COMPENSA
VIENNA INSURANCE GROUP

HEALTH INSURANCE CONDITIONS

Valid from September 1, 2026.

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GENERAL CONDITIONS

1. Definitions

1.1. **The insured person or the insured** is a natural person, who is a resident of Estonia and an employee of the policyholder named in the insurance policy or in its appendix, who works on the basis of an employment contract or another contract under the Law of obligations (subcontractor's contract, agency contract, board member's contract, service contract, etc.), including a member of the management body, a procurator or a person working in the public service (hereinafter referred to as an insured employee) whose related risk is insured. The insured person can also be a family member of the insured employee if the insurer and the policyholder have separately agreed on this.

1.2. **A family member of the insured person** is the spouse or life partner of the insured person and a child of the insured person under 21 years of age.

1.3. **The insurer** is Compensa Life Vienna Insurance Group SE (registry code 10055769).

1.4. **The insurance coverage** is the insurer's obligation to pay insurance compensation in the case of an insured event under the conditions specified in the insurance contract. The insurance cover is valid during the insurance period specified in the policy. Insurance coverage applies to the insured person during the period the person is entered in the list of insured persons.

1.5. **The insurance contract** or **contract** is an agreement concluded between the insurer and the policyholder on the basis of which the policyholder pays the insurance premiums and the insurer pays out the insurance compensation.

1.5.1. The contract documents are:

- The insurance application with annexes;
- The terms and conditions;
- The policy with its annexes.

1.5.2. If there is a contradiction in the documents of the contract, the interpretation is based on the following order of importance, where the preceding document takes precedence over the following:

- The policy with its annexes;
- The terms and conditions;
- The insurance application with annexes.

1.6. **The insurance territory** is the Republic of Estonia.

1.7. **The insurance premium is the sum of money that the policyholder pays to the insurer on the basis of the contract.**

1.8. **The policyholder** is a legal person who has concluded an insurance contract with the insurer.

1.9. **The insurance compensation** is a financial compensation paid according to the insurance contract for a loss caused due to an insured event. The insurer will only compensate the beneficiary for the costs related to an insured event that occurred during the insurance period if the service has already been provided and was provided by a service provider accepted in these terms and conditions. Reimbursable prescription drugs, glasses or other purchased aids must be purchased in the Republic of Estonia, unless otherwise stated in the policy.

1.10. **The insured event** is an event specified in the contract, upon the occurrence of which the insurer pays out the insurance compensation. The insurer does not reimburse expenses incurred before or after the validity of the insurance period.

1.11. **The insurance period** is the period of time specified in the policy during which the insurance cover is valid. Unless otherwise stated in the policy, the insurance period is one (1) year.

1.12. **The client** is any person, including the policyholder, the insured person, and the beneficiary, to whom the insurer provides or has provided an insurance service or who has had contact for using such a service. The client is also the representative of the previously described person.

1.13. **A medical indication** is the appearance of ailments, complaints, symptoms, or other health-related circumstances in the insured person as a result of which the need arises to consult a family or specialist doctor and to perform additional analyses, studies or other diagnostic procedures to confirm the diagnosis. The medical indication is evidenced by a (digital) referral issued by the healthcare provider, a medical history record or the decision of an occupational health doctor. The (digital) referral issued by the doctor, the medical history record or the occupational health doctor's decision must have been issued before the reimbursable expense occurred.

1.14. **A deductible** is the amount stated in the insurance policy, to the extent of which the insured person is obliged to pay for the health services they have consumed or purchased products (e.g., medicines, aids, glasses, lenses, etc.). The remaining amount is to be reimbursed by the insurer to the extent of the insurance coverage limit.

1.15. **The policy** is a document certifying the conclusion of the contract, issued by the insurer.

1.16. **The beneficiary** is an insured person or a policyholder.

1.16.1. In the case of an occupational health inspection and repatriation coverage, the beneficiary is the policyholder.

1.17. **The healthcare provider** is a service provider:

1.17.1. Who has a license to provide healthcare services in the Republic of Estonia; or

1.17.2. Who is a company entered in the register of the Health Board; or

1.17.3. Who has a professional certificate valid at the time of providing healthcare services.

1.18. **Web office and mobile applications** are electronic service channels of the insurer that the insurer and the insured person use for mutual communication under the conditions established by the insurer.

1.19. **An international sanction** is an economic or financial sanction, embargo, or other similar sanction, ban, or restrictive measure established in accordance with UN resolutions or legislation of the European Union, or the Republic of Estonia, or the United Kingdom, or the United States (including sanctions administered or enforced by the Office of Foreign Assets of the US Department of the Treasury Control).

2. Applicable law

2.1. In addition to these terms and conditions and other contract documents, the laws and other legal acts in force in Estonia apply to the relationship between the insurer and the client.

3. Client identification

3.1. In order to identify their identity and right of representation, the client submits the data and documents required by the insurer that meet the legal requirements. The insurer may require the client to be identified by direct contact in the presence of a representative of the insurer.

3.2. The insurer does not have to accept a document proving the right of representation in which the right of representation is not expressed unambiguously and clearly.

3.3. If the client's power of attorney has been revoked or declared invalid they shall immediately notify the insurer, even if the corresponding notification has been published in the Official Announcements.

CONCLUSION OF INSURANCE CONTRACT AND JOINING THE CONTRACT, PAYMENT OF INSURANCE PREMIUMS

4. Conclusion of the insurance contract and joining the contract

4.1. In order to conclude the contract the policyholder submits an insurance application together with the documents required by the insurer, including the names and personal IDs of the insured persons.

4.2. In order to join or remove the insured person from the contract, the policyholder must submit a corresponding application.

4.3. If the insurance risks are acceptable to the insurer, the insurer issues a policy to the policyholder, which is an offer to conclude a contract. Together with the policy, the insurer issues an invoice for the first insurance premium payment.

4.4. The insurance contract is deemed concluded and all terms of the contract are accepted at the moment the first insurance premium payment is received by the insurer.

4.5. If the contract is changed, the insurer makes the necessary changes to the policy. The insurer issues a revised policy at the policyholder's request. In the case of the loss or destruction of the policy, the insurer issues a replacement policy at the request of the policyholder. The latest policy supersedes previous policies of the same contract.

5. Payment of insurance premiums

5.1. The policyholder pays insurance premiums in the amount and frequency agreed in the insurance contract.

5.2. If the policyholder pays the insurance premiums differently than agreed, the insurer may, in agreement with the policyholder, change the payments to be paid in the future.

THE CLIENT'S OBLIGATION TO NOTIFY

6. The client's obligation to notify upon conclusion of the insurance contract and during its validity

6.1. The policyholder and the insured **must notify the insurer of**

6.1.1. **An important matter** that may affect the insurer's decision regarding the conclusion of the insurance contract and the terms of the contract.

6.1.1.1. Important matters, in particular, are those that the insurer has requested information before concluding the insurance contract.

6.1.2. **Data and circumstances** that have changed compared to what was disclosed to the insurer. The insurer must be notified, for example, of changes in the data of the insured person themselves or of the person related to the contract/representative, including changes in contact details and rights of representation, as well as revocation and invalidation of the power of attorney;

6.1.3. **Other circumstances** that may affect the performance of the contract concluded with the insurer. The insurer must be notified, for example, of the transformation, merger, or division of a legal entity, and the initiation of bankruptcy, forced termination, or liquidation proceedings;

6.1.4. **All the circumstances the insurer needs to know, at the insurer's request**, in order to fulfil the requirements arising from the legislation.

6.2. The obligation to notify must be followed during the entire period of validity of the insurance contract, it should be done as soon as a circumstance requiring notification arises. Necessary documents must be submitted at the request of the insurer.

6.3. The policyholder and the insured provide the aforementioned information to the insurer even if it is public, for example, such as being published in the media or registered in public registers. A document proving the change must be submitted at the request of the insurer.

6.4. Until receiving contrary information, the insurer considers that the data in its possession is correct.

6.5. When fulfilling the obligation to notify the policyholder the insured shall comply with the data transmission requirements described in Clause 15.

INSURANCE COVERAGE AND INSURANCE COMPENSATION

7. Insurance coverage

7.1. The basic health insurance cover is Outpatient treatment, in addition to which the policyholder can choose the following insurance covers:

7.1.1. Inpatient treatment;

7.1.2. Rehabilitation;

7.1.3. Prophylactic examinations;

7.1.4. Dental care;

7.1.5. Post-accident dental care;

7.1.6. Mental health services;

7.1.7. Optical aids;

7.1.8. Vaccination;

7.1.9. Prescription drugs;

7.1.10. Occupational health inspection;

7.1.11. Obstetrics;

7.1.12. Repatriation.

7.2. Insurance coverage selected in addition to the basic coverage is only valid if it is indicated in the policy.

7.3. The scope of insurance coverage specified in these terms and conditions is listed as an exhaustive list.

Outpatient treatment

7.4. On the basis of outpatient treatment insurance coverage, the following costs are covered by the insurer:

- Healthcare provider visits, remote appointments and consultation fees, both with and without a referral;
- Visit fees, which are not reimbursed by the Health Insurance Fund;
- Surgery (including day surgery), procedures, examinations, analyses, and other diagnostics prescribed by a doctor with a (digital) referral, record in the medical history or an occupational health doctor's decision;
- Day care;
- Fee for preparing a treatment plan.

7.5. In addition to the exclusions listed in Clause 9, the following are not covered by the insurer on the basis of ambulatory care insurance coverage:

7.5.1. Coaching services; COVID-19 tests; dietitian and nutritionist services; bariatrics; preventive treatment; prophylactic examinations (birthmark examinations, allergy and food intolerance tests, trichologist services, etc.); hypnotist services; procedures performed for cosmetic, plastic and/or aesthetic purposes, including treatment of acne and pimples, treatment of rosacea, lipolysis and liposuction, abdominoplasty, thigh, buttock and upper-arm lifts; removal of skin lesions, eyelid surgery, breast augmentation, reduction, lifting or correction, reshaping of the nose, ears or chin, botulinum toxin and dermal filler injections, skin tightening, rejuvenation and resurfacing procedures, aesthetic correction of scars, stretch marks, pigmentation and dilated blood vessels, hair removal and hair transplantation, removal of tattoos and permanent make-up, and other procedures or treatments performed to alter or improve appearance without a medical indication; medical pedicure, including treatment of warts and corns; costs related to dry eye syndrome; costs related to not appearing at an appointment; alternative health services and methods; comfort services (home visits); narcologist services; treatment and monitoring of oncological diseases; consultations, examination and analyses related to family planning and infertility treatment; planned day care (dialysis, haemodialysis, immunoglobulin therapy, chemotherapy, etc.); regular pregnancy monitoring and consultations, all pregnancy-related examinations, geneticist consultations, (gene) tests, analyses and obstetric care; sexual pathologist services, diagnosis and treatment of sexually transmitted diseases; sclerotherapy and vein therapy; inpatient treatment; dental care, including costs related to post-accident dental care; vision correction surgery, including cataract surgery, procedures, examinations and glasses or contact lenses; prescription drugs, including costs related to the administration, insertion and removal of a prescription medicine where the cost of the relevant prescription medicine is not reimbursable under the insurance contract;; rehabilitation services (including sports doctor, rehabilitation specialist, occupational therapist, technical orthopaedist and prosthetist services, as well as other services listed in 7.13); health certificates; occupational health inspection; the cost of mental health support; vaccination; costs of consultations with a sleep specialist or sleep counsellor, examinations, diagnostics and treatment, including the use of devices and other related services; costs of post-operative service packages (e.g. wound dressing or similar services); costs related to blood plasma and hyaluronic acid treatments; costs of any laser treatment of the skin..

7.6. The insurer reimburses proven costs for ambulatory care within the limits of the insurance limit specified in the contract.

Inpatient treatment

7.7. Planned inpatient treatment must be agreed upon in advance with the insurance provider by e-mail or in a form that allows written reproduction.

7.8. On the basis of inpatient treatment insurance coverage, if there is a medical indication and agreement with the insurer, the following costs are covered by the insurer:

- Scheduled and emergency medical consultations, surgeries, and procedures;
- Examinations, analyses, and diagnostics performed in the hospital;
- Medicines prescribed by a doctor in a hospital and administered by the insured person;
- Hospital bed-day fees, including the cost of the postpartum family room.

7.9. In addition to the exclusions listed in Clause 9, the following are not covered by the insurer on the basis of inpatient treatment insurance coverage:

7.9.1. Bariatrics; sclerotherapy and vein therapy; organ and tissue transplantation; dental care; costs related to not appearing at an appointment; the stay of a caregiver with the insured person during hospitalisation; termination of pregnancy without medical indication and the accompanying complications; procedures and operations performed for cosmetic, plastic and/or aesthetic purposes; pre- and post-surgery ambulatory services and/or personal care services; obstetric care, including paid midwife services; rehabilitation; inpatient treatment related to mental health support (including administered medications).

7.10. The insurer reimburses the proven costs for inpatient treatment within the limits of the insurance limit specified in the contract.

Rehabilitation

7.11. The prerequisite for the application of rehabilitation insurance coverage is the insured person's need for help to restore or maintain the functions of the impaired support and movement organs or adapting to disability. Rehabilitation treatment must be assigned to the insured person by a doctor or an occupational health doctor and is subject to compensation only if the rehabilitation treatment began no later than 90 days after the need for rehabilitation treatment arose, unless otherwise specified in the referral letter.

7.12. In the case of rehabilitation insurance coverage, the rehabilitation service provider may also provide services outside the treatment facility.

7.13. On the basis of rehabilitation insurance coverage the following costs are covered by the insurer if there is a medical indication:

- Rehabilitation doctor visit and consultation fee;
- Sports physician's visit and consultation fee;
- Costs for renting or purchasing aids: wheelchair, crutches, joint prosthesis, support bandages, orthoses, maternity bandages/belts, orthopaedic shoes, support devices, hearing aids;
- Electrotherapy;
- Physical therapy;
- Salt therapy;
- Pulse therapy;
- Kinesio taping;
- Chiropractic care;
- Speech therapy and other speech therapist services;
- Laser treatment;
- Intra-articular injections;
- Magnetic therapy;
- Manual therapy;
- Mud therapy;
- Osteopathy;
- Therapeutic massage, including classic and sports massage;
- Therapeutic gymnastics;
- Occupational therapy;
- Ultrasound therapy;
- Hydrotherapy.

7.14. In addition to the exclusions listed in Clause 9, the following are not covered by the insurer on the basis of rehabilitation insurance coverage:

7.14.1. The cost of rehabilitation treatment if rehabilitation is not prescribed by a doctor;

7.14.2. The cost of rehabilitation treatment that took place before the (digital) referral was issued by the doctor;

7.14.3. Accessories and spare parts for assistive devices; massages that do not fall under the services listed in Clause 7.13, including roller, LPG, cryo-massage, lymphatic massage, lymphatic drainage etc.; costs related to not appearing at an appointment; any costs related to swimming; facial massage and other beautician services and procedures; sanatorium or spa packages; sports club monthly memberships or expenses for personal training; accommodation and food expenses related to rehabilitation; acupuncture, including needle therapy; reflexology;

7.14.4. Expenses incurred in following other recommendations given by an (occupational health) doctor related to exercise habits or a healthy lifestyle;

7.14.5. Expenses related to ergonomic workplace equipment (ergonomic mice, keyboards, mouse pads, footrests, etc.).

7.15. The insurer reimburses the proven costs for rehabilitation within the insurance limit specified in the contract.

Prophylactic examinations

7.16. On the basis of insurance coverage for prophylactic examinations, the following costs for prophylactic examinations performed without medical indication are covered by the insurer:

- Allergy and food intolerance studies and tests;
- Antibody tests;
- Dietitian and nutritionist services (including menu preparation);
- Genetic tests;
- Stress tests and other sports studies;
- Vision check or other eye examinations (including issuing a prescription for glasses);
- Medical advice for travel;
- Renewing a prescription;
- Sexually transmitted disease tests and examinations;
- Birthmark examinations;
- Health certificates;
- Trichologist services;
- Sleep doctor or consultant visit and consultation fee;
- Blood tests and medical examinations (e.g., ECG, spirometry, audiometry, mammography, etc.);
- General health surveys and health audits;
- Specialist consultation to interpret test results.

7.17. In addition to the exclusions listed in Clause 9, the following are not covered by the insurer on the basis of prophylactic examinations insurance coverage:

7.17.1. Diet foods; regular consultation of a gynaecologist/midwife/andrologist, consultations related to family planning and infertility treatment, studies, analyses including pregnancy detection; regular monitoring and consultations during pregnancy, all pregnancy-related examinations, geneticist consultations, (gene) tests (including NIPT, NIPTIFY, Panorama, OSCAR), analyses and obstetric care; dental care; over-the-counter rapid tests and rapid testing; costs related to not appearing at an appointment; alternative health services and methods; glasses, contact lenses, sunglasses with optical lenses; prescription drugs; blue light glasses or other optical aids; dietary supplements; occupational health inspection; costs related to sleep-treatment diagnostics, examinations and treatment, including the use of devices and other related services; vaccination.

7.18. The insurer reimburses the proven cost of prophylactic examinations within the limits of the insurance limit stated in the contract.

Dental care

7.19. On the basis of dental care insurance coverage, the following costs are covered by the insurer:

- Dental specialist visit and consultation fees;
- Dental services: opening abscesses, tooth extraction, lip and tongue tissue removal, root canal treatment, fillings;
- Fee for treatment plan preparation;
- Anaesthesia;
- X-ray;
- Oral hygienist services: tartar removal, pearl washing, soda washing, and polishing;
- Tooth restoration;
- Gingivoplasty;
- Costs of implants (including both maintenance and installation);
- Aligners and other orthodontic devices (e.g., facets, arches, braces, tubes, elastics, composites);

- Orthodontics;
- Osteopathy;
- Treatment of periodontal diseases;
- Prosthetics.

7.20. In addition to the exclusions listed in Clause 9, the following are not covered by the insurer on the basis of dental care insurance coverage:

7.20.1. Aesthetic and cosmetic procedures of the teeth and oral cavity (e.g., the installation of laminates, dental decorations, dental coverings, etc.); teeth whitening; dental care aids; costs related to not appearing at the reception; myofunctional therapy; the cost of repairing prostheses; prescription drugs.

7.21. The insurer reimburses the proven costs for dental care within the limits of the insurance limit stated in the contract.

Post-accident dental care

7.22. On the basis of post-accident dental care insurance cover, the insurer shall reimburse costs related to the repair of teeth damaged as a result of an accident, reconstructive surgery involving the jaw or teeth, and prosthetic treatment, including orthodontic treatment.

7.23. An accident is a sudden event beyond the insured person's control in which an external mechanical, thermal, chemical or electrical force causes injury to the insured person's teeth.

7.24. An extract from the medical records showing the circumstances of the accident must be submitted together with the expense documents, including confirmation that the accident was recorded by a healthcare professional. Dental treatment must commence no later than 30 days after the accident.

7.25. In addition to the exclusions listed in Clause 9, the following are not covered by the insurer on the basis of post-accident dental care insurance coverage:

7.25.1. Costs resulting from the insured person accidentally causing injury to themselves, including injuries caused by incorrect biting and similar incidents.

7.26. The insurer reimburses proven costs for post-accident dental care services within the limits of the insurance limit specified in the contract.

Mental health services

7.27. The insured event of the insurance coverage for mental health services is a situation wherein the insured person turns to a service provider for mental health support with any problem affecting the quality of life.

7.28. On the basis of insurance coverage for mental health services, the following costs are covered by the insurer:

- Clinical psychologist visit and consultation fee;
- Psychiatrist visit and consultation fee;
- Psychologist's visit and consultation fee;
- Psychotherapist visit and consultation fee;
- Occupational psychologist's visit and consultation fee;
- Mental health nurse visit and consultation fee;
- Diagnostics and treatment of psychiatric illnesses;
- Prescription drugs, including antidepressants, sleeping pills, and ADHD medications.

7.29. In the case of couple, family or group therapy, the cost is divided proportionally according to the number of participants (it is assumed that the number of participants is at least two). Only the service consumed by the insured person is eligible for compensation.

7.30. In addition to the exclusions listed in Clause 9, the following are not covered by the insurer on the basis of extended dental care insurance coverage:

7.30.1. Alternative mental health support practices; services of an experienced counsellor and a creative therapist; inpatient treatment; rehabilitation; costs related to not appearing at an appointment.

7.31. The insurer reimburses proven costs for mental health services within the limits of the insurance limit specified in the contract.

Optical aids

7.32. On the basis of insurance coverage for optical aids, the following costs related to vision correction are reimbursed by the insurer based on a prescription issued by an ophthalmologist or optometrist or examination results:

- Ophthalmologist or optometrist consultation and visit fee;
- One (1) pair of glasses, including other glasses (optical sunglasses, glasses with photochromic lenses, binocular glasses, blue light glasses);
- Contact lenses, including coloured contact lenses;
- Cost of replacing existing glasses;
- The cost of repairing glasses, including installing optical lenses in a previously purchased frame;
- (Laser) surgeries to correct visual acuity, including cataract operations.

7.33. Optical aids must be purchased from a company whose main activity is the retail sale of glasses and other optical goods in specialized stores.

7.34. In addition to the exclusions listed in Clause 9, the following are not covered by the insurer on the basis of optical aid insurance coverage:

7.34.1. Contact lens containers; costs related to not appearing at an appointment; eye drops, including artificial tears; eyeglass cases; cleaning fluids, cleaning cloths; sunglasses, pharmaceuticals; food supplements, fee for installing optical glasses in frames purchased independently.

7.35. The insurer reimburses proven costs for vision correction aids within the insurance limit stated in the contract.

Vaccination

7.36. The prerequisite for vaccination insurance coverage is that vaccination is performed by a healthcare provider.

7.37. On the basis of vaccination insurance coverage, the following costs are covered by the insurer:

- Vaccines;
- Visit fees.

7.38. In addition to the exclusions listed in Clause 9, the following are not covered by the insurer on the basis of vaccination insurance coverage:

7.38.1. Vaccinations that are organised and paid for by the insured person's employer; Costs related to not appearing to an appointment.

7.39. The insurer reimburses the proven cost related to vaccination within the limits of the insurance limit stated in the contract.

Prescription drugs

7.40. On the basis of insurance coverage for prescription drugs, the insurer reimburses for drugs purchased in the Republic of Estonia on the basis of a prescription issued by a doctor with a license issued in the Republic of Estonia, with the exception of the drugs specified in Clause 7.42.

7.41. In order to receive insurance compensation the insured person must submit a prescription to the insurer. In the case of a paper prescription, it must be captured by photo or scanning before using the prescription.

7.42. In addition to the exclusions listed in Clause 9, the following are not covered by the insurer on the basis of prescription drugs insurance coverage:

7.42.1. Aids (including masks, needles, sensors, blood glucose meters; sleep therapy devices. etc.); antidepressants; contraceptives and medications; sex hormones; medications for addictive disorders; sleeping pills; weight loss medications; medications for erectile dysfunction.

7.43. The insurer reimburses the proven costs for prescription drugs within the limits of the insurance limit stated in the contract.

Occupational health inspection

7.44. On the basis of occupational health inspection insurance coverage, the following costs are covered by the insurer:

- Occupational health inspection;
- Other statutory health check required for work;
- Health certificates needed for the policyholder to work.

7.45. In addition to the exclusions listed in Clause 9, the following are not covered by the insurer on the basis of occupational health inspection insurance coverage:

7.45.1. Additional examinations and analyses determined during the occupational health inspection; prescription drugs; occupational physiotherapist or ergonomist consultation and visit fee; occupational psychologist consultation and visit fee; costs related to not appearing at an appointment.

7.46. The insurer reimburses proven costs for the occupational health inspection within the limits of the insurance limit specified in the contract.

Obstetrics

7.47. The insured event of the insurance coverage for obstetrics is a situation where the insured person herself or the mother of an unborn child needs inpatient treatment in connection with delivery that began during the insurance period.

7.48. On the basis of obstetrics insurance coverage, the following medically indicated, or obstetrics-related costs are covered by the insurer:

- Cost for paid hospital ward, if the insured person is the parent of the child to be born;
- Costs for paid services from the time of checking in to the hospital until checking out (for example, the cost for a doctor or midwife, medication consumed, caesarean section and other surgeries related to childbirth), if the insured person is the mother of the child to be born.

7.49. In order to receive insurance compensation on the basis of obstetrics insurance coverage, the insured person must submit the expense documents and a birth certificate in which the insured person is listed as a parent.

7.50. In addition to the exclusions listed in Clause 9, the following are not covered by the insurer on the basis of obstetrics insurance coverage:

7.50.1. Costs related to home birth; child's post-natal treatment and screening; regular pregnancy monitoring and consultations, all pregnancy-related examinations, geneticist consultations, (gene) tests, analyses; transportation cost; costs related to not appearing at the appointment.

7.51. The insurer reimburses proven cost for obstetrics within the limits of the insurance limit stated in the contract.

Repatriation

7.52. The insured event of repatriation insurance coverage is the death of the insured person, who is a foreign citizen and has died on the territory of the Republic of Estonia. Repatriation insurance coverage can only be taken for persons with foreign citizenship.

7.53. On the basis of repatriation insurance coverage, the insurer shall compensate the policyholder for the costs of burial in Estonia or the costs of transporting the ashes to the home country and/or the costs of cremation in Estonia, previously agreed upon with the insurer in writing or in a form that can be reproduced in writing.

7.54. The insurer reimburses the proven costs related to repatriation within the limits of the insurance limit specified in the contract.

8. Insurance compensation and payment procedure

8.1. The insurer is obliged to pay the insurance compensation only in the case of an insured event covered by the insurance cover(s) specified in the policy, except in the cases listed in Clause 9 and in legislation.

8.2. The policyholder and the beneficiary provide the insurer with truthful information and submit the evidence necessary to determine the fact of the occurrence of the insured event, the reason, and the amount of the insurance compensation.

8.3. In order to apply for insurance compensation, the beneficiary submits the documents required by the insurer within 90 calendar days at the latest, including:

- ID, if necessary;
- The insurer's application form for compensation;
- Medical history records (ambulatory and/or inpatient treatment epicrisis) and/or prescription directly related to the insurance event that occurred;
- Expense documents;
- The birth or death certificate of the insured person, if necessary;
- Other documents depending on the circumstances of the insured event.

8.4. The insurer decides on the payment of insurance compensation based on the documents submitted. The insurer has the right to check the soundness of the doctor's decision and the correctness of documents, to request additional data and documents from third parties, and to make relevant inquiries.

8.5. The insurer makes a decision on compensation or refusal of compensation no later than 30 days after receiving all necessary documents and data.

8.6. If the fulfilment of the insurer's obligations or the scope of the fulfilment depends on the circumstances that are investigated in criminal, administrative, or misdemeanour proceedings or court proceedings, the insurer may decide to pay the insurance compensation or refuse only after the proceedings have ended or the decision made in the proceedings has entered into force.

8.7. The insurer pays the compensation immediately after the compensation decision is made.

8.8. If the insurer transfers the compensation to a foreign bank account, it can withhold the transfer costs from the compensated amount.

8.9. The recipient of unjustified insurance compensation shall immediately return the compensation to the insurer.

8.10. If the insurer delays the payment of the insurance compensation, it shall pay the fine for delay at the request of the entitled person in accordance with the law.

9. Limitations and Exclusions

9.1. **The insurer refuses to pay the insurance compensation**, if:

9.1.1. It is not an insured event according to the terms and conditions;

9.1.2. The incurred expense does not correspond to the description of compensable expenses (for example, hygiene products, over-the-counter medicines, palliative treatment, transportation and accommodation costs, alternative health services, sports club fees, participation in medical training, lectures, or seminars, etc.)

9.1.3. The health service provider does not have the appropriate professional certificate or license to provide healthcare services;

9.1.4. The health service provider uses a methodology or technology that has not been approved in the Republic of Estonia for the treatment of humans.

9.1.5. There is an outbreak of an infectious disease causing an epidemic or pandemic in the territory of the Republic of Estonia and the insured event is related to the above;

9.1.6. A war or emergency situation has been established in the territory of the Republic of Estonia (for example, radiation, the use of chemical or biological substances for hostile purposes, etc.) and the insured event is related to the above;

9.1.7. The insured person knowingly put themselves in danger (for example, self-harm, suicide attempt, suicide, participation in a fight or armed conflict [except for self-defense, which is confirmed by a police investigation], a significant violation of safety requirements, driving a car while intoxicated or without the right to drive, or being a passenger in a car whose driver is drunk or without the right to drive);

9.1.8. The insured had consumed an alcoholic, narcotic, psychotropic, toxic, or other substance that causes intoxication, and a causal connection can be assumed between the intoxication and the insured event. Refusal to identify intoxication and causing intoxication after an insured event are also treated as intoxication;

9.1.9. The insured person has stopped following or changed prescriptions and/or the treatment assigned to them without the corresponding permission or recommendation from the doctor;

9.1.10. Expenses are related to the issuance of health certificates (for example, driver's license, weapons permit, visa, etc.), including consultations, courses, or other such things that are not related to the insured's work and are not necessary for work, if the coverage of prophylactic examinations has not been taken;

9.1.11. The insured committed an illegal act;

9.1.12. The insured participated in a mass riot or a military operation (except for compulsory military service and peacetime training) or suffered as a result of a weapon of mass destruction or a nuclear incident;

9.1.13. The insured participated in the preparation or perpetration of a terrorist act or contributed to its occurrence in another way;

9.1.14. Insured person presents a prepayment invoice, including a multi-session service card or an pre payment invoice for glasses;

9.1.15. Insured person presents a manually issued invoice where the invoice amount exceeds EUR 50 and was paid in cash.

9.2. **The insurer may refuse to pay the insurance compensation**, if:

9.2.1. The policyholder or beneficiary **has violated the obligations specified in points 8.1 or 8.2**;

9.2.2. The client **has misled** the insurer

- Or tried to mislead about the circumstances of the occurrence of the insured event and/or the amount of the insurance compensation;
- Or otherwise tried **to deceive** regarding the insurance contract or the circumstances of its performance;

9.2.3. The receiver of the payment is subject to an international sanction.

9.3. If, at the time of concluding the insurance contract, incorrect data was provided to the insurer, on the basis of which a lower premium has been calculated, the insurer will compensate the loss proportionally to the difference between the premium paid and the premium calculated based on the correct data.

CHANGING, ENDING AND TERMINATION OF THE INSURANCE AGREEMENT

10. Changing the insurance contract

10.1. The insurance provider and the policyholder shall change the insurance contract by written agreement, unless the contract (including the terms and conditions), the law, or other legislation states otherwise.

10.2. By agreement of the parties, insured persons may be added to or removed from the contract.

10.3. The policyholder may unilaterally terminate the insurance coverage for each insured employee or add a new insured employee to the insurance coverage by notifying the insurer.

10.3.1. The policyholder has the right to change the list of insured persons once a calendar month by notifying the insurer in a form that enables written reproduction no later than five (5) working days before the end of the calendar month. Notification must include the data of the insured person to be added or removed, including the name and personal ID. The changes will take effect from the first day of the following calendar month.

10.3.2. The insurer issues the Annex to the policy within five (5) working days of receiving the relevant notification.

10.3.3. The policyholder is obliged to pay the insurance premium on behalf of the insured person unless otherwise stated in the policy.

10.4. In order to change the insurance contract, a corresponding application must be submitted to the insurer.

10.5. If changes are made to the insurance contract concerning insurance coverage, the insurer will change the insurance premium accordingly.

10.6. If changes are made to the insurance contract concerning the insured persons, the insurer will change the insurance premium accordingly.

10.6.1 The insurance premium is calculated on a calendar month basis, regardless of the number of days the insured person's insurance coverage is valid in a specific calendar month.

10.7. The insurer has the right to unilaterally change the insurance premium in justified cases. The changes in following circumstances are considered justified for the change of the insurance premium:

- A circumstance independent of the parties specified in the insurance contract as the basis for calculating the insurance premium;
- Average life expectancy of insured persons;
- Frequency of use of the insurance coverage by the insured person according to this premium rate;
- Scope of state reimbursement for health insurance services;
- Healthcare providers' fees for using the healthcare services;
- Legislation changes in the healthcare system.

10.8. The insurer has the right to unilaterally change the terms and conditions and other terms of the insurance contract if:

10.8.1. The changes result from changes in legislation or requirements established by supervisory authorities;

10.8.2. The changes are necessary to protect the interests of the policyholder or the insured person or improve their situation;

10.8.3. The changes are necessary to protect the insurer's interests and are not unreasonable for the policyholder.

10.9. The insurer informs the policyholder of the change according to the procedure specified in Clause 12 at least 30 calendar days before the change takes effect.

10.10. If the policyholder does not agree with the change, they can terminate the contract by submitting a corresponding notice to the insurer before the change takes effect.

10.11. If the policyholder does not use the right to terminate the contract, it is considered that they have accepted the changes made.

10.12. When the insured person is removed from the contract, the policyholder has the right to get back the insurance premium paid in advance for the remaining insurance period for that insured person. The insurance premium paid in advance for the insured person removed from the contract is returned within 30 calendar days according to the used insurance limit and/or insurance period. If the insurance limit is fully used, the overpaid insurance premium will not be returned. Clauses 8.8 and 9.2.3 apply to the payments.

11. Ending and termination of the insurance contract

11.1. The insurance contract is concluded for a fixed term and is valid until the end of the insurance period.

11.2. The insurance contract ends when:

11.2.1. **The end date of the insurance period** arrives. The contract has no return value;

11.2.2. The policyholder or the insurer may **terminate** the contract in the case and according to the procedure prescribed in the terms and conditions, the law, or other legislation;

11.2.3. The insurer finds out that the insurance contract does not include any insured persons with valid insurance coverage.

11.3. **The policyholder or the insurer** may terminate the contract at any time by notifying the other party at least one (1) month in advance in writing or in a form that enables written reproduction.

11.4. To terminate the contract, the policyholder must submit the required application as described in Clause 13.1.

The day of the end of the contract is:

- The date shown on the policyholder's application or
- The day when the insurer receives the application (if it happens after the date specified in the application).

11.5. **The insurer** may **terminate the insurance coverage** if the policyholder or the insured has wrongfully violated the notification obligation described in Clause 6.1.1:

- The insurer has not been informed of an important circumstance or has been given incorrect or incomplete information about this, and
- An important circumstance, in which the insurer was not notified, has caused the insured event or had an impact on its occurrence or the validity or scope of the insurer's obligation.

11.6. **The insurer may terminate the insurance contract** without advance notice if

11.6.1. The policyholder does not agree to the changes made to the contract in accordance with the terms and conditions;

11.6.2. The client has withdrawn the consent given for processing of personal data and the insurer is unable to continue fulfilling the contract;

11.6.3. The client has provided the insurer with incorrect or incomplete data or documents with signs of forgery or refuses to provide data or documents;

11.6.4. The client has caused damage or the risk of damage to the insurer through their actions or inaction, has damaged the reputation of the insurer, or prevented the insurer from fulfilling its obligations arising from the law or other legislation.

11.7. Upon termination of insurance coverage, the insurer will reduce the premium accordingly.

11.8. Upon termination of the insurance contract, the insurer must make the payment no later than 30 calendar days after the termination of the contract according to the used insurance limit and/or insurance period. If the insurance limit is fully used, the overpaid insurance premium will not be returned. Clauses 8.8 and 9.2.3 apply to payments.

11.9. Termination of the contract does not end the insurer's claims regarding the recoverable insurance compensation specified in clause 8.9.

11.10. If the Policyholder terminates the health insurance contract, the insurer is entitled to refund the insurance premium paid in advance for the remaining insurance period, from which the insurer may deduct a 10% administrative fee and any indemnities already paid.

EXCHANGE OF INFORMATION AND DOCUMENTS

12. Notices from the insurer

12.1. The insurer informs clients via media, on its website, or in its offices. If necessary, the insurer sends a personal message to the client.

12.2. In order to send a personal message, the insurer chooses the best communication channel based on the content of the message, which can be, for example, an online office, e-mail, mail, phone call, SMS message, etc.

12.3. The insurer may decide not to send a personal message if it has reasonable grounds to believe that the contact data available to the insurer is incomplete or incorrect (for example, if the postal service provider has returned the letter with a note that the recipient does not live at this address).

12.4. A personal notice is deemed to have been received and the insurer's obligation to notify is fulfilled if the notice has been sent either to the online portal or to the client or the person entitled to receive the notice on their behalf, or to their contact details last given to the insurer.

12.5. A personal message sent to the client by mail is deemed to have been received on the fifth calendar day from the date of posting. A personal message sent through another communication channel is considered received on the same day.

12.6. Information publicly provided to clients is deemed to have been received on the day it was published.

12.7. Information about the insurance coverage and limits applicable to the insured person is available in the online portal.

13. Notices from the client and other documents submitted by the client

13.1. The client provides any application, request, explanation, notice, request for data or any other information or data in the form and manner required by the insurer and in accordance with the requirements set forth in law and other legislation. In general the insurer accepts notices submitted to it in a form that allows written reproduction. The insurer may require that the notice

- Is signed in a manner accepted by the insurer, including by hand in the presence of a representative of the insurer, with a digital signature, or a notarized signature, or
- Would be submitted through the online portal, through a mobile application or another method that, in the insurer's opinion, enables the identification of the person submitting the notice.

The time of preparation and sending of the notice must be identifiable.

13.2. The client checks the correctness of the information contained in the insurer's notice immediately and submits their objection to the insurer

immediately after receiving the notice.

13.3. The insurer may consider the information provided by the client submitted and its content correct if the client's contact details known to the insurer, such as an e-mail address, or the insurer's electronic service channels, such as the online portal, have been used for submitting the information.

13.4. The policyholder may request a copy of any statement they have submitted to the insurer regarding the insurance contract in a form that allows written reproduction.

13.5. The insurer may request a translation of a document in a foreign language into Estonian or another language accepted by the insurer.

13.6. If the submitted document does not meet the requirements or if the insurer has doubts about the authenticity of the document, it may refuse to carry out the transaction and request additional documents.

13.7. The insurer may record telephone calls related to the performance of the insurance contract.

13.8. The insurer provides information in Estonian. If the client has expressed a wish and the insurer is able to do so, the insurer may provide information in another language.

LIABILITIES, SETTLEMENT OF DISPUTE AND JURISDICTION

14. Responsibility

14.1. The insurer does not provide protection against any insured event and is not obliged to pay insurance compensation or make any other payments arising from the insurance contract or fulfil other obligations under the contract if the insurer would be in conflict with any international sanction as a result. The insurer is not responsible for claims or damages resulting from the above.

14.2. The insurer is not responsible for:

- Damage caused to the client due to termination of the contract or refusal of the transaction;
- Damage caused to the client or a third party as a result of a breach of the client's notification obligation.

14.3. The client compensates the insurer for the damage caused by providing false information or violating the notification obligation.

14.4. The policyholder is responsible for the accuracy of the list of insured persons, and the validity of the insurance coverage does not depend on whether the insured person was an employee of the policyholder or a family member of the insured employee at the time of the insured event. The validity of insurance coverage for a specific insured person depends only on being on the list of insured persons.

15. Settlement of disputes and jurisdiction

15.1. Disagreements between the insurer and the client are to be resolved through negotiations.

15.2. The client can submit a complaint to the insurer in a form that enables written reproduction or through the online portal. The complaint must indicate the circumstances and documents on which the complainant relies.

15.3. The insurer responds to the complaint within 15 calendar days from the receipt of the complaint. If it is not possible to resolve the complaint within the specified deadline, the insurer may extend the response deadline by notifying the complainant and explaining the reasons for extending the deadline.

15.4. The client can submit a complaint to the supervisory authority or the conciliation body operating at the Estonian Insurance Association, and the client can also go to court.

15.5. The disputes arising from the insurance contract will be resolved in an Estonian court if no other mandatory jurisdiction is provided by law or other legislation.

15.6. The Insurer is supervised by Finantsinspektsioon (Estonian Financial Supervision and Resolution Authority).