indicated in the policy for which the indemnity is disbursed in the case of the insured event.
1.7. MEDICAL SERVICES – services provided by the medical institution to the insured in accordance with the insurance program.
1.8. TREATMENT COSTS – costs of medical services at a medical institution according to the insurance program.
1.9. MEDICAL INSTITUTION – a medical institution or doctors' practice registered in the Register of Health Care Institutions, Companies and Practices of the Republic of Latvia, engaged in provision of preventive, treatment and rehabilitation assistance, as well as pharmacies and optician's offices that operate in the territory of the Republic of Latvia as provided for by laws and regulations, and sports institutions that provide services of improvement and prevention of the health condition. Sole traders or persons operating in the status of the self-employed that provide services of the improvement and prevention of the health condition are not defined as sports institutions for the purposes of these Conditions.
1.10. CONTRACTING ORGANISATION – a medical institution who has entered into an agreement with the insurer for the scope of particular services and in the case of the insured event provides medical services to the insured persons within the framework or in the scope of the insurance program agreed on with the insurer. The insurer covers the costs of the medical services provided to the insured persons at the contracting organisation. The updated list of contracting organisations is published on the Internet homepage www.balta.lv.
1.11. MAXIMUM COVER – a list of medical services determined by the insurer quoting the maximum cover determined by the insurer (for the particular service).
1.12. CARD – an individual health insurance card modelled by the insurer that is issued to the insured and that certifies the validity of the insurance agreement with respect to the insured. The insured shall produce the card together with a personal identification document upon receiving medical services at contracting organisations.
1.13. INSURED RISK – an event that is possible to occur in the future and cause medical treatment costs to the insured.

II General Provisions

2. General Provisions

2.1. The insurer enters into an insurance agreement with the policy holder according to these Conditions for the insurance of the health of natural persons – employees.
2.2. Any natural person who is a national or permanent resident of the Republic of Latvia or a person holding a permanent residence permit in the Republic of Latvia may be the insured, provided the insurer and the insured have agreed so.
2.3. The insurance is valid in the territory of the republic of Latvia.
2.4. The sum insured is determined separately for each insurance program and indicated in the insurance policy.
2.5. It is deemed the insured event if the insured received medical services during the insured period and the insurer has the obligation to cover the medical costs under the insurance program and these Conditions.

2.6. The principle of compensation is applied to the payment of medical costs of the received medical services in health insurance, whereby the indemnity is disbursed to the contracting organisation, the insured or his or her authorised representative.
2.7. The validity of the health insurance card expires upon submission thereof to the insurer.

III Entering into the Insurance Agreement

3. Elements of the Insurance Agreement

3.1. Before entering into the insurance agreement the policy holder completes the insurance application or provides the information necessary for the assessment of the insured risk in another format requested by the insurer. The insurance application does not oblige the insurer or the policy holder to undertake any obligations.
3.2. The insurance agreement consists of:
- 3.2.1. a written application by the policy holder (risk assessment questionnaire, list of the insured persons, etc.);
- 3.2.2. health insurance policy;
- 3.2.3. General Insurance Conditions, Health Insurance Conditions for Legal Entities;
- 3.2.4. special conditions, where the parties have agreed so;
- 3.2.5. the insurance program(s) and maximum covers, where appropriate;
- 3.2.6. the card(s), except where the parties have agreed not to issue the cards;
- 3.2.7. Annex on the processing of sensitive personal data;
- 3.2.8. all amendments and supplementations to the agreement that the insurer and the policy holder have agreed on during the validity of the insurance agreement.

IV Rights and Obligations

4. Rights and obligations of the insurer

4.1. The insurer shall disburse the indemnity upon occurrence of the insured event as provided for by the executed insurance agreement, in accordance with the procedure stipulated in Chapter V of these Conditions.
4.2. The insurer may recover from the insured and/or the policy holder the following amounts disbursed to the contracting organisation:
- 4.2.1. that exceed the sum insured;
- 4.2.2. that exceed the limit;
- 4.2.3. for receipt of a medical service that is not specified under the insurance program;
- 4.2.4. for receipt of a medical service after the termination of the validity of the individual health insurance card.

4.3. The insurer may exercise the right of unilaterally changing the medical institutions included in the list of contracting organisations.

5. Obligations of the policy holder

5.1. The policy holder shall:
- 5.1.1. issue cards (provided there are any) to the insured and inform the insured of that he or she has been insured and familiarise him/her with the insurance program and conditions. Otherwise the policy holder shall be liable for the consequences of failure to inform and shall bear the costs incurred by the insured as a result of not being informed;
- 5.1.2. submit changes in the list of insured persons to the insurer in writing;
- 5.1.3. return the health insurance card of the insured to the insurer after the insured is excluded from the list of insured persons;
- 5.1.4. before the due date indicated in the invoice issued by the insurer repay to the insurer the amount of money for which the insured has received medical services:
  - 5.1.4.1. if the sum insured has been exceeded;
  - 5.1.4.2. if the limit has been exceeded;
  - 5.1.4.3. if a medical service that is not specified under the insurance program has been received;
  - 5.1.4.4. if a medical service has been received after the termination of the validity of the card.

5.2. In the case of a dispute regarding the insured's correspondence to the status of the employee, upon a written request by the insurer the policy holder shall provide information to confirm that the tax payments specified by the laws and regulations of the Republic of Latvia have been made for that employee.

6. Rights and obligations of the insured

6.1. The insured shall:
- 6.1.1. care for the maintenance of his or her health;
- 6.1.2. become familiar with the information indicated in Clause 5.1.1;

6.1.3. comply with the directions of the attending physician in the case of the insured event;
6.1.4. not permit another person to have the possibility to use his or her card – such conduct is qualified as fraud;
6.1.5. return the card to the policy holder or the insurer upon being excluded from the list of insured persons;
6.1.6. monitor one's medical costs so that the sum insured and/or the limit is not exceeded;
6.1.7. before the due date indicated in the invoice issued by the insurer repay to the insurer the amount of money for which the insured has received medical services:
6.1.7.1. if the sum insured has been exceeded;
6.1.7.2. if the limit has been exceeded;
6.1.7.3. if a medical service that is not specified under the insurance program has been received;
6.1.7.4. if a medical service has been received after the termination of the validity of the card.
6.1.8. Should the card be lost or stolen, the insured shall notify the policy holder or the insurer as soon as possible. If the insured loses the card, it becomes invalid. In such case the insurer issues a duplicate on the basis of a written application by the policy holder or the insured.

6.2. During the insured period the insured may receive medical services at a medical institution that is not the contracting organisation of the particular insurance program, provided the insurance program permits such option. The insured covers the received medical services at his or her own expense during the insured period and as soon as possible, but not later than within 30 days after the expiry of the agreement submits the indemnity claim and other documents indicated in Clause 8.

6.3. The insured shall be liable for the accuracy of the data when submitting the original payment documents to the State Revenue Service (SRS) for the receipt of the compensation of eligible costs for medical services.

6.4. The insured certifies with his or her signature that he or she authorises the insurer to process and use the person's sensitive data and agrees to the examination conducted by an expert physician chosen by the insurer for conducting of an examination of the health condition in relation to the insured event. This authorisation is arranged as an annex on processing sensitive personal data appended to the policy.

6.5. Where the indemnity claim and other documents necessary to receive the indemnity are submitted electronically in the insurer's Internet homepage www.balta.lv, the insured shall store the respective original documents for 3 years after the receipt of the service and to produce such original documents upon a written request by the insurer.

V The Indemnity

7. Applying for the indemnity

7.1. The indemnity claim may be made:
7.1.1. by the insured, his or her authorised representative or statutory representative:
7.1.1.1. at the insurer's office;
7.1.1.2. by sending a mail;
7.1.2. exclusively by the insured – electronically on the Internet homepage www.balta.lv;

7.2. The following documents shall be submitted to receive the indemnity:
7.2.1. the application for indemnity claim, except when the indemnity is claimed electronically;
7.2.2. an excerpt from the out-patient's and/or in-patient's medical record that proves the received medical services and presents the full diagnosis, the treatment, progress of treatment, results of tests affirming the diagnosis;
7.2.3. financial documents confirming the treatment costs with accurate indication of the service recipient, the name, quantity and price of the service (goods);
7.2.4. other documents requested by the insurer related to the occurrence of the insured event and determining of the indemnity;
7.2.5. where the indemnity is received by the authorised representative of the insured – a notarised Power of Attorney;
7.2.6. where the indemnity is received by the statutory representative (the father, mother or custodian of a minor insured) – a copy of the child's birth certificate.

8. Disbursement of the indemnity

8.1. The insurer disburses the indemnity:
8.1.1. to the contracting organisation – according to the mutually executed agreement;
8.1.2. to the insured or his or her authorised representative, who has covered the costs of medical services at his or her own expense in accordance with the insurance program;
8.1.3. to the statutory representative of an insured child, who has covered the costs of medical services provided to the child at his or her own expense in accordance with the insurance program;

8.2. If the insured covered at his or her own expense services determined in the program at a medical institution that is not the contracting organisation of the respective insurance program or services that are not included in the list of services covered by the insurer at the contracting organisation, and provided the insurance program includes such option, the indemnity shall be disbursed to cover the actual costs, but not exceeding the maximum cover/payable amount for the respective medical service.
8.3. If the price of the medical service at the medical institution exceeds the payable amount determined by the insurer, the insured shall cover the difference at his or her own expense.
8.4. The total disbursable indemnity for one or several insured events within the validity of the insurance agreement shall not exceed the sum insured of the insurance program. After the disbursement of the indemnity the agreement shall remain effective with respect to the remaining difference between the initial sum insured and the disbursed indemnity.
8.5. The insurer shall pass the decision regarding the disbursement of the indemnity or refusal to disburse the indemnity within 7 working days after the date of receiving of all necessary documents. If the insurer is unable to comply with this term due to objective reasons the insurer may extend the same for a period not exceeding six months from the date of receipt of the indemnity claim, by notifying in writing the person entitled to the indemnity.
8.6. The insurer may refuse to disburse the indemnity if the policy holder or the insured fails to perform any obligations under these Conditions or the agreement entered into between the policy holder and the insurer, either in bad faith or due to negligence.

9. Exceptions

9.1. The indemnity will not be disbursed if the medical costs are incurred as a result of the following:
- 9.1.1. the insured participated in war or military hostilities similar to war, operations of any military organisation, due to terrorism or civil disturbance;
- 9.1.2. radioactive poisoning, radioactive pollution, Acts of God;
- 9.1.3. the insured treated himself or herself using medicines or narcotic substances where use thereof was not prescribed from a medical viewpoint or the physician did not prescribe such;
- 9.1.4. the insured event was a result of using of alcoholic, toxic, narcotic or other intoxicating substances;
- 9.1.5. the insured himself or herself consciously caused harm to his or her health;
- 9.1.6. the insured committed a criminal offence or participated in committing thereof and was found guilty.

9.2. The health insurance does not cover:
- 9.2.1. costs of services indicated as non-eligible under the relevant insurance program;
- 9.2.2. royalties;
- 9.2.3. diagnosis and treatment of sexually transmitted diseases, contracting AIDS and carrying the HIV, diagnosing and treatment thereof;
- 9.2.4. diagnosis and treatment of avian and swine influenza;
- 9.2.5. genetic tests;
- 9.2.6. pregnancy care agreements;
- 9.2.7. pre-surgery and post-surgery care agreements;
- 9.2.8. plastic surgery;
- 9.2.9. conservative and surgical (bariatric) treatment methods in patients with pathological obesity, incl. gastroplastic;
- 9.2.10. an individual room at hospital;
- 9.2.11. organ transplantation operations;
- 9.2.12. staying of a relative or a close person in hospital;
- 9.2.13. social care, care at home;
- 9.2.14. educational informative classes and lectures;
- 9.2.15. tissue substitute materials, expanders, prostheses, implants, medical equipment;
- 9.2.16. out-patient and in-patient services at institutions not registered in the Register of Medical Institutions and Certifications of the Republic of Latvia.