CONFIDO HEALTH PLAN
GENERAL CONDITIONS OF HEALTH INSURANCE

Valid from 12.05.2021

This document (hereinafter the **Terms and Conditions**) provides an overview of the principles and conditions of the Health Insurance offered by the Insurer in cooperation with the Insurance Agent within Confido Health Plan.

If something remains unclear when reading the Terms and Conditions, please contact the Insurance Agent (kindlustus@confido.ee; +372602 6795) or the Insurer (bta@bta.ee; +372 5 68 68 668).

1. DEFINITIONS USED

Confido Health Plan	Product developed in cooperation with Medical Center Confido OÜ (Registration code 12381384, address: Harju County, Tallinn, Kesklinna district, Veerenni tn 53a, 11313, hereinafter **Confido**) and the Insurer, under which Confido itself and through its partners, in agreement with the Policyholders, provides Health Care and Health Services to their Employees and, where applicable, Relatives, and the Insurer provides Policyholders with Health Insurance to insure Employees and, where applicable, Relatives against health insurance risk. Health insurance is offered only to Policyholders who have joined Confido Health Plan. AAS BTA Baltic Insurance Company (Latvian registration number 40103840140) who operates through the Estonian branch of AAS BTA Baltic Insurance Company Estonian branch (registration code 11223507, address: Harju County, Tallinn, Lasnamäe city district, Lõõtsa tn 2b, 11415, website: www.bta.ee) The Insurer is a Health Insurance service provider that enters into Insurance Contracts with the Policyholders and offers health insurance coverage to the Insured.
Insurance Agent	Confido Kindlustusagent OÜ (registry code 16207134, address Veerenni tn 51, 10138 Tallinn; indlustus@confido.ee; +372 504 5502). An Insurance Agent is an insurance intermediary within the meaning of subsection 174 (2) of the Insurance Activities Act, who markets Health Insurance, enters into Insurance Contracts on behalf of the Insurer, and assists the Insurer in performing them. An insurance agent may use other insurance agents in marketing, who assist him in concluding and managing Insurance Contracts.
Insurance indemnity	The amount payable for compensation for damage caused by an Insured Event.

Insured event	The emergence of a need for Health Care or Health Service agreed in the Insurance Contract, for optical products or prescription drugs for the Insured during the Insurance Period. Insured events are only the services under the Insurance Coverage agreed and fixed in the Insurance Contract.
Insurance card	An individual insurance card number issued by the Insurer to the Insured, which confirms the validity of the Insurance Coverage for the Insured. The Insurance Card number must not be shared with anyone. The Insurer, the Insurance Agent, and the Service Provider have the right to close the Insurance Card if it is established that the number of the Insurance Card is used by an unentitled person.
Insurance coverage	Risks against which the Insured is insured. The Insurance Coverage is determined according to the Health Care and Health Services covered by the Insurance Contract.
Insurance contract	Health Insurance Contract concluded between the Insurer and the Policyholder upon the decision of the Insurance Agent. The Insurance Contract consists of the Insurance Application, the Terms and Conditions, the Insurance Program, the Insurance Policy, the Information Sheet, and other documents concluded between the Policyholder and the Insurer, if applicable. The Insurance Contract allows the Policyholder to include Employees and, if applicable, Relatives as Insured Persons in the Insurance Contract, in which case Employees and Relatives will be entitled to health insurance benefits from the Insurer in a situation where the Employee or Relatives need treatment.
Insurance premium	The emergence of a need for Health Care or Health Service agreed in the Insurance Contract, for optical products or prescription drugs for the Insured during the Insurance Period.
Insurance policy	A document confirming the conclusion and validity of the Insurance Contract, and which is forwarded to the Policyholder after concluding or amending the Insurance Contract or extending the Insurance Period.
Insurance program	Insurance conditions (Insurance Coverage, Insurance Premium, Sum Insured, Limit, etc.) that are an integral part of the Insurance Contract and that apply to a specific Insured or all the Insured.
Insurance period	The period of time specified in the Insurance Contract during which the Insurance Coverage is provided for in the Insurance Contract and on the basis of which the Insurance Premiums are calculated. If the Insured is included in the Insurance Contract during the Insurance Period, the Insurance Coverage shall apply to him/her from the moment of joining until the end of the Insurance Period, unless the Insured is removed by the Policyholder earlier.
Sum insured	The maximum amount to be indemnified to the Insured during one Insurance Period within the framework of the Insurance Program selected by the Insurer (both in its entirety and separately by covered Health Care

Insurance statement	Application submitted by the Policyholder to the Insurance Agent to enter into the Insurance Contract. The Insurance Application contains a list of Employees and, if applicable, Relatives together with the necessary personal data according to the Insurance Agent form who wish to join the Insurance Contract as Insured Persons and the selection of the Insurance Program for each Employee/Relative. Upon addition of the Insured during the validity of the Insurance Contract, the Policyholder shall submit an additional Insurance Application to the Insurance Agent.
Insured person	An employee or his/her Relative who is indicated by name in the Insurance Contract as the Insured Person. On the basis of the Insurance Contract, the health insurance risk related to the Insured as a third party is insured. If the person has been removed from the list of insured by the Policyholder, it is presumed that the person is no longer
Policyholder	A legal entity that wishes to provide Health Insurance to its Employees and, if applicable, their Relatives and that assumes the obligation to pay insurance premiums (except if the Insurance Premium is paid by the Insured).
Contact person	Persons appointed by the parties to the Insurance Contract to receive notifications related to the Insurance Contract and to resolve current issues.
Limit	Percentages arising from the Insurance Contract to the extent to which the Insurer pays for the service received by the Insured or the number of paid services that do not exceed the Sum Insured specified in the Insurance Contract.
Relative	Employee's family member, spouse or partner, parents and children who are Insured persons under the Insurance Contract. For relatives, the provisions of the Terms and Conditions of the Employee shall apply, unless the context otherwise required.
Fact sheet	Standard form for the insurance product information document provided for in Commission Implementing Regulation (EU) No 2017/1469.
Service provider	Healthcare and Health Service Providers. The service providers are, among others, Confido and its partners.
Health care service	Activities of a healthcare professional/institution for the prevention, diagnosis, and treatment of disease, injury, or poisoning. The purpose of Health Care Services is to alleviate a person's ailments, prevent the deterioration of his or her state of health or exacerbation of the disease, and restore health.
Health service	Activities aimed at maintaining the good health of patients and improving their quality of life, but which are not Health Services under current legislation.

Health insurance	The health insurance product offered by the Insurer within the meaning of § 554 of the Law of Obligations Act and § 12 (1) 2) of the Insurance Activities Act, within which the Insurer insures the Insured against the need to provide Health and Health Services and incidental costs.
Employee	A person who works for the benefit of a policyholder on the basis of valid employment, board member, or other employment contract.
Authorized person	Persons appointed by the Insurance Agent and the Policyholder, appointed by the parties for the exchange of data in connection with the conclusion and performance of the Insurance Contract, including for the transmission of encrypted data.

2. OBJECT OF HEALTH INSURANCE

2.1. The object of health insurance is the health of the Insured and the risk of bearing the costs related to the provision of Health Care and Health Services (i.e., insurance risk) necessary for its maintenance.

2.2. The Insurance Coverages, applicable Sum Insured, Limits, and Insurance Premiums covered by the Health Insurance are provided in the Insurance Programs from which the Policyholder can choose, and the Terms and Conditions.

2.3. The Policyholder enters into the Insurance Contract for the purpose of insuring the insurance risks related to the Employees and, if applicable, Relatives, in order to protect their health and increase the Employees' ability to work and stay productive (insurance interest).

2.4. In cooperation with the Insurance Agent, the Policyholder selects the Insurance Programs suitable for his or her Employees and, if applicable, Relatives.

2.5. In order to include the Employees and, if applicable, Relatives as Insured Persons in the Insurance Contract, the Policyholder shall submit to the Insurance Agent an Insurance Application containing at least the following information on the Employees and Relatives:

2.5.1. Name and family name;

2.5.2. Personal identification code or in its absence date of birth;

2.5.3. Personal e-mail address;

2.5.4. Mobile phone number;

2.5.5. Insurance Program selected for all or for a specific person.

The Policyholder's Authorized Person shall submit the specified data in encrypted form by forwarding them to the Insurance Agent's Authorized Person.

2.6. By transmitting the data to the Insurance Agent, the Policyholder confirms that he or she is entitled to transmit the data of the Employees and, if applicable, Relatives to the Insurance Agent and the Insurer and that the Employees and, where applicable, the Relatives agree to their inclusion in the Insurance Contract as Insured under the terms of the Insurance Contract.

2.7. The Insurance Agent checks the data submitted by the Policyholder and, if they are correct,

forwards them to the Insurer for the inclusion of Employees and, if applicable, Relatives as Insured Persons in the Insurance Contract.

2.8. The Insurer has the right to refuse to include the Employee or, if applicable, his/her Relatives as the Insured in the Insurance Contract, if the person:

2.8.1. has provided false information or has previously committed insurance fraud;

2.8.2. has failed to pay insurance premiums earlier;

2.8.3. is unsuitable to be the Insured for other compelling reasons.

2.9. Upon inclusion of the Insured Person in the Insurance Contract, the Insurer shall forward to the Policyholder the Insurance Policy certifying the Insurance Coverage, the number of the Insured's Insurance Card, and other relevant information through the Insurance Agent. If applicable, the Insurance Agent shall also forward the information on the Insurance Coverage to the Insured himself/herself, using the contact details of the Insured. The Policyholder is obliged to inform the Insured of the entry into force of the Insurance Coverage for him or her and to acquaint him or her with the terms and conditions of the Insurance Contract.

2.10. The Policyholder has been bound by the Insurance Application since submission of the signed form thereof to the Insurance Agent. Employees and, if applicable, Relatives are covered by the Insurance from the moment they are included in the Insurance Contract as Insured. After that, it is possible to remove the Insured from the Insurance Contract only pursuant to the procedure provided in the Terms and Conditions.

2.11. The Policyholder is obliged to keep the List of Insured up to date and update it immediately if necessary. The Policyholder bears the risk if the list of Insured Persons is not up-to-date, or the information provided therein is incorrect.

2.12. The selected Insurance Program applies to the Insured during the entire Insurance Period. During the insurance period, the Policyholder has the right to deduct from the list of the Insured if the Policyholder has terminated the employment or other employment relationship with the Employee. In order to deduct from the list of the Insured Employee, the Policyholder shall submit the data of the respective Employee. The Employee shall be deemed to be removed from the list on the date of termination of employment or other employment with the Employee or on any other later date specified by the Policyholder, but not earlier than 14 (fourteen) days after the Policyholder notifies the Insurance Agent of the employee's removal from the list of the Insured Persons. Removal of the Insured's Relative from the list of Insured during the Insurance Period is possible only in agreement with the Insurer.

3. BASIC INSURANCE COVERAGE AND SCOPE

NB! The Insurance Coverages covered by the Insurance Contract is determined by the Insurance Programs selected by the Policyholder for all or each Insured separately.

3.1. **Outpatient treatment**

Outpatient treatment - non-inpatient Healthcare service, in which case the Insured's appointment at a healthcare institution is limited to a few hours, and a 24-hour hospital stay is not necessary.

3.1.1. The Insurer shall reimburse the appointment and consultation fee of the Service Provider, including the family doctor if the contact with the Health Care Service Provider

is due to the Insured Event.

3.1.2. The following costs are reimbursed without a doctor's referral:

- Insured's appointment fee;
- Compulsory health examination of the Insured Employees to the extent necessary for the performance of work duties on the basis of the legislation in force once during the Insurance Period;
- Medical examination for the preparation of medical documentation (driving a vehicle, weapons permit, going to an educational institution);
- Vaccination against influenza, tick-borne encephalitis, hepatitis A, hepatitis B, hepatitis A+B;
- Home visits and medical services are provided during visits, including transport services.

3.1.3. Only the costs to the following procedures with the referral of a doctor are reimbursed:

- tests, examinations, treatment procedures;
- expensive diagnostic technologies, including anesthesia, digital tomography, and magnetic resonance imaging up to EUR 300 during the insurance period.

3.1.4. A doctor's referral letter, digital referral letter, an entry in medical history or decision of an occupational health doctor, etc., must be issued before the reimbursable analysis, examination, or procedure is performed.

3.1.5. The following are not covered under the Insurance Coverage of Outpatient Treatment:

- the cost of dental services;
- the cost of maternity care;
- the cost of prescription drugs;
- the cost of glasses, contact lenses;
- the cost of outpatient rehabilitation;
- the cost of rehabilitation with a hospital stay;
- the cost of preventive examinations.

3.2. **Inpatient treatment**

Inpatient or hospital treatment - Healthcare service that requires the Insured to be in the hospital.

Daycare - Healthcare service in which the Insured needs to be monitored for a few hours in a treatment bed due to treatment or examinations but leaves home in the evening/at night.

3.2.1. The Insurer shall indemnify the costs for paid services in the 24 hours and day inpatient care.

3.2.2. The following costs are reimbursed:

- inpatient stay;
- surgeries;

- medical consultations;
- tests, examinations, treatment procedures;
- treatment under conditions of enhanced service for up to 10 days if the medical institution provides such services.

3.2.3. The following are not covered under the Insurance Coverage of Inpatient Treatment:

- the cost of dental services;
- the cost of maternity care;
- the presence of a relative or close person in the hospital for the Insured;
- preoperative and post-operative care services.

3.3. **Preventive health examinations**

Prevention or preventive health examinations - a prophylactic health examination is a medical health examination at the request and choice of the Insured and for which there is no medical indication.

3.3.1. The following are reimbursed without a medical indication:

- health examination to monitor a chronic or pre-existing illness;
- medical examinations in connection with family planning or contraception;
- a doctor's appointment in connection with the dispensing of prescription medicines;
- paid medical examination.

3.4. **Dentistry**

Stomatology or dentistry - in the narrower sense, dentistry is the correction of dental defects with various filling materials (composite materials, glass ionomers, gold, or porcelain inlays).

3.4.1. Under the Insurance Contract, the costs related to dental treatment are reimbursed to the extent specified in this clause 3.4.

3.4.2. Costs of cosmetic whitening or cosmetic operations are not reimbursed under the insurance contract.

3.4.3. Indemnifiable expenses for the following dental services:

- consultation with a specialist and preparation of a treatment plan;
- dentistry;
- oral hygiene procedures;
- outpatient surgical, dental services;
- treatment of periodontal diseases;
- orthodontics;
- local anesthesia, prosthetics, implant-related costs.

3.4.4. The following are not subject to compensation:

- the cost of cosmetic surgery on the teeth and mouth;

- the cost of cosmetic teeth whitening.

3.5. **Outpatient rehabilitation**

Outpatient rehabilitation means a type of treatment aimed at restoring, maintaining, or adapting to a disability. It is a treatment that restores the ability to work or cope. Rehabilitation treatment implements treatments and procedures to comprehensively restore the Insured's impaired functions from a medical, physical, mental, and social point of view.

3.5.1. The following services related to outpatient rehabilitation are subject to reimbursement only on the prescription of a doctor:

- physiotherapy;
- therapeutic massage;
- manual therapy;
- osteopathy;
- chiropractic.

4. SUPPLEMENTARY INSURANCE COVERAGE AND SCOPE

NB! The Supplementary Insurance Coverage apply only in conjunction with the Basic Insurance Coverage selected with the applicable Insurance Program and provided that a specific Supplementary Insurance Coverage Insurance Program, as listed below, has been selected.

4.1. **Optics - optical products**

4.1.1. The Insurer will indemnify the costs of purchasing one pair of glasses (including sunglasses with optical glasses) or contact lenses.

4.1.2. The Insurer shall not indemnify for the costs of glasses without optical lenses, colored contact lenses, care products.

4.2. **Prescription drugs**

4.2.1. The Insurer shall indemnify for the costs for the acquisition of prescription medicines prescribed by a doctor and registered in the European Union Register of Medicinal Products.

4.2.2. The Insurer does not reimburse the costs of over-the-counter medicines, as well as food supplements, dietary foods, vitamins, sleeping pills, vaccines, antidepressants, contraceptives, and medicines for infertility treatment.

4.3. **Pregnancy and maternity care**

4.3.1. The Insurer reimburses the costs of paid maternity services.

4.3.2. The following pregnancy-related services are indemnified:

- a doctor's appointment in connection with pregnancy;
- gynecological and midwifery consultations;
- tests, examinations, and treatment procedures
- hospital stay.

4.3.3. The following maternity services are indemnified:

- hospital stay (incl. paid ward);
- participation of a midwife or doctor in childbirth;
- cesarean section for medical reasons;
- services related to the postpartum period until discharge from the hospital: gynecologist consultation, examinations, lactostasis removal.

4.3.4. If the father of the child born is Insured, the expenses of the family room are to be indemnified.

4.3.5. Insurance does not cover the costs of performing a cesarean section at the request of the Insured, childbirth at home, post-natal treatment, and transport.

4.4. **Inpatient rehabilitation**

Inpatient rehabilitation - a rehabilitation service provided during certain days in a hospital/rehabilitation center. In general, patients require inpatient rehabilitation after a serious illness, surgery, or trauma, and in some cases after a chronic condition and their exacerbation.

4.4.1. The following costs of services prescribed by a doctor and provided in rehabilitation centers (convalescence homes) are indemnified:

- rehabilitation;
- accommodation and catering in rehabilitation centers.

4.4.2. Expenses incurred in restaurants or bars of rehabilitation centers, as well as expenses for SPA procedures, are not indemnified.

4.5. **Venous therapy and sclerotherapy**

4.5.1. Indemnifiable expenses for appointment and consultation fees in a medical institution if the referral is related to venous therapy and due to an insured event.

4.5.2. The Insurer shall be reimbursed for the costs of tests, examinations, and outpatient or inpatient procedures of the Insurer for venous therapy and sclerotherapy with a doctor's referral.

5. INSURANCE PREMIUMS AND THE CONSEQUENCES OF FAILURE TO PAY THEM

5.1. The Insurance Coverage enters into force as of the inclusion of the Insured in the Insurance Contract pursuant to the procedure provided in these Terms and Conditions and the date of payment of the Insurance Premium or the first part of the Insurance Premium.

5.2. The Insurer authorizes the Insurance Agent to accept Insurance Premiums.

5.3. The date of payment of the Insurance Premium is the day when the respective amount of money is received in the current account of the Insurance Agent.

5.4. In order to pay the Insurance Premiums, the Insurance Agent submits invoices. If applicable, the Insurance Agent submits e-invoices through the e-invoice operator.

5.5. If the Policyholder pays the insurance premiums on the basis of the insurance policy issued for the current Insurance Period, the parties shall consider this as the Policyholder's consent to the insurance offer. If the Insurance Policy differs from the insurance offer, the information and agreements specified in the insurance offer are considered valid and correct.

5.6. Insurance premiums are payable for each Insured in accordance with the Insurance Program

selected for the said Insured.

5.7. Insurance premiums are payable for the time when the Insured is included in the Insurance Contract and until the end of the Insurance Period unless the Insurance Coverage is terminated before the end of the Insurance Period in accordance with these Terms and conditions.

Upon termination of the employment or other employment relationship by the Policyholder with the Insured Employee, the Policyholder's obligation to pay the Insurance Premium to the Insurance Agent shall terminate from the date of termination of employment or other employment relationship with the Employee, but not earlier than 14 (fourteen) days after the Policyholder notifies the Insurance Agent of the removal of the Employee from the list of Insured. The Policyholder and the Employee may agree that the Insurance Coverage of the departed Employee is valid until the end of the Insurance Period (provided that the Policyholder has paid the Insurance Premiums) or that the Policyholder pays the following Insurance Premiums on the Employee even after termination of employment. The departed Employee can notify the Insurer of they wish to continue using the Health Insurance service within 1 (one) month from the removal of the Employee from the list of Insured Persons. In such a case, the Insurer shall separately assess whether and under what conditions the Insurer can offer similar insurance coverage to the ex-Employee.

5.8. The Policyholder pays the Insurance Premiums for the Insured Employees. If the Insurance Premium of the Insurance Program selected by the Employee exceeds the amount payable by the Policyholder, the Insured can pay the remaining part of the Insurance Premium himself/herself.

5.9. The Policyholder pays the insurance payments in quarterly payments based on the invoices filed by the Insurance Agent.

5.10. The Insurance Agent submits a report to the Policyholder together with the invoice, which shows the list of Insured persons who have joined the Insurance Contract, the basis for calculating the Insurance Premium, and the calculated amount of the Insurance Premium for each Insured. The respective report shall be submitted to the Policyholder's Authorized Person in encrypted form if the Policyholder has objections to the submitted invoice and/or report (e.g., inaccuracies in the number of Insured or in the implemented Insurance Programs), the respective claims must be submitted within the term for payment of the invoice.

5.11. Unless otherwise agreed with the Policyholder, the Employee/Relative shall pay the Insurance Premiums for the Insurance Coverage of the Relative, as well as for the Employee's Insurance Coverage, which is not paid by the Policyholder.

In this respect, the Insurance Agent invoices the Relative/Employee directly, and the Insurance Premium is payable at once for the entire Insurance Period. In such case, the Insurance Premium is deemed to have been paid pursuant to the procedure provided for in § 455 (1) of the Law of Obligations Act. Prior to the payment of the invoice by the Relatives/Employees, the Insurer shall not transfer the Relatives/Employees as Insured to the Insurance Contract.

5.12. If the Insured is added to the Insurance Contract or removed from the Insurance Contract in the middle of the Insurance Period, the Insurance Premium is calculated in proportion to the number of days when the Insured is included in the Insurance Contract.

5.13. The payment term of the invoice is the term indicated on the invoice, which is not shorter than 14 (fourteen) calendar days. If the invoice is not paid on time, the Insurance Agent has the right to demand from the payer of the invoice interest on arrears of 0.05% (zero-point zero five percent) of the amount not paid on time for each day of delay in payment.

5.14. Insurance premiums are not deductible due to the taxes applicable to them and consequently any additional taxes payable.

5.15. If the Insurance Premium or the first part of the Insurance Premium is not received by the Insurance Agent within the term set for payment, the Insurance Coverage shall not enter into force, and the Insurer may withdraw from the Insurance Contract.

If the Insurance Premium or the first part of the Insurance Premium that has become collectible is not received by the time of the Insured Event, the Insurer shall be released from the obligation to perform.

5.16. If the second or subsequent installment of the Insurance Premium is not paid on time, the Insurance Agent shall grant an additional term for payment.

If the installment is not paid for the additional term and an Insured Event occurs after the term for payment of the additional installment, the Insurer shall be released from the obligation to perform. The Insurer also has the right to cancel the Insurance Contract in such a case.

5.17. If the Policyholder is late in paying the Insurance Premium and does not pay the Insurance Premium within the additional term specified by the Insurance Agent, the Insurer shall be released from its obligation to perform in the event of the Insured Events occurring after the additional payment term.

6. SUM INSURED AND LIMITS

6.1. The amount specified in the Insurance Contract for each Insurance Program and Insurance Coverage for each person of the Insured and in the event of an Insured Event is the maximum amount payable by the Insurer.

6.2. If several Insured Events occur during the same Insurance Period, the expenses will be indemnified up to the Sum Insured indicated in the Insurance Program/Insurance Coverage.

6.3. The deductible is the part of the loss specified in the Insurance Contract, which is borne by the Insured. The deductible is the part of the loss that exceeds the Insurance Indemnity Limit according to the specific Insurance Program. In addition, the Insurance Indemnity never exceeds the Sum Insured.

7. EXCLUSIONS

NB! The exclusion specified in clause 7 does not apply if the Healthcare or Health Service covered by the exclusion or the reason for the exclusion is insured with the basic and/or additional Insurance Coverage within the Insurance Program selected by the Policyholder as provided in clauses 3 or 4.

7.1. **General exclusions**

The following events are not considered an insured event, and expenses are not indemnified:

7.1.1. cases of force majeure, i.e., an extraordinary event which the Insured could not have foreseen or prevented (e.g., natural disasters, acts of terrorism, riots, strikes and other mass disturbances, war);

7.1.2. cases emerged as a result of self-medication, use of drugs or narcotics, the use of which is not medically necessary and which in this case have not been prescribed by the treating physician;

7.1.3. if the Insured has intentionally caused damage to his or her health, including a suicide attempt;

7.1.4. cases of alcohol, narcotic drugs, or psychotropic substances. Expenses for the treatment and diagnosis of alcoholism, drug addiction, and toxic addiction, as well as expenses for the detection of alcohol, drugs, and toxic substances in the body;

7.1.5. cases that have occurred during the commission of criminal acts by the Insured;

7.1.6. cases caused by the Insured in connection with a pandemic. A pandemic is defined as the spread of an infectious disease to the extent that exceeds the prevalence of intensive spread of morbidity or disease that has not previously been recorded in a specific territory, covering a large geographical area or continent, and notified by the responsible institution of the Republic of Estonia. This restriction does not apply to COVID-19 related cases.

7.2. **Non - indemnifiable costs**

The following costs shall not be considered or indemnified (unless otherwise expressly and unambiguously provided otherwise in the selected Insurance Program):

7.2.1. cosmetic care and treatment, aesthetic surgery operations and services, including treatment of non-malignant skin tumors (e.g., birthmarks, papillomas, warts, keratosis), plastic, reconstructive and bariatric surgery, weight loss programs, lymph drainage, vacuum massage, radiotherapy, pediatric consultation and services, pedicure services;

7.2.2. laser vision correction surgery, organ transplant surgery, venous surgery, sclerotherapy, and paid services;

7.2.3. the cost of purchasing optical products and aids (e.g., corsets, fixators, elastic bandages, plaster, stockings, orthopedic insoles, hygiene kits), the cost of replacement materials used in tissue surgery (e.g., implants, prostheses, meshes);

7.2.4. diagnosis, treatment, and genetic testing for viral hepatitis C and chronic hepatitis, as well as Hansen's disease;

7.2.5. diagnosis and treatment of sexually transmitted diseases, including ureaplasma, HIV and AIDS, spirochetes and chlamydial infections;

7.2.6. diagnosis and treatment of fungal diseases, avian and swine flu virus;

7.2.7. early health checks on drivers;

7.2.8. immunoglobulin therapy, intravenous laser therapy, and laser organ therapy (e.g., incontinence therapy), autohemotherapy (e.g., PRP injections), biotherapy, orthokine injection, intraocular injections;

7.2.9. services of a narcologist, hypnologist, andrologist, geneticist, trichologist, technical orthopedist and prosthetist, occupational therapist, sports physician, physiotherapist, rehabilitation specialist or physician of physical and rehabilitation medicine,

chiropractor, dietician, nutritionist, homeopath, dentist, cosmetology and beautician;

7.2.10. alternative medicine services (e.g., acupuncture, iridodiagnostics, biomagnetic resonance, electropuncture), complementary medicine services, use of the biofeedback method;

7.2.11. paid services relating to pregnancy, fetal diagnosis, childbirth;

7.2.12. family planning, contraceptive measures, infertility treatment, artificial insemination, abortions without medical indications;

7.2.13. diagnosis or treatment of congenital pathologies, degenerative diseases, and mental illness;

7.2.14. general massage, prostate or gynecological massage, whole body diagnostics, polysomnography, examination and treatment of sleep disorders, outpatient rehabilitation services in a day hospital or rehabilitation centers, stay in a day hospital at night;

7.2.15. treatment of diseases included in the public health program to the extent of paid services;

7.2.16. payments to choose a doctor for a surgery;

7.2.17. preparation of medical documents and printing of medical examinations, documents, and other communications as a separate service, including 3D and 4-dimensional examinations related to pregnancy;

7.2.18. medical services provided without medical indications, as well as the costs of regular health check-ups, etc., palliative care, social welfare;

7.2.19. educational information sessions, lectures, or courses;

7.2.20. the presence of a relative or close person in the hospital with the Insured;

7.2.21. preoperative and post-operative care services covered by an insurance contract.

8. INSURED EVENT. PAYMENT AND RECOVERY OF INSURANCE INDEMNITY

8.1. The Insured Event is considered, and the Insurance Indemnity is paid by reimbursing the Insured's expenses for Health Care or Health Services:

8.1.1. related to the health of the Insured;

8.1.2. In accordance with and within the limits of the Insurance Coverages provided for in the Insurance Contract;

8.1.3. to the extent of the Sum Insured and the Limit;

8.1.4. referred to during the Insurance Period;

8.1.5. provided by Service Providers operating in the territory of Estonia, Latvia, Lithuania;

8.1.6. obtained from medical institutions registered in the register of medical institutions and persons registered in the register of medical staff, sports facilities, a point of purchase of optical equipment, or a pharmacy;

8.1.7. performed with the help of medical technology registered in the state database of technology used for the provision of health care services of the Republic of Estonia, as well as the acquisition of optics or medicines;

8.1.8. which are not excluded under the Terms and Conditions, and which are not subject to indemnification.

8.2. The Insurer pays the Insurance Indemnity:

8.2.1. To the Insured, if the costs of Health Care or Health Services were borne by the Insured; or

8.2.2. To a service provider who has provided Health Care or Health Services to the Insured or has borne the costs related to the said service. In such a case, the Insured loses the right to claim the Insurance Indemnity.

8.3. The occupational health inspection indemnity is paid to the Policyholder or the Service Provider who provided the occupational health inspection service.

8.4. In order to receive the Insurer's insurance indemnity for the received Health Care or Health Services, for which the Insured has paid independently, the Insurer must submit the following documents to the Insurer or the Insurance Agent as soon as possible, but no later than within 90 (ninety) days of receiving the service:

8.4.1. a written statement in a form that can be reproduced in writing;

8.4.2. the original of the invoice or a certified copy thereof containing the following information:

service provider, service recipient, service name, quantity, price, date of provision;

8.4.3. other documents required by the Insurer/Insurance Agent regarding the services received by the Insured in order to ascertain the circumstances related to the Insured Event or to determine the amount of the Insurance Indemnity to be paid.

8.5. In order to receive the Insurer's insurance indemnity for the Health Care or Health Services provided to the Insured, the Service Provider shall submit data and documents to the Insurer in accordance with the data volume agreed between the Service Provider and the Insurer.

8.6. Upon receipt of the relevant claims from the Insurer, the Insured is obliged to return to the Insurer within 10 (ten) working days the amounts paid by the Insurer to the Policyholder, Service Provider or directly to the Insured for Healthcare or Health Services received by the Insured:

8.6.1. In case of exceeding the Sum Insured provided for in the Insurance Contract;

8.6.2. In case of exceeding the limit provided for in the Insurance Contract, including exceeding the number of paid services;

8.6.3. to the extent of payments not provided for in the Insurance Contract;

8.6.4. Upon termination of the Insurance Contract, or Insurance Card for any reason;

8.6.5. In the event of fraud or other unjustified reasons for the Insured receiving the Insurance Indemnity.

9. RIGHTS AND OBLIGATIONS OF THE PARTIES

9.1. **Obligation to provide information**

9.1.1. Upon concluding the Insurance Contract, the Policyholder and the Insured must submit to the Insurance Agent and the Insurer all the information required by them, which is necessary for concluding and performing the Insurance Contract.

9.2. **Rights and obligations of the Policyholder**

9.2.1. The Policyholder has the right to:

- to receive information about the Insurance Contract from the Insurance Agent and the Insurer;
- to submit claims to the Insurance Agent and the Insurer in connection with the performance of the Insurance Contract pursuant to the procedure provided in the Terms and Conditions.

9.2.2. The Policyholder is obliged to:

- to inform the Insured about the conclusion of the Insurance Contract in their favor and to acquaint them with the terms and conditions of the Insurance Contract, including the Insurance Program, as well as to explain to them the rights and obligations arising from the Insurance Contract;
- to pay Insurance premiums in the amount specified in the Insurance Contract and by the term specified.
- to keep the data on the Insured up to date and immediately inform the Insurance Agent about the change of data and submit new data;
- to ensure that the Insured consents to the transfer of the personal data of the Insured to the Insurance Agent and the Insurer for the conclusion and performance of the Insurance Contract and their inclusion as Insured in the Insurance Contract. These consents must be at least in a reproducible form and available to the Insurance Agent and the Insurer upon request.

9.3. **Rights and obligations of the Insured**

9.3.1. The Insured has the right to:

- receive information and consultations regarding his or her Insurance Contract;
- receive the services agreed in the Insurance Contract;
- receive Insurance Indemnity for the services agreed in the Insurance Contract, for which the Insured has paid from his or her own funds;
- receive a motivated written decision regarding refusal to pay the Insurance Indemnity in full or in part.

9.3.2. The Insured is obliged:

- to pay the Insurance Premiums to the extent that, in accordance with the Conditions, they are not payable by the Policyholder;
- to take care of the maintenance of one's health and to follow the instructions of the treating physician in case of illness and not to increase the risk circumstances related to the Insured;
- not to allow another person to use his/her Insurance Card and to notify the Insurer or the Insurance Agent immediately in case of loss of the Insurance Card;
- to submit an identity document and the Insurance Card before receiving the

service covered by the Insurance Coverage from the Service Provider;

- to monitor the extent of the Insurance Indemnity, if necessary by contacting the Insurer or the Insurance Agent, inter alia, in order not to exceed the Sum Insured or the Limit provided in the Insurance Contract;
- to comply with the terms and conditions set forth in any other document of the Insurance Contract, such as the terms and conditions of the Insurance Programs.

9.4. **Rights and obligations of the Insurance Agent:**

9.4.1. The Insurance Agent is obliged to:

- Provide the Insurer with relevant information and documents about the Employees and, if applicable, Relatives who wish to join the Insurance Contract;
- Provide the Policyholder with the information and documents of the relevant Insurance Contract about the Insured;
- At the request of the Policyholder/Insured, notify the remaining Sum Insured or the Limit;
- To forward the Insurance Invoices to the Policyholder/Insured on time;
- To gather the necessary information from the Policyholder for concluding the Insurance Contract and entering the Insured to the Insurance Contract.

9.5. **Rights and obligations of the Insurer**

9.5.1. The Insurer is obliged:

- In the event of an Insured Event, pay the Insurance Indemnity in accordance with the terms and conditions of the Insurance Contract;
- At the request of the Insured, notify the remaining Sum Insured or the Limit;
- To forward to the Policyholder the information and documents of the relevant Insurance Contract regarding the Insured, if the Policyholder so requests;
- To issue replacement policies to the Policyholder upon request, as well as copies of the statements of intent submitted by the Policyholder in a form that can be reproduced in writing;
- Upon receipt of a corresponding request from the Policyholder, to issue the Policyholder the data and copies of documents in possession of the Insurer that affect the rights and obligations of the Policyholder arising from the Insurance Contract, if such activity is not in conflict with mandatory requirements arising from legislation;
- To process the personal data of the Insured in accordance with the applicable legislation. The Insurer also has the right to receive information about the Insured from state agencies or the debtors' register if the Insurer deems it necessary.

9.6. **Consequences of non-compliance**

9.6.1. If the Policyholder or the Insured intentionally, including for criminal purposes, or due to gross negligence, fails to perform any obligation specified in legislation or the Insurance Contract, the Insurer has the right to refuse to pay the Insurance Indemnity. The Insurer may reduce the indemnity, but not more than 50% (fifty percent), if the

Policyholder or the Insured fails to comply with any condition prescribed by legislation or the Insurance Contract due to negligence.

10. CONCLUSION, AMENDMENT, AND TERMINATION OF THE INSURANCE CONTRACT

10.1. The insurance contract is concluded for an indefinite period.

10.2. The insurance period is 1 (one) year.

10.3. No later than 30 (thirty) days before the end of the valid Insurance Period, the Policyholder shall submit a new Insurance Application to the Insurance Agent, on the basis of which the Insurance Agent shall draw up a new Insurance Policy for the following Insurance Period.

If the Policyholder does not submit a new Insurance Application, the Insurance Agent shall draw up the Insurance Policy on the basis of the latest available information and forward it to the Policyholder.

10.4. The terms and conditions of the Insurance Contract can be amended and/or supplemented (incl. terminated) only by a written agreement between the Insurer and the Policyholder, which is drawn up as an appendix to the Insurance Contract.

Regardless of this, the Insurer has the right to unilaterally review and change the terms and conditions of the Insurance Contract in the following cases:

10.4.1. The Insurer can unilaterally and without prior notice always change the terms and conditions of the Insurance Contract to the benefit of the Policyholder/Insured, incl. to reduce the Insurance Premiums, increase the Insurance Coverages, increase the Limits, etc;

10.4.2. The Insurer may unilaterally increase the Insurance Premiums and/or reduce the scope of the Insurance Coverages, including reducing the Healthcare and Health Services subject to indemnification, reducing the Sum Insured, reducing the Limits, etc., if this is due to changes in the following circumstances:

- A circumstance independent of the parties specified in the Insurance Contract as the basis for calculating the Insurance Premium;
- The average life expectancy of insured persons;
- Frequency of the use of the Insurer's obligation to perform according to this insurance premium rate by the Insured Person;
- The extent of state compensation for health insurance services;
- Service provider fees for the use of Health Care or Health Services;
- Legislation amending healthcare management.

10.4.3. The Insurer may unilaterally amend the documents of the Insurance Contract to the extent not covered in clauses 10.4.2 and 10.4.3 in order to specify the terms and conditions of the Insurance Contract.

10.5. In the cases specified in clauses 10.4.2 and 10.4.3, the amendments shall enter into force not earlier than 1 (one) month after the notification of the change to the Policyholder.

10.6. The Insurer or the Insurance Agent shall notify of the amendments to the Insurance Contract pursuant to the procedure provided for in clause 12.3.

10.7. The Policyholder has the right to regularly cancel the Insurance Contract by notifying the Insurance Agent thereof at least 3 (three) months in advance so that the Insurance Contract expires at the end of the year.

10.8. The Insurer has the right to regularly cancel the Insurance Contract in the cases provided by law.

10.9. The Insurer has the right to cancel the Insurance Contract in an extraordinary manner for the following reasons:

10.9.1. The Policyholder is in arrears with the payment of the first or subsequent financial obligation arising from the Insurance Contract beyond the terms provided for in clauses 5.15 and 5.16 of the Terms and Conditions;

10.9.2. The Policyholder/Insured materially violates the Insurance Contract and does not eliminate the violation additionally within the given term;

10.9.3. In the case of bankruptcy of the Policyholder.

10.10. The Insurer may exceptionally cancel the Insurance Contract within 1 (one) month of becoming aware of the violation.

11. PROCESSING OF PERSONAL DATA

11.1. The Insurer processes the data of the Policyholder and the Insured Persons, including special types of personal data, in accordance with the relevant legislation and the principles of the Insurer's customer data processing, which are available on the Insurer's website https://www.bta.ee/media/bta-privaatsuspoliitika-ee.pdf.

11.2. The Insurer has the right to receive information about the Policyholder and the Insured from state agencies or the register of debtors if the Insurer deems it necessary.

11.3. Upon termination of the Insurance Contract, the Insurer undertakes to transfer to the Policyholder or a third party appointed by the Policyholder all data on the Insured Persons collected in the framework of the performance of the Insurance Contract, including Health Care and Health Services, provided to them and indemnified under the Insurance Contract.

12. OTHER TERMS AND CONDITIONS

12.1. **Priority of Insurance Contract documents**

12.1.1. In the event of any discrepancies between the documents of the Insurance Contract, the terms and special conditions of the Insurance Program and the Insurance Coverages covered by it shall prevail for the parties.

12.2. **Confidentiality**

12.2.1. The Contracting Parties undertake not to disclose confidential information about the participants in the Insurance Contract or third parties received within the framework of

the Insurance Contract and not to use it to the detriment of the participants in the Insurance Contract, except in cases provided by the legislation of the Republic of Estonia.

12.2.2. The Insurer has the right to submit information related to the Insurance Contract to experts and reinsurers.

12.2.3. The Insurer and the Insurance Agent have the right to store information related to the Insurance Contract in the databases of the Insurer and the Insurance Agent, respectively.

12.2.4. The Insurer and the Insurance Agent have the right to submit the information received in connection with the conclusion and performance of the Insurance Contract about the participants in the Insurance Contract to the Service Providers to the extent necessary for the provision of Health Care and Health Services.

12.3. **Notifications**

12.3.1. The Parties shall forward all notices related to the Insurance Contracts through Authorized Persons and Contact Persons.

12.4. **Submission of Complaints against the activities of the Insurer or the Insurance Agent**

12.4.1. The Policyholder, the Insured, and the beneficiaries, if applicable, have the right to file a Complaint with the Insurer against the activities of the Insurer or the Insurance Agent in connection with the performance of the obligations arising from the Insurance Contract.

12.4.2. When submitting a Complaint, the Complainant must provide at least the following information:

- information about the Complainant:
  - private person - first and last name, address, telephone number, and e-mail address (if any);
  - legal entity - name, address, telephone number, and e-mail address of the company/company (if any);
- the date on which the Complaint was lodged;
- an overview of the circumstances and reasons for the dissatisfaction with as clear and comprehensive a description as possible and, if possible, attach documents proving the circumstances referred to in the Complaint.

12.4.3. The Complaint can be submitted:

- by mail, sending:
  - To the address of the Insurance Agent;
  - To the address of the Insurer;
- by e-mail, sending:
  - to the Insurance Agent's e-mail;
  - to the Insurer's e-mail.

12.4.4. Upon forwarding the Complaint to the Insurance Agent, the Insurance Agent shall forward the Complaint to the Insurer immediately, but not later than within five (5)

business days from the date of receipt of the Complaint and shall notify the Complainant thereof.

12.4.5. Upon receipt of the Complaint, the Insurer shall register the Complaint and notify the Complainant in writing of the registration number of the Complaint and the term for reply in a reproducible form.

12.4.6. The Insurer shall submit a reasoned written response to the Complaint to the Complainant within 30 (thirty) days from the day when the Complainant has submitted the Complaint to the Insurer or the Insurance Agent. If the term of 30 (thirty) days cannot be resolved due to its complexity or other good reasons, the Insurer shall notify the Complainant in writing of the reasons for the extension of the procedure and the additional term for the reply. The Insurer may extend the term by no more than 4 (four) months from the date of submission of the Complaint.

12.4.7. The Insurer always responds to complaints concerning the activities of the Insurance Agent.

12.4.8. The Policyholder, the Insured, and the beneficiaries, if applicable, have the right to request (in writing or electronically) from the Insurer additional information on the procedure for handling complaints.

12.4.9. Complaint's processing is free of charge for the Complainant.

12.5. **Applicable law**

12.5.1. The legislation in force in the Republic of Estonia is applied to regulate the contractual relations arising from insurance contracts.

12.6. **Settlement of disputes**

12.6.1. Disputes arising from Insurance Contracts shall be sought to be resolved by agreement of the parties.

12.6.2. If an agreement is not possible, disputes arising from the Insurance Contract shall be settled in Harju County Court in accordance with the legislation of the Republic of Estonia.

12.6.3. The parties to the insurance contract do not have the right to transfer the rights arising from the contract to third parties.

12.6.4. The parties to the Insurance Contract have the right to turn to the Insurance Agent or the Insurer to resolve a dispute, if it is not possible to resolve disagreements with the Insurer:

- To the conciliation body operating at the Estonian Insurance Association (tel. +372 6 67 18 00, lepitus@eksl.ee, Mustamäe tee 46, Tallinn 10621);
- In case of violation of consumer rights, to the Consumer Protection and Technical Regulatory Authority (tel. +372 6 20 17 07, info@ttja.ee, Sõle 23a, 10614 Tallinn);
- In case of data protection disputes, to the Data Protection Inspectorate (+372 5 62 02 341, info@aki.ee , Tatari 39, Tallinn 10134).

12.6.5. The Policyholder has the right to submit a complaint regarding the activities of the Insurer or the Insurance Agent to the Financial Supervision Authority at the address Sakala 4, 15030 Tallinn, info@fi.ee .