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Gjensidige

Health Insurance Terms and Conditions No 14.9.

Valid as of August 22, 2018

1. Terms and definition

1.1. **Insured** — a natural person (citizen of the Republic of Latvia, permanent resident, person with a permanent residence card in the Republic of Latvia or non-resident), in whose favour the Insurance Contract has been concluded.
1.2. **Employee** — a natural person employed by the Policy holder.
1.3. **Employee's family member** — a natural person whose kinship with the Employee can be approved by documents.
1.4. **Insurable object** — the health of the Insured.
1.5. **Sum Insured** — maximum amount of money specified in the Contract for which the health of each Insured Person is insured and that is the maximum extent of liability of the Insurance Company that may be paid as the Insurance Indemnity upon occurrence of an Insurable Event.
1.6. **Medical institution** — doctors' practices, governmental and municipal authorities, businessmen and business companies providing medical services, registered with the Register of Health Care Institutions and corresponding to compulsory requirements of applicable legislation regulating the activity of health care institutions and their structural units.
1.7. **Partner organization** — institution or a company, with whom the Insurer has signed a cooperation agreement on providing services to the Insured persons in accordance with the insurance program. The updated list of partner organizations is published on the internet web page www.gjensidige.lv.
1.8. **Outpatient setting** — a medical institution where the Insured receives primary or secondary outpatient health care services, including the treatment in a day hospital, the services other than the treatment in an inpatient hospital, as well as including rehabilitation services.
1.9. **Day hospital** — a medical institution (day hospital) where the Insured stays for more than 4 hours, which does not include staying overnight.
1.10. **In-patient institution** — a medical institution (24/7 hospital) where the Insured stays for more than 24 hours.
1.11. **Health promoting establishment** — an institution rendering the health improving and prophylaxis services (for example, sports club).
1.12. **Health Insurance Application** (hereinafter the Application) — a form filled in by the Policyholder before making of a health insurance contract based on the health insurance offer prepared by the Insurer.
1.13. **Application for the insurance indemnity** (hereinafter the Claim form) — a form for claiming an insurance indemnity if the Insured has paid for the services included in the Health Insurance Program at his/her own expense.
1.14. **Health Insurance Program** — the complex and the scope of healthcare services chosen by the Policyholder and defined in the Contract, which the Insurer covers in full or in part in case of an Insurable Event within the Health Insurance program chosen by the Policyholder.
1.15. **List of the insured persons** — document prepared and signed by the Policyholder specifying the data of the Insured.
1.16. **Individual Insurance Card** (hereinafter the Card) — a document of a certain form which has been issued to the Insured Person by the Insurer and which verifies that the Insured Person is entitled to receive the services provided for by the Insurance Program.

2. General provisions

2.1. The Insurance is valid in the territory of the Republic of Latvia, unless the Parties have agreed otherwise.
2.2. In the execution of the Insurance Contract the provisions of these Terms and Conditions shall be applied, unless otherwise specified in the Insurance Contract.

3. Entering into Insurance Contract and the procedure for payment of premium

3.1. The Insurance Contract is concluded on the basis of the risk-related information provided by the Policyholder for receiving of an insurance offer, as well as based on the insurance offer provided by the Insurer.
3.2. The insurance shall come into effect on the date and time specified in the Policy, provided that the Insurance Premium payment or its first instalment has been made within the term and to the extent specified in the Policy.
3.3. The insurance shall be valid until 24:00 of the last day of the Insurance Period, provided that the Contract has not been terminated prematurely.
3.4. The Insurance shall be valid only with regard to the services defined in the Insurance Program and specified in the Policy.
3.5. The payment of the Insurance Premium or its part shall be made not later than on the day specified in the Policy (when paying the Insurance Premium by several instalments - in accordance with the insurance premium payment schedule) irrespective of whether the invoice is received.
3.6. The Policyholder shall have an obligation to inform the Insured about the prohibition to use the Card starting with the day of receipt of the notice of incomplete payment of the Insurance Premium until the day when the Insurance premium or its part is paid in full. Should the Insured fail to pay the Insurance premium within the period and in accordance with the procedure specified in the respective notice, the Insured, within 3 (three) working days after the deadline specified in the notice, shall return to the Insurer all Cards issued.
3.7. Should the Policyholder fail to observe the procedure specified in Clause 3.6 of these Terms and Conditions, he/she covers the expenses/losses incurred during the period when the usage of the Card was prohibited based on a separate invoice issued by the Insurer.

4. Rights and obligations of the Insurer

4.1. Responsibilities
4.1.1. Within 10 (ten) working days after conclusion of the Contract to prepare the Cards and Terms and Conditions of the Insurance Program for the Insured persons and issue them to the Policyholder together with the invoice for payment of the insurance premium or its part;
4.1.2. Upon occurrence of an insurable event to pay the Insurance Indemnity to the Insured or a Partner Organization in accordance with Terms and Conditions of the Contract signed.
4.2. Rights
4.2.1. Upon mutual agreement with the Policyholder the Terms and Conditions of the Insurance program may be sent electronically without issuing them separately to each Insured Person.
4.2.2. To recover from the Insured or Policyholder the losses incurred, which the Insured refuses to pay or to recover from the Insured the expenses for the unjustified services in compliance with Clause 6.1.8 of these Terms and Conditions.
4.2.3. To terminate the validity of the Card, if the Insurer establishes that the Card has been used by another person, and to recover all the losses incurred. The Insurance Premium for the Cards terminated due to such reasons shall not be returned.
4.2.4. To unilaterally amend the Contract if inconsistency of information initially provided by the Policyholder is stated.
4.2.5. To unilaterally amend the list of Partner organizations, not worsening the conditions as they were on the moment the Contract was signed. The respective amendments shall be binding for the Insurer as of the moment they are published on the Insurer's website www.gjensidige.lv.

5. Obligations of the Policyholder

5.1. Responsibilities

5.1.1. Prior to conclusion of the Insurance contract to submit the Application and a List of Insured Persons.

5.1.2. Upon a written request of the Insurer, to provide the Insurer with all the documents required verifying the number of employees of the Policyholder or containing other information necessary for the Insurer to assess and verify the compliance of the lists submitted by the Policyholder to these Terms and Conditions.

5.1.3. To issue the Card to the Insured personally against a signature for the receipt of the Card and to inform about the Insurer's rights to process personal data, including person's health data for the purpose to execute the Insurance Contract.

5.1.4. To return the Cards to the Insurer immediately in case the Insurance contract is terminated or a specific Card if it's validity is terminated or in cases provided for in Clause 3.6 hereof.

5.1.5. To cover the losses caused to the Insurer or repay expenses in the event the Insured refuses from his/her obligation set forth in Clause 6.1.8 of these Terms and Conditions.

5.1.6. Should the Contract need any amendments in the number of the Insured persons (it is enlarged or reduced), they should be made in compliance with the procedure for making amendments, which is enclosed in the annex of the Insurance contract.

6. Rights and obligations of the Insured

6.1. Responsibilities

6.1.1. To sign for the receipt of the Card and confirm that terms and conditions of the Insured has been read.

6.1.2. To familiarize him/herself with the Insurance Program and to comply with these Terms and Conditions. To coordinate the receipt of services with the Insurer in accordance with the procedure and terms specified in the Insurance program.

6.1.3. In case the Card is partly or in full paid at the cost of the Insured, the Insured shall pay the invoice issued by the Insurer for the insurance premium. In this case the Insured shall acquire the right to receive the Card only after complete payment of the invoice.

6.1.4. To prevent the Card from being used by other persons. In case the Card has been used by another person, the Insurer shall be entitled to recover all the losses incurred from the Insured Person and to terminate the Card.

6.1.5. Prior to receiving a service from the Partner Organization to present the Insurance Card and the ID document (passport or ID card), as well as to confirm with his/her signature the fact of receiving the service.

6.1.6. To receive the Insurance indemnity, to submit a claim form to the Insurer in accordance with the procedure and time limits defined herein and in the Insurance Program.

6.1.7. To control the scope of the services received to avoid exceeding of the Sum Insured or Limits defined for the respective Insurance Program. In case the paid out Sums Insured or Limits have reached the amount defined in the Insurance Contract, it shall be the obligation of the Insured to avoid any further usage of the Card.

6.1.8. To cover the losses caused to the Insurer or refund the expenses of the Insurer for the services received in accordance with an Insurer's invoice in cases when:

a) the Sum Insured and the Limit is exceeded;

b) the services have been received which are not provided for in the Insurance Program;

c) the Services have been received after the Card was suspended or terminated.

6.1.9. to inform the Policyholder in case of loss or theft of the Insurance Card as soon as it is possible. The Insurer shall issue a duplicate of the Card based on the Policyholder's written application.

6.2. Rights

6.1.1. To use health insurance services in compliance with the Insurance Contract signed between the Policyholder and the Insurer and the Terms and Conditions of the respective Insurance Program.

6.1.2. To receive information from the Insurer related to the Insurance Program and the services enclosed therein, as well as the information about the personal Limit of the Insured. The information about the Insured shall be provided to the Insured personally only based on his/her written request or electronically if the Insured has specified his/her e-mail address in the written request submitted in advance.

7. Insurance Indemnity

7.1. Insurance Indemnity shall be paid to the Insured upon occurrence of the Insurable event and if the Insured has paid expenses for the received services out of his/her personal funds.

7.2. To receive the Insurance Indemnity the Insured or his/her representative shall fill in the Claim form and enclose the documents specified in the Insurance program. The Insured shall submit the Claim form no later than within one month after the validity of the Card has terminated.

7.3. In case the indemnity is reported or received by the Insured Person's representative, the Insurer shall be entitled to request to present a document (original) to the Insurer verifying the right of representation (e.g., a child's birth certificate, judicial decision or a power of attorney).

7.4. The Insurer shall be entitled to request from the Insured other documents, which are related to the Insurable Event and calculation of the Insurance Indemnity.

7.5. For reimbursement of expenses the principle of compensation shall be applied, not exceeding the amount of insurance indemnity specified in the Insurance Program.

7.6. The total amount of the Insurance Indemnity paid for one or several insurable events during the validity of the Insurance Contract may not exceed the Sum Insured defined in the Insurance Program.

7.7. The Insurance Contract after the payment of the Insurance Indemnity remains valid to the extent of the difference between the initial Sum Insured and the paid Indemnity.

8. Exceptions

8.1. **The following events shall not be deemed as an Insurable Event and the Insurance Indemnity shall not be paid if the Insurable Event is caused by some of general exceptions:**

8.1.1. an event that does not correspond to the particular type of the Insurance Contract;

8.1.2. an insurable risk that is not specified in the Insurance Contract;

8.1.3. medical services received outside the Republic of Latvia or the territory specified in the Insurance Contract, beyond the validity period of the Insurance Contract; more than a year after the issuance date of the doctor's referral;

8.1.4. medical services if they are not included in the list of services covered by the program or had not been available in Latvia as to the moment of concluding the Insurance Contract;

8.1.5. medical services which are marked as non-reimbursable in the Insurance Program chosen;

8.1.6. medical services have been rendered by a person who is not registered with the Register of Medical Practitioners of the Republic of Latvia, or the service provided does not comply with the medical practitioner's certificate, or the medical establishment is not registered with the Register of Medical Institutions of the Republic of Latvia and the practitioner's activity or the service provided does not comply with mandatory requirements stipulated in the laws and regulations for medical institutions and their structural units;

8.1.7. any medical services which have been rendered outside a medical institution (off site services) and have not been approved by the Insurer in writing;

8.1.8. medical treatment measures which have been carried out anonymously or without a doctor's referral, and are medically unreasonable, including examinations and manipulations which have been received without medical indications;

8.1.9. expenses which are not approved if approval is required by the Terms and Conditions of the Insurance program;

8.1.10. for treatment of the Insured at the in-patient institution if the treatment may be carried out with the help of outpatient care;
8.1.11. the Insured while being at in-patient institution, simultaneously received paid out-patient services or out-patient rehabilitation;
8.1.12. examinations and consultations for the processing of foreign visas;
8.1.13. the agreements on nursing and medical attendance of the Insured, keeping his/her relative or close person in a hospital;
8.1.14. educational and informative classes and lectures;
8.1.15. processing of medical documentation and printouts or records of medical examinations (including X-ray photographs, their printouts, CD records and other data storage mediums) as a separate service;
8.1.16. medical items and equipment (including the items of technological prosthetics and orthotics, elastic bandages, postoperative dressings, posture correctors), incontinence and hygiene products, tissue replacement materials used for surgery, implants, high technology disposable instruments, etc.;
8.1.17. physicians' fees or payments for services which are not directly related to medical treatment, fee for the choice of a doctor for surgical operations, council of physicians, administrative expenses, personal care nurse/specialist during hospitalization;
8.1.18. expenses occurred as a result of trauma or injuries suffered in professional sport;
8.1.19. the Insured person's deliberate action that is hurtful to his/her health, including the Insured person's suicide, suicide attempt, exposure to extreme danger, except when saving someone else's life;
8.1.20. when the Insured has committed or participated in a crime or when a convicting judgement or decision has entered into legal force;
8.1.21. events which occurred as a result of radioactive poisoning, contamination, natural disasters, pandemic disease, warfare, invasions, civil wars, effects of war, revolutions, rebellions, uprising, upheaval, mass riots, strikes, sabotage and terror acts;
8.1.22. the Insurance Contract has been signed with the aim to compensate the necessary or planned healthcare services;
8.1.23. the Insurable event related to paid services at an in-patient institution has occurred 30 days after the start of the validity date of the Insurance Contract specified on the Card and the Insured already needed the specific service prior to receiving the Card (does not apply for re-concluded Insurance Contracts).

8.2. **Unless otherwise is directly and unmistakably stated in the Insurance Contract (special exceptions are stipulated, or services are included in the program as paid services), the following events shall not be deemed as an Insurable Event and the Insurance Indemnity shall not be paid if the Insurable Event is caused by some of these special exceptions:**

8.2.1. medical services paid by the state health care program: disease treatment and case follow-up in oncology, phthisiology, haemotology, hepatology, immunology, invasive dermatology, haematology, combustiology);
8.2.2. treatment services (including payment for consultations, examinations, treatment sessions), which are related to microsurgic, cosmetic, plastic, bariatric, reparative treatment; laser surgery, invasive and aesthetic dermatology; trichology; plasmapheresis; immune therapy; sleep disorders treatment; dentistry (incl. 3D CT/DT stomatology), logopedia, phoniatrics; invasive radiology and cardiology, electrocardiostimulation; capsule endoscopy; intravitreal injections; lithotripsy; barotherapy, positron emission tomography (PET/ECT);
8.2.3. accelerated vaccination and pre-vaccination checkups if such are listed as separate services;
8.2.4. photo, laser, mechanical and electromagnetic wave manipulations, therapy and surgeries, paid neurosurgery, spine surgeries, vein surgeries, cardiac, vascular surgeries, vision correction surgeries and expenses related thereto;
8.2.5. nutrition specialist, weight improvement programs, dietology, metabolic disorders and treatment of osteoporosis (including osteodensitometry), lactose tolerance test, pharmacogenetic trials (including genotyping); celiac disease treatment;
8.2.6. services of sports medicine physicians (including the stress tests) and medical services of technical orthopaedist, podologist and podiatrist (including foot treatment); varicose vein treatment (including consultations with phlebologist and ultrasonography); treatment of deformation of bones and connective tissues;
8.2.7. serologic, immunologic and virologic treatment;
8.2.8. specific laboratory tests (e.g. Fecal tests - calprotectin, cardiac markers - homocysteine, BNP, dysbiosis tests; tick-borne encephalitis IgG etc.);
8.2.9. psychiatric, psychological, psychotherapeutic, sexopathologic treatment, hypnosis;
8.2.10. treatment of sexually transmitted diseases; HIV and AIDS, spirochete and semen tests; diagnostics and treatment of chlamydia infection diseases, treatment of fungal diseases;
8.2.11. family planning (including artificial insemination), infertility treatment and examination (including oviduct permeability), diagnostic laparoscopy, separation of adhesions and laparoscopic operations for oviduct permeability, determination of Anti-Müllerian hormone; andrology, genetics, reproductology and embryology); therapeutic abortion without medical indications and treatment of the consequences thereof, treatment of inherited illnesses, neonatology, 3D and 4D scans (including in relation to pregnancy); paid pregnancy services and paid labour and delivery assistance.
8.2.12. general non-contact, vacuum, facial, prostate and gynaecological massage; barotherapy, horseback riding therapy, hydrocolon therapy, lymphatic drainage, etc.; cellulite treatment; outpatient rehabilitation in non-certified centres (SPA centres, sports clubs etc.) performed outside the certified medical institutions; homoeopathic treatment; medical services of alternative (complementary) medicine; alternative treatment (Foll and iridodiagnostics, acupuncture, trigger point massage, needle therapy, etc.); osteotherapy and reflexotherapy, etc;
8.2.13. diagnostics and treatment of alcoholism, narcomania and toxicomania, including health conditions related to the use of alcohol, narcotic and/or toxic substances;
8.2.14. health promotion services and general diagnostics of a body (check-up, imago-aurum, bioresonance, etc.).