GENERAL TERMS & CONDITIONS OF THE CONFIDO HEALTH SOLUTION

Effective as of 27 January 2022

This document (hereinafter the **T&C**) sets out the principles and conditions of the Health Insurance provided by the Insurer in cooperation with the Insurance Agent as part of the Confido Health Solution.

If you have any questions after reading the Terms & Conditions, please contact your Insurance Agent (kindlustus@confido.ee; +372 602 6795) or the Insurer (bta@bta.ee; +372 5 68 68 668).

1. DEFINITIONS USED

Confido Health Solution – a product developed in cooperation by Arstikeskus Confido OÜ (registry code 12381384, address Veerenni 53a, Kesklinn, 11313 Tallinn, Harju County, hereinafter **Confido**) and the Insurer, within the scope of which Confido offers, both itself and via its partners, based on agreements with Insurers to their Employees and, if appropriate, their Relatives Health and Medical Services and the Insurer offers the Policyholders Health Insurance to insure the Employees and, if appropriate, their Relatives against health insurance risk.

Health insurance is only offered to Policyholders who have subscribed for the Confido Health Solution.

Insurance Card – the individual insurance card number issued by the Insurer to the Insured Person confirming the validity of the Insurance Cover for the Insured Person. The Insurance Card number may 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 Insurance Card number is being used by an unauthorised person.

Insurance Cover – the risks against which the Insured Person is insured. The Insurance Cover is determined according to the Health and Medical Services covered by the Insurance Contract.

Insurance Contract – the Health Insurance Contract entered into between the Insurer and the Policyholder through the Insurance Agent. The Insurance Contract consists of the Insurance Request, the T&C, the Insurance Scheme, the Insurance Policy, the Factsheet and other documents entered into between the Policyholder and the Insurer, if applicable. The Insurance Contract allows the Policyholder to include Employees and, where applicable, Relatives as Insured Persons in the Insurance Contract, in which case the Employees and the Relatives will be entitled to health insurance benefits from the Insurer in the event that the Employee or Relative needs treatment.

Insurance Premium – the fee agreed on in the Insurance Contract and paid by the Policyholder (or, if appropriate, the Employee or the Relative) for the Insurance Cover.

Insurance Policy – the document confirming the entry into and validity of the Insurance Contract, which is sent to the Policyholder after the entry into or amendment of the Insurance Contract or the extension of the Insurance Period.

Insurance Scheme – the terms and conditions of insurance (Insurance Cover, Insurance Premium, Sum Insured, Limit, etc.) which form an integral part of the Insurance Contract and which apply to a specific Insured Person or to all Insured Persons.

Insurance Period – the period of time specified in the Insurance Contract during which the Insurance Cover set out in the Insurance Contract is in force and on the basis of which the Insurance Premiums are calculated. If the Insured Person is added to the Insurance Contract during the Insurance Period, the Insured Person will be subject to the Insurance Cover from the addition to the end of the Insurance Period, unless the Insured Person is removed by the Insurer earlier.

Sum Insured – the maximum amount subject to compensation to an Insured Person in one Insurance Period within the scope of the Insurance Scheme selected by the Insurer (both in full and in terms of separately covered Health and Medical Services).

Insurance Request – the Policyholder's Request to enter into an Insurance Contract submitted to the Insurance Agent. The Insurance Request includes a list of Employees and, where appropriate, Relatives with the necessary personal data in accordance with the Insurance Agent's form, who would like to join the Insurance Contract as Insured Persons and the choice of Insurance Scheme with regard to each Employee/Relative. If Insured Persons are added during the term of the Insurance Contract, the Policyholder submits an additional Insurance Request to the Insurance Agent.

Insured Person – an Employee or their Relative who is named in the Insurance Contract as the Insured Person. The health insurance risk related to the Insured Person as a third party is insured on the basis of the Insurance Contract. If a person has been removed from the list of insured persons by the Policyholder, it is presumed that the person is no longer an Insured Person.

Policyholder – a legal person who wants to provide Health Insurance to their Employees and, if appropriate, their Relatives, and who assumes the obligation to pay insurance premiums (unless the Insurance Premium is paid by the Insured Person themselves).

Contact Person – persons appointed by the parties to the Insurance Contract to receive notices related to the Insurance Contract and to resolve current issues.

Limit – the percentages arising from the Insurance Contract to the extent of which the Insurer pays for the service received by the Insured Person or the number of paid services that do not exceed the Sums Insured set out in the Insurance Contract.

Relative – a family member, spouse or partner, parents and children of the Employee who are Insured Persons on the basis of the Insurance Contract. The provisions of the T&C applicable to the Employees are also applied to the Relatives, unless otherwise provided by the context.

Factsheet – the standard form of the insurance product information document provided for in Commission Implementing Regulation (EU) No 2017/1469.

Service Provider – Health and Medical Service Providers. Service Providers include Confido and its partners.

Health Service – the activities of health care professionals/institutions for the prevention, diagnosis and treatment of diseases, injuries or poisoning. The purpose of the Health Service is to alleviate a person's complaints, prevent the deterioration of their state of health or the exacerbation of a disease and restore their health. A Health Service may be either outpatient or inpatient.

Health Insurance – the health insurance product offered by the Insurer within the meaning of § 554 of the Law of Obligations Act and clause 12 (1) 2) of the Insurance Activities Act, within the scope of which the Insurer insures the insured risk arising from the need to provide Health and Medical services to the Insured Persons and cover the related costs.

Employee – a person performing work for the benefit of the Policyholder on the basis of a valid and effective employment, management board member or other service contract.

Authorised Person – persons appointed by the Insurer and the Policyholder whom the parties have appointed for data exchange in connection with entry into and performance of the Insurance Contract, incl. for transmission of encrypted data.

2. OBJECT OF HEALTH INSURANCE

2.1. The object of Health Insurance is the health of the Insured Person and the risk of incurring the costs associated with the provision of the Health and Medical Services necessary to maintain it (i.e. the insurance risk).

2.2. The Insurance Covers covered by Health Insurance, the applicable Sums Insured, Limits and Insurance Premiums are set out in the Insurance Schemes between which the Policyholder can choose, and in these T&C.

2.3. The Policyholder enters into an Insurance Contract in order to insure the insurance risks related to Employees and, where applicable, their Relatives, to protect their health and to increase the Employees' capacity for work and productivity (insurable interest).

2.4. In cooperation with the Insurance Agent, the Policyholder selects the Insurance Schemes suitable for its Employees and, if appropriate, for the Relatives.

2.5. In order to add Employees and, if appropriate, Relatives to the Insurance Contract as Insured Persons, the Policyholder submits an Insurance Request to the Insurance Agent, which includes at least the following information about the Employees and the Relatives:

2.5.1. name and surname;

2.5.2. ID code or, if there is no ID code, the date of birth;

2.5.3. personal e-mail address;

2.5.4. mobile number;

2.5.5. the Insurance Scheme selected for everyone or a specific person.

The Authorised Person of the Policyholder submits said data in encrypted format by sending them to the Authorised Person of the Insurance Agent.

2.6. By transmitting data to the Insurance Agent, the Policyholder confirms that it has the right to submit the data of Employees and, where applicable, the Relatives to the Insurance Agent and the Insurer and that the Employees and, where applicable, the Relatives consent to their inclusion in the Insurance Contract as Insured Persons under the terms of the Insurance Contract.

2.7. The Insurer checks the data submitted by the Policyholder and, if they are correct, sends them to the Insurer for the addition of Employees and, if appropriate, Relatives to the Insurance Contract as Insured Persons.

2.8. The Insurer has the right to refuse to include an Employee or, where appropriate, their Relative in the Insurance Contract if the person:

2.8.1. has submitted false data or committed insurance fraud in the past;

2.8.2. has failed to pay insurance premiums in the past;

2.8.3. is unsuitable as an Insured Person for another good reason.

2.9. When an Insured Person is added to the Insurance Contract, the Insurer will send the Insurance Policy proving the Insurance Cover, the number of the Insured Person's Insurance Card and other relevant information to the Policyholder via the Insurance Agent. Where appropriate, the Insurance Agent will, using the contact details of the Insured Person, also provide the Insured Person with information on the Insurance Cover. The Policyholder is obliged to inform the Insured Person of the entry into force of the Insurance Cover and to familiarise them with the terms and conditions of the Insurance Contract.

2.10. The Policyholder is bound by the Insurance Request from the moment the signed Insurance Request is submitted to the Insurance Agent. The Insurance Cover applies to the Employees and, if appropriate, to the Relatives as of the moment of their entry into the Insurance Contract as Insured Persons. Thereafter, Insured Persons may be removed from the Insurance Contract only in accordance with the procedure set out in the T&C.

2.11. The Policyholder is obliged to keep the list of Insured Persons up to date and to update it immediately if necessary. The Policyholder bears the risk if the list of Insured Persons is out of date or the information provided is incorrect.

2.12. The selected Insurance Scheme applies to the Insured Person for the entire Insurance Period. During the Insurance Period, the Policyholder has the right to remove an Insured Person from the list if the Policyholder has terminated their employment or other service relationship with the Employee. In order to remove an insured Employee from the list, the Policyholder will submit the details of the relevant Employee. The Employee is deemed removed from the list as of the date of termination of employment or other service with the Employee or such later date as the Policyholder may specify, but no earlier than fourteen (14) days after the Policyholder notifies the Insurance Agent of the Employee's removal from the list of Insured Persons. The removal of an insured Relative from the list of Insured Persons during the Insurance Period is only possible by agreement with the Insurer.

3. MAIN INSURANCE COVERS AND THEIR SCOPE

Please note! The Insurance Covers covered by the Insurance Contract are determined with the Insurance Schemes selected by the Policyholder for all or separately for each Insured Person.

3.1. Outpatient care

Outpatient care – non-inpatient Health Service, in the case of which the visit of the Insured Person to a health care institution is limited to a couple of hours and staying in hospital 24 hours a day is not necessary.

3.1.1. The Insurer indemnifies the appointment and consultation fees of the Service Provider, incl. the family physician, if the Health Service Provider was contacted as a result of an Insured Event.

3.1.2. The following expenses are subject to compensation for without the referral of a doctor:

- appointment fee of the Insured Person;
- compulsory medical check-ups of insured Employees to the extent necessary for the performance of their duties once during the Insurance Period, not included in the Confido 200s and Confido 200m plans;
- medical check-ups for the purposes of medical documentation (driving, weapons licence, admission to educational establishments);
- vaccinations up to €150 in the Insurance Period;
- the services of a psychologist, psychotherapist, psychiatrist up to €300 in the Insurance Period;
- home visits and medical services, incl. transport, provided during these visits.

3.1.3. The costs of the following procedures are reimbursed only if based on a doctor's referral:

- analyses, tests and treatment procedures;
- expensive diagnostic technology, including anaesthesia, digital tomography and magnetic resonance imaging up to €300 during the Insurance Period;

3.1.4. The doctor's referral, digital referral, entry in medical records or decision of the occupational health specialist, etc. must be issued before the analysis, test or procedure that is subject to be indemnified is carried out.

3.1.5. The following is not indemnified on the basis of outpatient care cover:

- the cost of dental services;
- the cost of obstetric care;
- the costs of prescription medicinal products;
- the cost of glasses, contact lenses;
- the cost of outpatient rehabilitation;
- the cost of rehabilitation in the case of an overnight stay in hospital;
- the cost of prophylactic tests.

3.2. Inpatient care

Inpatient or hospital care – Heath Service the provision of which requires the Insured Person to stay in hospital.

Day Treatment – a Health Service where the Insured Person needs to be monitored for a few hours in a hospital bed for treatment or checks, but leaves for the evening/night.

3.2.1. The insurer will indemnify for the costs of paid services during 24 and day treatment.

3.2.2. The following costs are subject to indemnification:

- being in inpatient care;
- surgeries;
- consultations with doctors;
- analyses, tests and treatment procedures;
- up to 10 days of treatment in the conditions of enhanced service, if the institution provides such services.

3.2.3. The following is not subject to indemnification on the basis of inpatient care cover:

- the cost of dental services;
- the cost of obstetric care;
- the stay of a relative or loved on in the presence of the insured in an inpatient ward;
- pre-operative and post-operative care services.

3.3. Prophylactic heath check

Prophylactic or preventive medical check-up – a prophylactic medical check-up is a medical check-up at the request and choice of the Insured Person and where there is no medical indication.

3.3.1. The following are subject to indemnification without medical indications:

- medical check-ups for monitoring a chronic illness or illness that predates the entry into the Insurance Contract;
- medical check-ups related to family planning or contraceptives;
- doctor's appointments for prescription medicine;
- paid medical check-ups.

3.4. Stomatology

Stomatology or dentistry – dentistry in its narrower sense is the repair of tooth defects with different filling materials

(composite materials, glass ionomers, gold or porcelain fillings).

3.4.1. Under the Insurance Contract, the expenses of dental treatment will be indemnified to the extent set out in this point 3.4.

3.4.2. Cosmetic whitening and cosmetic operations are not covered under the Insurance Contract.

3.4.3. The expenses related to the following services related to dental treatment are subject to indemnification:

- consultation with a specialist and preparation of a treatment scheme;
- dental treatment;
- oral cavity hygiene procedures;
- outpatient surgical dental services;
- treatment of periodontal diseases;
- orthodontics;
- expenses related to local anaesthesia, prostheses, implants.
- The following are not subject to indemnification:

- expenses of cosmetic dental and oral surgery;
- expenses of cosmetic teeth whitening.

3.5. Outpatient rehabilitation

Outpatient rehabilitation – a type of care aimed at restoring or maintaining impaired functions or adapting to disability. This is treatment that restores the capacity for work or coping. Rehabilitation implements treatment and procedures to recover the insured person's impaired functions from the medical, physical, psychological and social aspect as a whole.

3.5.1. Insurance covers the following services related to outpatient rehabilitation only on the basis of a doctor's prescription:

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

4. ADDITIONAL INSURANCE COVERS AND THEIR SCOPE

Please note! Additional Insurance Covers apply only with the main Insurance Covers selected with the respective Insurance Scheme and provided that the specific additional Insurance Scheme of Insurance Cover, as listed below, has been selected.

4.1. Optics – optical products

4.1.1. The Insurer indemnifies the expenses of acquisition of one pair of glasses (including sunglasses with optical lenses) or contact lenses.

4.1.2. The Insurer does not indemnify the cost of glasses without optical lenses, coloured contact lenses, care products.

4.2. Prescription-only medicinal products

4.2.1. The Insurer indemnifies the purchase of prescription-only medicinal products prescribed by a doctor and registered in the European Union Register of Medicinal Products.

4.2.2. The Insurer does not indemnify the cost 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. Obstetric care

4.3.1. The insurer indemnifies the expenses of paid services related to pregnancy and childbirth.

4.3.2. The following pregnancy-related services are covered:

- doctor's appointment in relation to pregnancy;
- consultations with a gynaecologist and midwife;
- analyses, tests and treatment procedures;
- hospitalisation.

4.3.3. The following childbirth-related services are covered:

- hospitalisation (incl. in a paid room);
- attendance of a midwife or doctor at childbirth;
- caesarean section for medical reasons;
- postnatal services until discharge from hospital (gynaecological advice, tests, elimination of lactostasis).

4.3.4. If the father of the baby is insured, the expenses relate to the family room are subject to indemnification.

4.3.5. Insurance does not cover the expenses of a caesarean section at the request of the Insured Person, home birth, postnatal care and transport.

4.4. Inpatient rehabilitation

Inpatient rehabilitation – rehabilitation service provided in a hospital/rehabilitation centre over a certain number of days. Patients usually need inpatient rehabilitation after a serious illness, surgery or trauma and, in some cases, after chronic conditions and their exacerbation.

4.4.1. The expenses of the following services prescribed by a doctor and provided in rehabilitation centres (sanatoriums) are covered:

- rehabilitation;
- accommodation and food service at rehabilitation centres.

4.4.2. Insurance does not cover the expenses incurred in the restaurants or bars of rehabilitation centres, or expenses of spa procedures.

4.5. Vein treatment and sclerotherapy

4.5.1. The costs of visits and consultations in medical institutions that are related to vein treatment and caused by an insured event are subject to indemnification.

4.5.2. The expenses of tests, examinations and outpatient or inpatient procedures for vein treatment and sclerotherapy prescribed by a doctor are covered.

5. INSURANCE PREMIUMS AND CONSEQUENCES OF NON-PAYMENT

5.1. Insurance Cover will take effect from the date of inclusion of the Insured Person in the Insurance Contract in accordance with the procedures set out in these T&C and from the date of payment of the Insurance Premium or the first instalment of the Insurance Premium.

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

5.3. The date of payment of the Insurance Premium is the date on which the corresponding amount is received in the current account of the Insurance Agent.

5.4. The Insurance Agent issues invoices for the payment of Insurance Premiums. Where applicable, the Insurance Agent will submit e-invoices via an e-invoicing operator.

5.5. If the Policyholder pays the Insurance Premiums on the basis of an Insurance Policy issued for the current Insurance Period, the parties will consider this as the Policyholder's acceptance of the insurance quote. If the Insurance Policy differs from the insurance quote, the information and agreements specified in the insurance quote are deemed to be valid and correct.

5.6. Insurance Premiums are payable for each Insured Person in accordance with the Insurance Scheme selected for said Insured Person.

5.7. Insurance Premiums are due for the period during which the Insured Person has been added to the Insurance Contract and until the end of the Insurance Period, unless the Insurance Cover is terminated before the end of the Insurance Period in accordance with these T&C. In the event of termination by the Policyholder of the employment or other service relationship with the Insured Employee, the Policyholder's obligation to pay the Insurance Premium to the Insurance Agent expires from the date of termination of the employment or other service relationship with the Employee, but not earlier than fourteen (14) months after the date of termination) days after the Policyholder notifies the Insurance Agent that the Employee has been removed from the list of Insured Persons. The Policyholder and the Employee may agree that the Insurance Cover of the Employee who left will continue until the end of the Insurance Period (provided that the Policyholder has paid Insurance Premiums for this), or that the Policyholder will continue to pay subsequent Insurance Premiums for the Employee also after the termination of employment. The Employee who left can notify the Insurer of their wish to continue using the Health Insurance Service within one (1) month of the Employee's removal from the list of Insured Persons. In this case, the Insurer will assess separately whether and under which conditions the Insurer can offer similar insurance cover to the Employee.

5.8. The Policyholder pays the Insurance Premiums for the Insured Employees. If the Insurance Premium for the Insurance Scheme chosen by the Employee exceeds the amount to be paid by the Policyholder, the Insured Person can pay the shortfall themselves.

5.9. The Policyholder pays the Insurance Premiums in quarterly instalments in accordance with the invoices submitted by the Insurance Agent.

5.10. Together with the invoice, the Insurance Agent submits to the Policyholder a report showing the list of Insured Persons who have joined the Insurance Contract, the basis for calculating the Insurance Premium and the amount of the Insurance Premium calculated for each Insured Person. The respective report will be submitted to the Policyholder's Authorised Person in encrypted form. If the Policyholder has any objections to the submitted invoice and/or report (e.g. inaccuracies in the number of Insured Persons or in the Insurance Schemes applied), such objections must be submitted during the deadline for payment of the invoice.

5.11. Unless otherwise agreed with the Policyholder, the Employee/Relative will pay the Insurance Premiums for the Insurance Cover of a Relative as well as for the Insurance Cover of the Employee not paid by the Policyholder. In this respect, the Insurance Agent will invoice the Relative/Employee directly and the Insurance Premium will be payable for the entire Insurance Period at once. In this case, the Insurance Premium will be deemed to have been paid in accordance with the procedure provided for in subsection 455 (1) of the Law of

Obligations Act. The Insurer will not add the Relative/Employee to the Insurance Contract as an Insured Person until the Relative/Employee has paid the invoice.

5.12. If the Insured Person is added to or removed from the Insurance Contract in the middle of the Insurance Period, the Insurance Premium will be calculated in proportion to the number of days the Insured Person was added to the Insurance Contract.

5.13. The payment term of an invoice is the term specified on the invoice that is no shorter than fourteen (14) calendar days. In the event of late payment of the invoice, the Insurance Agent is entitled to charge the payer of the invoice a late payment penalty of 0.05% (zero point zero five percent) of the overdue amount for each day of delay.

5.14. Insurance Premiums are not subject to reduction due to the taxes applicable to them and the additional taxes due as a result thereof.

5.15. If the Insurance Premium or the first instalment of the Insurance Premium is not received by the Insurance Agent within the deadline set for payment, the Insurance Cover will not take effect and the Insurer may withdraw from the Insurance Contract. If the Insurance Premium or the first instalment of the Insurance Premium which has become due is not received by the time of the occurrence of the Insured Event, the Insurer is released from the performance of its obligations.

5.16. If the second or subsequent instalment of the Insurance Premium is not paid when due, the Insurance Agent will allow an additional period for payment. If the instalment is not paid by the additional deadline either and the Insured Event occurs after the additional deadline for payment of the instalment the Insurer is released from the performance of its obligations. In this case, the Insurer also has the right to cancel the Insurance Contract.

5.17. If the Policyholder is late with the payment of the instalment of the Insurance Premium and fails to pay the Insurance Premium within the additional deadline set by the Insurance Agent, the Insurer will be released from the performance of its obligations in relation to the Insured Events that occur after the additional payment deadline has lapsed.

6. SUM INSURED AND LIMITS

6.1. The sum per each Insured Person and the maximum amount to be paid out by the Insurer in the case of an Insured Event is specified for each Insurance Scheme and Insurance Cover in the Insurance Contract.

6.2. If several Insured Events occur during the same Insurance Period, the expenses will be indemnified up to the Sum Insured specified in the Insurance Scheme/Insurance Cover.

6.3. Excess means the part of the loss determined in the Insurance Contract that will be paid by the Insured Person. Excess is the part of the loss that exceeds the Limit of the Insurance Indemnity set out in the specific Insurance Scheme. Also, the Insurance Indemnity will never exceed the Sum Insured.

7. EXCLUSIONS

Please note! The exclusion specified to in point 7 does not apply if the Health or Medical Service covered by the exclusion or the cause of the exclusion is insured under the Insurance Scheme selected by the Policyholder with basic and/or additional Insurance Cover as set out in points 3 or 4.

7.1. General exclusions

The following are not deemed to be Insured Events and the related expenses are not indemnified:

7.1.1. events caused by force majeure, i.e. an extraordinary event that the Insured Person could not foresee or avoid (e.g. natural disasters, acts of terrorism, riots, strikes and other mass unrest, war);

7.1.2. events emerging as a result of self-treatment, use of medicinal products or narcotic substances, the use of which is not necessary from the medical standpoint and which were not prescribed by a medical doctor;

7.1.3. if the Insured Person intentionally harmed their health, such as through a suicide attempt;

7.1.4. events caused by consumption of alcohol or narcotic or psychotropic substances. Expenses on treating and diagnosing alcoholism and abuse of drugs and other intoxicating substances, as well as expenses on determining the presence of alcohol, drugs and intoxicating substances in the body;

7.1.5. events arising at the time of the commission of criminally punishable acts by the Insured Person;

7.1.6. events arising for the Insured Person in connection with a pandemic. A pandemic is the spread of an communicable disease to an extent that exceeds the ordinary incidence or occurrence of an illness for a specific territory and intense spread over a territory where it was not previously registered, and which encompasses a large geographic area or land mass, and which has been notified by a responsible institution of the Republic of Estonia. This restriction does not apply to COVID-19-related events.

7.2. Expenses not subject to indemnification

The following expenses are not deemed an Insured Event or indemnified (unless otherwise explicitly and unambiguously provided for in the selected Insurance Scheme):

7.2.1. cosmetic care and treatment, aesthetic surgery operations and services, including treatment of non-malignant skin tumours (such as birthmarks, papillomas, warts, keratosis), plastic, restorative and bariatric surgery, weight loss programmes, lymph drainage, vacuum massage, treatment using radio waves, paediatric consultation and services, pedicure services;

7.2.2. corrective eye surgery with laser technology, organ transplant operations, vein surgery, sclerotherapy and paid services;

7.2.3. expenses on purchase of optical products and aids (e.g. corsets, fixators, elastic bandages, casts, pressure stockings, orthopaedic inserts, hygiene kits), expenses on replacement materials used in tissue operations (such as implants, prosthetics, mesh);

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

7.2.5. diagnosis and treatment of sexually transmitted diseases, including ureaplasma, HIV and AIDS, syphilis and chlamydia;

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

7.2.7. early medical checks for drivers;

7.2.8. immunoglobulin treatment, intravenous laser treatment and laser treatment of organs (e.g. treatment of incontinence), autohemotherapy (e.g. PRP injections), barotherapy, orthokine injections, intraocular injections;

7.2.9. services of a narcologist, hypnologist, andrologist, geneticist, trichologist, technical orthopaedist and prosthetic doctor, ergotherapist, sports doctor, physiotherapist, rehabilitation specialist or doctor of physical and rehabilitative medicine, manual therapist, dietologist, dietician, coach, homeopath, cosmetologist and cosmetician;

7.2.10. alternative medicine services (e.g. acupuncture, iridodiagnostics, bariomagnetic resonance, electropuncture), additional medical services, use of biofeedback method;

7.2.11. paid services related to pregnancy, foetal diagnosis, obstetrics;

7.2.12. family planning, prescription of contraceptives, infertility treatment, artificial fertilisation,

abortions without medical indication.

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

7.2.14. general massage, prostatic or gynaecological massage, full-body diagnostics, polysomnography studies and treatment of sleep disorders, outpatient rehabilitative care services as day inpatient or rehabilitation centres, being in daytime inpatient wards during night-time hours;

7.2.15. treatment of illnesses in the national health programme within the scope of paid services;

7.2.16. payments for operations for selecting a physician;

7.2.17. preparation of medical tests, documents and other transmissions of information as a separate service, including 3 and 4 dimensional tests in connection with pregnancy;

7.2.18. costs of medical services intended without medical indication, as well as regular health medical examination services (check-ups etc.), palliative care, social welfare;

7.2.19. educational information sessions, lectures or courses;

7.2.20. the stay of a relative or loved on in the presence of the insured in an inpatient ward;

7.2.21. pre-operative and post-operative care services included in Insurance Contract.

8. INSURED EVENT. PAYMENT AND RECOVERY OF INSURANCE INDEMNITY

8.1. An Insured Event is deemed to have occurred and the Insurance Indemnity will be paid out by indemnifying the Insured Person's expenses of Health or Medical Services:

8.1.1. which are related to the Insured Person's health;

8.1.2. according to and within the limits of the Insurance Covers provided for in the Insurance Contract;

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

8.1.4. provided during the Insurance Period;

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

8.1.6. received at medical institutions registered in the register of medical institutions and at persons registered in the register of medical workers, sports facilities, optical equipment sale outlets or pharmacies;

8.1.7. carried out using a medical technology registered in the Republic of Estonia's national database of technology used to provide healthcare services, likewise for acquisition of optical equipment or medicinal products;

8.1.8. which are not excluded under the T&C and which are not subject to indemnification.

8.2. The Insurer pays the Insurance Indemnity:

8.2.1. to the Insured Person if the expenses of the Health or Medical Services were paid by the Insured Person themselves; or

8.2.2. to the Service Provider who has provided the Health or Medical Services to the Insured Person or incurred costs related to said service. In this case, the Insured Person loses the right to claim the Insurance Indemnity for themselves.

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

8.4. In order to receive the Policyholder's Insurance Indemnity for the Health or Medical Services received, for which the Insured Person has paid themselves, the latter must submit the following documents to the Insurer or

the Insurance Agent as soon as possible, but no later than within ninety (90) months:

8.4.1. application in a format that can be reproduced in writing;

8.4.2. the original invoice or a certified copy of the invoice, indicating the following information: the service provider, the service recipient, the name of the service, quantity, price and date of provision;

8.4.3. any other documents required by the Insurer/Insurance Agent concerning the services received by the Insured Person for the purpose of establishing the circumstances of the Insured Event or determining the amount of the Insurance Indemnity payable.

8.5. In order to receive the Insurer's Insurance Indemnity for the Health or Medical Services provided to the Insured Person, the Service Provider submits to the Insurer the data and documents according to the data volume agreed between the Service Provider and the Insurer.

8.6. Upon receipt of the relevant complaints from the Insurer, the Insured Person is obliged to return to the Insurer, within ten (10) working, the sums of money paid by the Insurer to the Policyholder, the Service Provider or directly to the Insured Person for the Health or Medical Services received by the Insured Person:

8.6.1. if the Sum Insured set out in the Insurance Contract is exceeded;

8.6.2. if the Limit set out in the Insurance Contract is exceeded, including if the number of paid services is exceeded;

8.6.3. to the extent of the payments not set out in the Insurance Contract;

8.6.4. upon the expiry of the Insurance Contract or the Insurance Card for any reason;

8.6.5. if the Insured Person has committed fraud or received the Insurance Indemnity for any other unjustified reason.

9. RIGHTS AND OBLIGATIONS OF PARTIES

9.1. Obligation to provide information

9.1.1. Upon entry into the Insurance Contract, the Policyholder and the Insured Person must submit to the Insurance Agent and the Insurer all the information required by them that is necessary for entry into and performance of the Insurance Contract.

9.2. Rights and obligations of Policyholder

9.2.1. The Policyholder has the right to:

- receive information from the Insurance Agent and the Insurer about the Insurance Contract;
- file complaints with the Insurance Agent and the Insurer in connection with the performance of the Insurance Contract pursuant to the procedure provided for in the T&C.

9.2.2. The Policyholder must:

- inform the Insured Persons of the entry into the Insurance Contract in their favour and familiarise them with the terms and conditions of the Insurance Contract, including the Insurance Scheme, as well as explain to them their rights and obligations under the Insurance Contract;
- pay the Insurance Premiums indicated in the Insurance Contract in the amount and by the deadline specified;
- keep the data on the Insured Persons up to date and promptly inform the Insurance Agent of any changes and provide new data;
- ensure that the Insured Persons consent to the transmission of the personal data of the Insured Persons

to the Insurance Agent and the Insurer for the purposes of entry into and performance of the Insurance Contract and their inclusion as Insured Persons in the Insurance Contract. Such consent must be at least in a format that can be reproduced in writing and accessible to the Insurance Agent and the Insurer upon request.

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

9.3.1. The Insured Person has the right to:

- receive information and advice in relation to their Insurance Contract;
- receive the services agreed in the Insurance Contract;
- receive an Insurance Indemnity for the services agreed in the Insurance Contract for which the Insured Person has paid out of their own resources;
- receive a reasoned written decision on the refusal to pay all or part of the Insurance Indemnity.

9.3.2. The Insured Person must:

- pay the Insurance Premiums to the extent that, under the T&C, they are not payable by the Policyholder;
- take care to maintain their own health and follow the instructions of their doctor in the event of sickness and not increase the risk factors associated with the Insured Person;
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- not allow any other person to use their Insurance Card and, if the Insurance Card is lost, notify the Insurer or the Insurance Agent immediately thereof;
- present an identity document and the Insurance Card before receiving a service covered by the Insurance Cover from the Service Provider;
- monitor the scope of the Insurance Indemnity, including, where necessary, by contacting the Insurer or the Insurance Agent for information, so as not to exceed the Sum Insured or the Limit set out in the Insurance Contract;
- comply with the terms and obligations set out in any other document of the Insurance Contract, such as the terms and conditions of the Insurance Schemes.

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

9.4.1. The Insurance Agent must:

- send to the Insurer relevant information and documents about the Employees and, if appropriate, their Relatives who would like to join the Insurance Contract;
- send to the Policyholder relevant information of the Insurance Contract and the documents regarding the Insured Persons;
- upon request of the Policyholder/Insured Person, provide notice regarding the remainder of the Sum Insured or Limit;
-
- send the invoices for Insurance Premiums to the Policyholder/Insured Person in a timely manner;
- collect the necessary information from the Policyholder for entry into the Insurance Contract and the inclusion of Insured Persons in the Insurance Contract.

9.5. **Rights and obligations of Insurer**

9.5.1. The insurer must:

- in the case of an Insured Event, pay the Insurance Indemnity in accordance with the terms and conditions of the Insurance Contract;
- upon request of the Insured Person, provide notice regarding the remainder of the Sum Insured or Limit;
- send to the Policyholder relevant information of the Insurance Contract and the documents regarding the Insured Persons, if requested by the Policyholder;
-
- on request, issue replacement policies to the Policyholder as well as copies of the declarations of intent made by the Policyholder in a format that can be reproduced in writing;
- Upon the respective request of the Policyholder, issue to the Policyholder the data and copies of documents in the possession of the Insurer, which affect the Policyholder's rights and obligations under the Insurance Contract, unless such activities are in conflict with the imperative requirements arising from legislation;
- process the Insured Person's personal data in accordance with applicable law. The Insurer also has the right to obtain information about the Insured Person from public authorities or from the register of debtors if the Insurer deems it necessary.

9.6. **Consequences of non-performance of obligations**

9.6.1. If the Policyholder or the Insured Person fails to perform any of the obligations set out in legislation or in the Insurance Contract intentionally, including for criminal purposes or through gross negligence, the Insurer has the right to refuse to pay the Insurance Indemnity. The Insurer may reduce the indemnity, but not by more than 50% (fifty percent) if the Policyholder or the Insured Person fails to comply with any condition set out in legislation or the Insurance Contract due to negligence.

10. ENTRY INTO, AMENDMENT AND TERMINATION OF INSURANCE CONTRACT

10.1. The Insurance Contract is entered into for an unspecified term.

10.2. The Insurance Period is one (1) year.

10.3. No later than thirty (30) days prior to the end of the current Insurance Period, the Policyholder will submit to the Insurance Agent a new Insurance Request, on the basis of which the Insurance Agent issues a new Insurance Policy for the following Insurance Period. If the Policyholder does not submit a new Insurance Request, the Insurance Agent will draw up the Insurance Policy for the Insurance Agent on the basis of the latest information known and send it to the Policyholder.

10.4. The terms and conditions of the Insurance Contract may be amended and/or supplemented (including terminated) only by written agreement between the Insurer and the Policyholder made as an annex to the Insurance Contract. Notwithstanding the foregoing, the Insurer has the right to unilaterally review and amend the terms and conditions of the Insurance Contract in the following cases:

10.4.1. the Insurer can always change the terms and conditions of the Insurance Contract unilaterally and without prior notice in a way that is more favourable to the Policyholder/Insured Persons, including reduce the Insurance Premiums, increase the Insurance Cover, increase the Limits, etc;

10.4.2. the Insurer may unilaterally increase the Insurance Premiums and/or reduce the scope of Insurance Covers, including reduce the Health and Medical Services subject to indemnification, reduce the Sums Insured, reduce the Limits, etc., if this is due to a change in the following circumstances:

- 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;
- the frequency of use of the Insurer's performance obligation by the Insured Person according to the Insurance Premium rate;
- the scope of indemnification of health insurance services by the state;
- fees of the Service Provider for the use of the Health or Medical Services;
- legislation that changes the organisation of healthcare.

10.4.3. The Insurer may unilaterally change the documents of the Insurance Contract to the extent not covered by points 10.4.2 and 10.4.3 to specify the terms and conditions of the Insurance Contract.

10.5. In the cases referred to in points 10.4.2 and 10.4.3, the changes will enter into force no earlier than one (1) month after the Policyholder has been notified of the change.

10.6. The Insurer or the Insurance Agent will notify of changes to the Insurance Contract in accordance with the procedure set out in point 12.3.

10.7. The Policyholder has the right to effect standard termination of the Insurance Contract by notifying the Insurance Agent thereof at least three (3) months in advance in such a manner that the Insurance Contract will terminate at the end of the year.

10.8. The Insurer has the right to effect standard termination of the Insurance Contract in the cases stipulated by law.

10.9. The Insurer has the right to effect extraordinary termination of the Insurance Contract for the following reasons:

10.9.1. the Policyholder has delayed the payment of the first or any subsequent financial obligation under the Insurance Contract beyond the deadlines set out in points 5.15 and 5.16 of the T&C;

10.9.2. the Policyholder/Insured Person is in serious breach of the Insurance Contract and does not remedy the breach within the additional deadline given;

10.9.3. if the Policyholder is declared bankrupt.

10.10. The Insurer may effect extraordinary termination of the Insurance Contract within one (1) month of becoming aware of the breach.

11. PERSONAL DATA PROCESSING

11.1. The Insurer processes the data of the Insurer and the Insured Persons, incl. sensitive personal data, in accordance with relevant legislation and the Insurer's privacy policy that is available on the Insurer's website https://www.bta.ee/media/bta-privaatsuspoliitika-ee.pdf.

11.2. The Insurer has the right to obtain information about the Policyholder and the Insured Person from public authorities or from the register of debtors if the Insurer deems it necessary.

11.3. Upon the expiry of the Insurance Contract on any ground, the Insurer undertakes to transfer all of the data collected in the context of the performance of the Insurance Contract about the Insured Persons, including the Health and Medical Services provided to them and indemnified under the Insurance Contract, to the Policyholder or to a third party designated by the Policyholder.

12. OTHER TERMS AND CONDITIONS

12.1. Priority of Insurance Contract documents

12.1.1. In the event of any inconsistencies between the documents of the Insurance Contract, the terms and conditions and the special terms and conditions of the Insurance Scheme and Insurance Covers it provides are primary for the parties.

12.2. Confidentiality

12.2.1. The Parties undertake not to disclose confidential information obtained within the scope of the Insurance Contract about the participants in the Insurance Contract or third parties and not to use it to the detriment of the participants in the Insurance Contract, except in the cases stipulated by the legislation in force in the Republic of Estonia.

12.2.2. The Insurer has the right to provide experts and reinsurers with information relating to the Insurance Contract.

12.2.3. The Insurer and the Insurance Agent have the right to store information relating 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 disclose information obtained in connection with the entry into 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 and Medical Services.

12.3. Notices

12.3.1. The Parties communicate all notices relating to the Insurance Contract through the Authorised Persons and the Contact Persons.

12.4. Complaints against the Insurer or the Insurance Agent

12.4.1. The Policyholder, the Insured Person and the beneficiaries, where applicable, have the right to file a complaint with the Insurer against the actions of the Insurer or the Insurance Agent in relation to the performance of their obligations under the Insurance Contract.

12.4.2. When filing a complaint, the complainant must provide at least the following information:

- information about the complainant:
    - private individual – name and surname, address, telephone number and e-mail address (if any);
    - legal entity – name, address, telephone number and e-mail address (if any) of the company/undertaking;
- date of filing the complaint;
- an overview of the circumstances of and reasons for the dissatisfaction provided with as clear and detailed description as possible and the documents certifying the circumstances referred to in the complaint must be appended, if possible.

12.4.3. It is possible to file a complaint:

- by post, sending it to:
    - the address of the Insurance Agent;
    - the address of the Insurer;
- by e-mail, sending it to:
    - the e-mail address of the Insurance Agent;
    - the e-mail address of the Insurer.

12.4.4. When a complaint is sent to the Insurance Agent, the Insurance Agent will pass it on to the

Insurer immediately, but no later than five (5) business days from the date of receipt of the Complaint and will notify the complainant thereof.

12.4.5. When a complaint is received, the Insurer registers the complaint and informs the complainant in writing in a format that can be reproduced in writing of the registration number of the complaint and the deadline for reply.

12.4.6. The Insurer submits to the complainant a reasoned written reply to the complaint within thirty (30) days of the date on which the complainant submitted the complaint to the Insurer or the Insurance Agent. If the complaint cannot be resolved during the deadline of thirty (30) days due to its complexity or other good reasons, the Insurer informs the complainant of the reasons for extending the procedure and the additional deadline for responding in writing. The insurer may extend the deadline by no more than four (4) months from the date of the complaint.

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

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

12.4.9. Complaints handling is free of charge for the complainant.

12.5. **Applicable law**

12.5.1. The relationships arising from the Insurance Contract are governed by the legislation in force in the Republic of Estonia.

12.6. **Resolution of disputes**

12.6.1. The parties will seek to resolve any disputes arising from Insurance Contracts by agreement between the parties.

12.6.2. If an agreement cannot be reached, the disputes arising from the Insurance Contract will be resolved in the 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 Insurance Contract to third parties.

12.6.4. The parties to the Insurance Contract have the right to refer the dispute with the Insurer or the Insurance Agent to the following organisations if resolving the disagreements with the Insurer fails:

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

12.6.5. The policyholder has the right to file complaints about the activities of the Insurer or the Insurance Agent with the Financial Supervision Authority at the address Sakala 4, 15030 Tallinn, info@fi.ee.