BALTIJAS APDROŠINĀŠANAS NAMS

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TERMS AND CONDITIONS OF HEALTH INSURANCE NO 08.02.

Translation from Latvian to English.
Text in Latvian has priority to this translation.

1. TERMS AND DEFINITIONS

1.1. **Insurer** – „Baltijas Apdrošināšanas Nams" joint-stock insurance company.

1.2. **Policy holder** – the legal person which signs the insurance contract for the benefit of a natural person.

1.3. **Insured interest** – the interest of the insured person not to suffer losses when an insured event occurs.

1.4. **Insured person** – the natural person referred to in the insurance policy who has an insured interest and for whose benefit the insurance contract has been signed. The Insured person is the Policy holder's employee or a relative of the Policy holder's employee.

1.5. **Employee** – the Policy holder's employee with whom the Policy holder has signed a contract of employment, to whom the Policy holder pays a salary pursuant to the contract of employment and for whom the Policy holder pays taxes set forth in regulatory enactments.

1.6. **Relative** – the Insured person's spouse, children (children under the age of majority and dependent grown-up children at the age of 18-25 years) and parents.

1.7. **Insurance premium** – the insurance payment set out in the Insurance contract.

1.8. **Insurance amount** – the maximum amount of money set out in the Insurance policy which the Insurer may use to pay for the services received by the Insured person within the selected insurance programme.

1.9. **Insurance limit** – in the insurance programme indicated amount of money and/or the number of services and/or visits , within the limit of which, upon occurrence of insurance event, costs of services included in the Insured person's insurance programme are paid.

1.10. **Insurance period** – the validity period of the Insurance contract which is set out in the Insurance policy. For those insured persons added to the list of insured persons during the validity period of the Insurance contract, the Insurance period starts on the date set out in the annex of the Insurance contract and ends when the Insurance policy expires.

1.11. **Insurance indemnity** – the amount of money to be paid or services to be delivered for an insured event under the Insurance contract signed.

1.12. **Insured event** – an unforeseen event having occurred during the Insurance period regardless of the Insured person's will, consequential to insured risks at the occurrence of which the payment of the insurance indemnity in accordance with the Insurance contract and the Insurance programme is provided.

1.13. **Insurance contract** – an agreement between the Insurer and the Policy holder, under which the Policy holder undertakes the obligation to pay the Insurance premium in the way, terms and amount set out in the Insurance contract, as well as to fulfil other obligations set out in the Insurance contract, and the Insurer undertakes an obligation to pay an insurance indemnity to the Insured person referred to in the Insurance contract when an insured event occurs, pursuant to the Insurance contract and the insurance programmes selected.

1.14. **Health insurance application** – the document set by the Insurer which the Policy holder submits to the Insurer to inform the latter about the facts needed to evaluate risks and sign the insurance contract. The health insurance application does not oblige the Insurer to sign the Insurance contract.

1.15. **Insurance indemnity request** – the document set by the Insurer which the Insured person submits to the Insurer together with payment documents and medical documentation confirming the Insurance indemnity to receive the Insurance indemnity pursuant to the Insurance contract signed.

1.16. **The Insurance policy** – the document which confirms the conclusion of the Insurance contract and includes terms and conditions of the Insurance contract, terms and conditions of the insurance programme (-s) and all annexes, amendments and supplements of the Insurance contract on which the Insurer and the Policy holder have agreed.

1.17. **Insurance card** – a plastic card of standard pattern issued to the Insured person which confirms that the Insured person's health is insured.

1.18. **Medical institution** – medical practices, state and municipal institutions, commercial companies which are registered in the registry of medical institutions of the Republic of Latvia, conform to the mandatory requirements set out for medical institutions and their structural units in regulatory enactments of the Republic of Latvia and deliver medical services.

1.19. **Medical services** – services which the Insured person has received in a medical institution and which have been delivered by a person having received a certificate for practice in a certain speciality. As medical services are considered the medical methods registered in the Republic of Latvia database of medical technologies which are used for therapy.

1.20. **Contracted institution** – a medical institution, pharmacy or another legal entity with which the Insurer has signed a cooperation contract on the delivery of services included in Insurance programmes to insured persons pursuant to the mutually signed contract.

1.21. **Sudden illness** – with no prior signs, unforeseeable and unexpected worsening of health condition during the Insurance period, which did not occur previously and is not a continuation or consequence of the health condition which existed before the Insurance period.

1.22. Initial acute exacerbation of a chronic disease – a sudden and first appearance of symptoms typical to a chronic disease that did not manifest before the start of the Insurance period, as a result of which the Insured person has an urgent need for medical services.

1.23. **Chronic disease** – a condition opposite to a sudden disease – gradual deterioration of physiological processes and functions in the organism over a longer period of time, which is characterized by more or less frequent sudden changes of health condition (acute exacerbation of a disease).

2. GENERAL INSURANCE

2.1. The Insurer signs an Insurance contract with the Policy holder for health insurance pursuant to these terms and conditions, the Law on Insurance Contract and other regulatory enactments of the Republic of Latvia.

2.2. The Insurance contract is valid in the territory of the Republic of Latvia, for the period set out by the Insurance contract, 24 hours a day, 7 days a week.

2.3. Any paragraph hereof may be amended, excluded or supplemented in writing by mutual agreement between the Policy holder and the Insurer.

2.4. The terms and conditions of the Insurance contract are binding on and apply to all the parties involved in the Insurance contract – the Insurer, the Policy holder and the Insured person.

3. INSURED OBJECT AND INSURANCE PROGRAMMES

3.1. The Insured object is the Insured person's health.

3.2. An Insurance programme includes services which, in accordance with conditions mentioned in insurance contract, may be received in medical institutions, pharmacies, optics institutions or sports institutions registered in the registry of sports centres.

3.3. Services which may be included in the Insurance programme:

3.3.1. **the patient fee** is the patient's payment set in the country, which a medical institution collects from a patient for a medical service delivered within the minimum of health care services:

3.3.1.1. services provided for patient fee are available at those institutions having signed contracts with the National Health Service (NVD);

3.3.1.2. the amount of the patient fee is set out in Annexes No. 1 and 2 of Cabinet of Ministers regulations No.1046 „The Order of Organising and Funding Health Care";

3.3.1.3. the patient fee does cover chargeable medical services (services which are not paid from the state budget).

3.3.2. **Chargeable medical out-patient services** are services received by the Insured person in out-patient institutions (polyclinic, health centre, out-patient department or reception of a hospital, etc.), without staying in an in-patient medical institution, and which are not paid from the state budget:

3.3.2.1. the following chargeable out-patient services are paid:

3.3.2.1.1. consultations and manipulations of a doctor;

3.3.2.1.2. instrumental or other types of diagnostic or laboratory examinations prescribed by a doctor;

3.3.2.1.3. mandatory health check-ups;

3.3.2.1.4. charges of drawing up medical certificate;

3.3.2.1.5. vaccination;

3.3.2.1.6. out-patient rehabilitation procedures and physiotherapeutic procedures;

3.3.2.1.7. emergency medical aid;

3.3.2.1.8. medical services received in the process of treating a chronic disease or an acute exacerbation of a chronic disease;

3.3.2.2. the following chargeable out-patient services are not paid:

3.3.2.2.1. non-payable services and cases referred to in Paragraph 9 hereof and in the insurance programme.

3.3.3. **Chargeable medical in-patient services** are services received by the Insured person in in-patient institutions (including day patient department) and which are not paid from the state budget:

3.3.3.1. as part of chargeable in-patient services, medical expenses are paid in case of a sudden illness or an initial acute exacerbation of a chronic disease, i.e.:

3.3.3.1.1. surgical operations;

3.3.3.1.2. staying in hospital, including in enhanced comfort conditions;

3.3.3.1.3. medical manipulations, laboratory, instrumental and other types of diagnostic examinations;

3.3.3.2. the following services are not paid as part of in-patient services:

3.3.3.2.1. services, the delivery of which the Insured person has not agreed with the Insurer, if such an agreement is provided for by the Insurance programme;

3.3.3.2.2. costs of choosing the treating doctor or another medical person (additional costs according to the medical institution's pricelist, in cases where the Insured person wants to be treated by a certain medical person and medical institution collects an additional charge for such choice);

3.3.3.2.3. costs of treating chronic diseases, as well as injuries received before the Insurance period;

3.3.3.2.4. non-payable services and cases referred to in Paragraph 9 hereof and in the insurance programme.

3.3.4. **Dentistry:**

3.3.4.1. the following services are paid as part of the „Dentistry" service:

3.3.4.1.1. consultations and X-rays diagnostics, emergency aid in case of acute tooth ache, therapeutic and surgical services;

3.3.4.1.2. dental hygiene services;

3.3.4.1.3. dental prosthetics and orthodontic services;

3.3.4.2. the following services are not paid as part of the „Dentistry" service:

3.3.4.2.1. non-payable services and cases referred to in Paragraph 9 hereof and in the insurance programme.

3.3.5. **Medicines:**

3.3.5.1. the following is paid as part of the „Medicines" services:

3.3.5.1.1. costs of buying medicines, vitamins and food supplements registered in the Republic of Latvia Drug Register;

3.3.5.2. the following is not paid within the „Medicines" services:

3.3.5.2.1. non-payable medicines and costs of buying medicines referred to in the Insurance programme, buying of which was necessitated by cases referred to in Paragraph 9 hereof or which are provided for the treatment of diseases specified in Paragraph 9.

3.3.6. **Optics:**

3.3.6.1. the following is paid within the „Optics" service:

3.3.6.1.1. purchase of optical glasses, frames, contact lenses, based on a prescription written by a medical specialist;

3.3.6.2. the following is not paid within the „Optics" service:

3.3.6.2.1. services which are referred to in the Insurance programme as non-payable.

3.3.7. **Sports:**

3.3.7.1. the following is paid within the „Sports" service:

3.3.7.1.1. costs of training in a gym, aerobics, yoga, pilates, tennis, squash, visits to a swimming pool;

3.3.7.1.2. gym subscription;

3.3.7.2. the following is not paid within the „Sports" service:

3.3.7.2.1. non-payable services and cases referred to in Paragraph 9 hereof and in the insurance programme.

4. SIGNING, COMING INTO FORCE AND VALIFITY PERIOD OF THE INSURANCE CONTRACT

4.1. The Insurance contract is signed on the basis of the Policy holder's health insurance application and the information about the insurable risk it contains, and on the basis of health insurance offer issued by the Insurer.

4.2. The Insurance contract is signed for a period of 1 (one) year, except for cases when the Insurer and the Policy holder have agreed on another period of the Insurance contract.

4.3. The Insurance contract is valid during the period set out in the Insurance policy, if the Policy holder has paid the Insurance premium or its first part (in cases where the Insurance premium is divided into several parts) until the date set out in the Insurance policy.

4.4. If the Policy holder has not paid the Insurance premium or its first part (in cases where the insurance premium is divided into several parts) until the date set out in the Insurance policy, the Insurance contract is not valid from the moment of its conclusion.

4.5. The Insurance premium or its part is to be paid not later than on the dates set out in the Insurance policy.

4.6. If a regular part of the insurance premium, except for the first one, is not paid within the time limits set out in the Insurance policy, the Insurer has the right to terminate the Insurance contract in accordance with the procedure set forth in the Law on Insurance Contract.

4.7. If the Insurance premium is paid by bank transfer, as the date of payment is considered the date when the Insurer received the insurance premium in its designated bank account.

4.8. The Insurer or the Policy holder may terminate the Insurance contract by mutual agreement in cases and according to the procedure established by regulatory enactments of the Republic of Latvia.

4.9. The Insurer calculates the part of the insurance premium due for the unused validity period of the Insurance contract within 45 (forty-five) days upon the expiry date of the Insurance contract, separately for each insured person and pursuant to the terms and conditions of the Insurance contract.

4.10. If the Insurance contract is terminated before the set date, the administrative expenses related to the contract conclusion in the amount of up to 25% (twenty-five percent) of the Insurance premium are deducted.

5. OBLIGATIONS AND RIGHTS OF THE POLICY HOLDER

5.1. To provide the Insurer with full and true information for the evaluation of risks.

5.2. To pay the Insurance premium in the form, amount and time set out in the Insurance policy. The Policy holder has to effect Insurance premium payments on a regular basis and according to the time schedule set out in the Insurance policy, regardless of whether the bill is received or not.

5.3. To submit the list of persons to be insured to the Insurer in due time.

5.4. To fulfil all the conditions of the Insurance contract.

5.5. To inform immediately the Insurer in writing about any changes in the information provided in the health insurance application.

5.6. To submit any information and/or requests in writing.

5.7. To inform the Insured persons that they are insured, to familiarize them with Insurance programmes, insurance conditions, terms of receiving services, as well as other conditions which are referred to in the Insurance contract and are binding to the Insured persons. The Policy holder explains to the Insured persons their rights, obligations and liabilities to the Insurer.

5.8. To hand over for the Insured person's use the insurance card, as well as other documents and information which the Insurer has prepared for the Insured persons.

5.9. To hand over immediately to the Insurer the Insured person's Insurance card where the Insurance contract has not come into force or has been terminated, as well as in cases where a new card is manufactured in the event of changes or a mistake in Insured person's data.

5.10. To submit, at the Insurer's request, a completed health declaration for the insurable/Insured person concerned.

5.11. To ensure for the Insurer the possibility of verifying the information provided about risks to be insured, to present immediately, at the Insurer's request, documents which confirm that taxes set forth in the regulatory enactments of the Republic of Latvia have been paid for the employee.

5.12. At the Insurer's request, to repay the amounts referred to in Paragraphs 6.9 and 6.16 to the Insurer, if the Insured person has not repaid it himself/herself on the set date.

5.13. The Policy holder has an obligation to inform the Insurer, if the Insurance premium due for the Insurance policy is not fully or partly paid from the Policy holder's finances and/or the Insurance premium is fully or partly paid from the Insured persons' finances (including the deduction of certain amounts from salaries).

5.13.1. The Insurer does not have an obligation to check whether the Insurance premium is fully or partly paid from the Policy holder's finances, as well as whether the insurance premium is fully or partly paid from the Insured persons' finances (including the deduction of certain amounts from salaries).

5.14. The Policy holder has the right to receive the unused Insurance premium, which is calculated in conformity with the Insurance contract.

5.15. The Policy holder has the right to make changes in the list of Insured persons in conformity with the Insurance contract signed.

6. RIGHTS AND OBLIGATIONS OF THE INSURED PERSON

6.1. The Insured person has the right to receive services pursuant to the Insurance contract signed by the Policy holder and the Insurer.

6.2. The Insured person has the right to submit a written claim on the decision taken by the Insurer in the indemnity case.

6.3. To fulfil the Insurance contract signed and enable the Insurer to exercise the rights provided for by the Insurance contract, the Insured person has an obligation to provide the Insurer with true and full information, as well as to authorize the Insurer in writing to use the Insured person's personal data, including sensitive personal data.

6.4. The Insured person has an obligation to allow the Insurer to get familiar with all the documents being at the medical institution, pharmacy or sports institution, which are or may be related to the declared insurance event. If the Insured person does not fulfil this requirement, as a result of which the possibility for the Insurer to clarify the circumstances of the event to which the insurance indemnity request received applies or the amount of the insurance indemnity to be paid is hindered or becomes impossible, the Insurer has the right not to pay the Insurance indemnity.

6.5. The Insured person has an obligation to submit all the documents requested by the Insurer, which the Insurer needs for settlement of insurance indemnity and/or for evaluation of the insured event.

6.6. The Insured person has an obligation to get familiar with the insurance conditions, Insurance programmes and all terms and conditions of the Insurance contract which concern the Insured person before receiving the service and observe them.

6.7. The Insured person has an obligation to follow that insurance amounts and insurance limits are not exceeded when receiving the services included in the Insurance programme.

6.8. The Insured person has an obligation to present the insurance card together with an identification document when receiving services at the Insurer's contracted institutions.

6.9. If the Insured person has handed his/her insurance card over to another person and, using the card, this person tried to receive or has received services in a medical institution, pharmacy or sports institution, the Insurance contract with regard to this Insured person is terminated on the day when the attempt to receive services was made, or, if the services have been received, at the moment of receiving the services. The Insured person has an obligation to immediately compensate the losses which the Insurer has suffered due to above activities.

6.10. The Insured person has an obligation to take care of his/her health and follow all the recommendations given by the medical person.

6.11. If the insurance card is lost, the Insured person has an obligation to inform the Insurer about the loss as soon as possible. The Insurance card is restored after receiving written information from the Insured person, with deduction of administrative costs provided by the contract. The administrative costs are not deducted if the Insured person presents a police certificate confirming that the insurance card was stolen.

6.12. The Insured person has an obligation to ensure the storage of electronically issued original payment documents during 3 (three) years after their presentation to the Insurer and to present these documents to the Insurer within 5 working days at the Insurer's request.

6.13. If the Insured person has also received a compensation for services fully or partly paid by the Insurer, the Insured person has an obligation to repay to Insurer the Insurance indemnity paid by the latter.

6.14. The Insured person has an obligation to submit, without delay, as soon as possible, to the Insurer the Insurance indemnity request together with payment documents, medical documentation confirming the Insurance indemnity, as well as other documents requested by the Insurer. If the above documents are submitted after more than 3 (three) months from receiving the service or after more than 30 (thirty) days from the end of the Insurance period, the Insured person has to prove that it was impossible to submit the documents earlier, otherwise the Insurer has the right to refuse to pay the Insurance indemnity.

6.15. To submit the Insurance card to the Insurer in cases where it expires before the set date.

6.16. The Insured person has an obligation, within 30 (thirty) days from the moment of receiving a written claim from the Insurer, to repay the Insurer the amount of money which the Insurer has paid to the Contracted institution or the Insured person:

6.16.1. for the services which the Insured person has received after the termination of the Insurance contract;

6.16.2. for the services which the Insurer has not to pay for under the Insurance contract signed;

6.16.3. has exceeded any of the insurance limits set out in the Insurance programme or the total Insurance amount – in the amount by which any of the insurance limits or the total insurance amount has been exceeded.

7. RIGHTS AND OBLIGATIONS OF THE INSURER

7.1. The Insurer has an obligation to pay the insurance indemnity in conformity with the Insurance contract signed between the Policy holder and the Insurer, when the Insured event occurs.

7.2. The Insurer has an obligation, at the request of the Insured person or the Policy holder, in conformity with their rights, to provide information about spent and remaining insurance limits, as well as to issue certified copies of receipts, with the Insurer's reference to the amount which the Insurer has paid for the service indicated in the receipt.

7.3. The Insurer has the right to verify how and whether the Insured person or the Policy holder has observed the conditions of the Insurance contract.

7.4. The Insurer has the right to verify the information provided by the Insured person and, prior to taking a decision in the indemnity case, to get familiar with all the documentation being at the disposal of the medical institution, medical person, pharmacy or the sports institution which may be related to the declared Insurance case, as well as in case of questions to refer the Insured person to a certified medical specialist for a health check.

7.5. The Insurer has an obligation not to disclose the Insured person's sensitive data, except for the cases provided for by regulatory enactments of the Republic of Latvia.

7.6. The Insurer has an obligation, in case of signing the Insurance contract, to issue to the Policy holder the package of the documents which make an integral part of the Insurance contract.

7.7. The Insurer has an obligation to restore the insurance card within 5 (five) working days from the day of receiving the request and the payment provided for by the Insurance contract.

7.8. The Insurer has the right to change, during the Insurance period, the list of contracted institutions, as well as to change the procedure of paying the services and/or set other restrictions for receiving services in the contracted institutions, without notifying the Insured person or the Policy holder.

7.9. The Insurer has the right, by mutual agreement with the Policy holder, to request the payment of an additional insurance premium and/or to change the services included in the Insurance programme, if during the Insurance period changes are made in the regulatory enactments of the Republic of Latvia, which directly affect the costs of

services, and/or there have been changes regarding services paid by the state. In case no mutual agreement is reached, the Insurer has the right to terminate the existing Insurance contract.

7.10. The Insurer takes over from the Insured person the right of claim against the person guilty of causing damage in the amount of the insurance indemnity paid.

7.11. The Insurer has the right to ask the repayment of the paid amount from the Insured person or the Policy holder in cases specified by Paragraphs 6.9, 6.16.1, 6.16.2 and 6.16.3 hereof.

7.12. The Insurer has the right to obtain and use the Insured person's data, including sensitive data, in the process of implementing the Insurance contract.

8. INSURANCE INDEMNITY

8.1. When the Insurance indemnity is paid to a Contracted institution, the Insured person or his/her authorized representative, the principle of compensation is applied. Only confirmed expenses are compensated. Costs incurred before or after the Insurance period are not compensated.

8.2. The Insurer pays the Insurance indemnity to the Contracted institution for the service it has delivered to the Insured person, pursuant to the co-operation contract mutually signed.

8.3. If the Insured person has received a service included in the Insurance programme in an institution which is not the Insurer's Contracted institution, or the Insured person used personal finances to pay for the service in the Contracted institution, as well as in case where a full payment of the service is not available in the Contracted institution, the Insurance indemnity is paid to the Insured person or his/her authorized representative.

8.4. The Insurance indemnity is calculated in conformity with the selected Insurance programme, terms and conditions of the Insurance contract and the price list set by the Insurer for the payment of services delivered outside Contracted institutions.

8.5. To receive the Insurance indemnity, the Insured person has to submit the following documents:

8.5.1. an Insurance indemnity request;

8.5.2. a receipt of electronic cash register or a controlled accountancy receipt, which contains the following information:

8.5.2.1. the name, registration number, and legal address of the service provider;

8.5.2.2. the name, surname, and identity number of the service recipient;

8.5.2.3. detailed description of the service, its price and the date when the service was delivered;

8.5.3. medical documentation confirming the Insurance indemnity:

8.5.3.1. an extract from medical records or/and a referral indicating the diagnosis, treatment used and examinations performed, which confirms determined diagnosis – if chargeable out-patient or in-patient services, out-patient or in-patient rehabilitation was received;

8.5.3.2. a copy of prescription – if medicines or optical goods have been purchased;

8.5.3.3. an extract from medical records indicating the diagnosis or medical manipulations performed – if dentistry services have been received;

8.5.3.4. a copy of the gym subscription or gym subscription card indicating the number of visits to the gym and the precise name of services received– if sports services have been received;

8.5.4. other documentation requested by the Insurer to evaluate whether an Insured event has occurred.

8.6. If not all the documents necessary for taking the decision have been submitted to the Insurer or additional documents are required, these are requested from the Insured person. The Insured person has to submit the requested documents within 30 (thirty) days upon receiving the request. In cases where the Insured person does not fulfil this condition, the Insurer has the right to reduce the amount of payable Insurance indemnity or refuse to pay the Insurance indemnity at all.

8.7. After receiving all the necessary documents, the Insurer takes the decision to pay or to refuse to pay the Insurance indemnity within the time limit set out by the Insurance policy.

8.8. If the Insurer has decided to refuse to pay the Insurance indemnity, it sends a motivated written statement to the Insured person about the decision taken, using the information given by the Insured person. The Insurer has the right to send such a statement to the e-mail address given by the Insured person.

8.9. If the Insurance indemnity paid is less than the Insurance amount, the Insurance contract remains in force until its expiry date for the difference between the Insurance amount set out in the Insurance contract and the total Insurance indemnity amount paid out during the Insurance period.

9. EXCEPTIONS

9.1. The Insurer does not pay the Insurance indemnity for:

9.1.1. services which were received by the Insured person without observing the conditions or instructions included in the Insurance contract;

9.1.2. medical services which have not been received in a medical institution or do not correspond to the definition of medical services, and costs of medicines which were not bought in pharmacies;

9.1.3. events where the Policy holder or the Insured person misled the Insurer and/or provided untrue information about their health condition;

9.1.4. gratitude payments and/or other payments to medical persons for services which have been already paid;

9.1.5. social and domestic care, drawing up of documents, medical transport services, podometry, podiatry (except in case of a medically diagnosed diabetes), polysomnography, plasmapheresis, dialysis, information trainings and lectures (for diabetes patients, pregnant women etc.);

9.1.6. medical goods and therapeutic appliances (including orthoses, prosthetic devices, implants, crutches, wheelchairs, insoles, X-ray pictures, compression stockings);

9.1.7. services received without well-grounded medical indications, including routine health checkups;

9.1.8. treatment of diseases, traumas and injuries, which the Insured person received in the state of intoxication by alcohol, narcotic drugs or toxic substances or under their impact and any costs related to health problems which result from using these substances;

9.1.9. costs related to treatment of mental diseases, consultations of psychotherapist, psychologist;

9.1.10. the following chargeable surgical operations: cardiac, prosthetic, venous, correcting refraction of eyes, bariatric, laser correction of vision, transplantation of organs;

9.1.11. methods of treatment and/or diagnostics of non-traditional medicine (including osteoreflexotherapy, osteopathy, equine therapy, iridium diagnostics), if these are not provided for by the Insurance programme;

9.1.12. chargeable medical services related to the treatment of oncologic diseases (except for services received before the diagnosis was set), deformation of bones and connective tissue, congenital pathologies;

9.1.13. cosmetology, aesthetic dermatology, plastic surgery and dietology services, including all the expenses related to these services;

9.1.14. diagnostics and treatment of sexopathological, sexually transmissible diseases (including HIV and AIDS), immune diagnostics and immune therapy, including all the expenses related to these services;

9.1.15. diagnostics and treatment of infertility, family planning, artificial impregnation, contraception, services related to the course of pregnancy and chargeable obstetric aid, including all the expenses related to these services, except for the cases where these are provided for by the Insurance programme.

9.2. The Insurer has the right to depart from the exceptions referred to in Paragraph 9.1 hereof, as well as to set additional restrictions by mutual agreement with the Policy holder.

10. PERSONAL DATA PROCESSING

10.1. When signing the Insurance contract and starting to use the Insurance card, the Policy holder and the Insured person agree to personal data, including sensitive personal data, being processed and stored in the Insurer's data bases. When signing the Insurance contract and starting to use the Insurance card, the Policy holder and the Insured person authorise the Insurer, if the need arises and for the purpose of fulfilling the Insurance contract, to get familiar with the Insured person's medical documentation (which contains information about the diagnosis, case history and previous treatment, results of examinations confirming the diagnosis, treatment received and its duration, prescribed and bought medicines etc.), as well as documentation about other services paid under terms of the Insurance contract.

10.2. The Insurer ensures the confidentiality of information received and processes personal data in accordance with the Law on Protection of Natural Persons' Data and other regulatory enactments of the Republic of Latvia. To ensure the fulfilment of the Contract, the Insurer has the right to process the information received about the Policy holder and the Insured person, to use it in its insurance business, to store it in data bases and to transfer it to its employees, specialists, experts and reinsurers, as well as to other persons in cases specified by laws.

11. PROCEDURE OF SOLVING DISPUTES

11.1. If the Policy holder and/or the Insured person dispute the fulfilment of the Insurer's obligations arising from the Insurance contract, complaints to Insurer have to be submitted in writing.

11.2. All disputes that may arise in relation with the fulfilment of the Insurance contract shall be solved by means of negotiations between the parties. If the parties are unable to solve disputes by negotiations, any dispute, difference or claim arising from the Insurance contract, related to it or its violation, termination or invalidity, is solved in court according to the procedure established by regulatory enactments of the Republic of Latvia.

11.3. All legal relations, which arise from the Insurance contract and are not regulated by these terms and conditions, the Insurance policy and its annexes, shall be considered in accordance with regulatory enactments of the Republic of Latvia, including the special Law on Insurance Contract, as well as the Republic of Latvia Civil law, as far as it is not limited by the special law.