GENERAL TERMS AND CONDITIONS OF THE CONFIDO HEALTH PLAN

Valid from 08.12.2022

The general terms and conditions of Confido Health Plan (hereinafter the **terms and conditions**) describe the principles and conditions of the health insurance offered by AS LHV Kindlustus (hereinafter **the insurer**) within the framework of the Confido Health Plan. If you would like to receive additional information about the conditions, please contact Tervisekindlustusagent OÜ (hereafter **insurance agent**, kindlustus@confido.ee, tel. 602 6795) or the insurance provider (kindlustus@lhv.ee, tel. 699 9111).

Definitions

Confido Health Plan is a non-life insurance service (hereinafter **health insurance**) developed by the insurer, within the framework of which AS Arstikeskus Confido (hereinafter **Confido**, registry code 12381384, address Veerenni 51, Tallinn, 10138 Harju County) itself or through its cooperation partners or other health care providers offers its health services for employees (and, if applicable, also their close relatives) within the limits of the agreed health insurance risk.

An **authorized person** is a person designated by the insurance agent and the policyholder whom they have authorized for data exchange in connection with the conclusion and execution of the insurance contract, including the transmission of encrypted data.

The **close relatives are** family members of the policyholder's employee. Family members are spouses or partners, parents, and children up to 18 years of age. A close relative is an insured person under the insurance contract if the close relative has given a relevant confirmation. Unless otherwise indicated by the context, the same applies to the close relative to the employee specified in the terms and conditions.

Contact persons are people appointed by the parties to the contract to receive notifications

related to the insurance contract and to resolve other current issues.

Deductible is the part of the damage specified in the insurance contract, the costs of which are borne by the insured person in the event of an insured event.

An **employee** is a person who works on the basis of a valid employment, board member, or other service relationship contract for the benefit of the policyholder.

Health care service is the activity of a health care worker or institution to prevent, diagnose and treat illness, injury or poisoning. The purpose of providing health care services is to relieve a person's ailments, prevent deterioration of their health condition or exacerbation of the disease, and restore their health.

The **indemnity limit** is the largest indemnified amount per insurance cover for one insured person during the insurance period. The indemnity limit is reduced by the indemnity paid.

The **information sheet** is the standard form of the insurance product information document stipulated by the European Commission Implementing Regulation (EU) No. 2017/1469.

The **insurance agent** is Terviskindlustusagent OÜ (registration code 16572262, address Veerenni 51, Tallinn, 10138 Harju county).

An **insurance card** is an electronic card issued by an insurance agent to an insured person, which confirms that the insured person is covered by insurance.

An **insurance contract** is a health insurance contract concluded between an insurance agent and a policyholder, on the basis of which health insurance cover is provided based on the principles of non-life insurance. The insurance contract consists of the policyholder's statement, conditions, description of insurance coverage, insurance policy, information sheet, and other documents proving the agreements concluded between the policyholder and the insurance agent. The insurance contract makes it possible to provide insurance coverage to the policyholder's employees and, with an additional written agreement, also to the close relatives of the insured person.

Insurance cover is the cover chosen by the policyholder when concluding an insurance contract, to the extent of which a person can be insured and with which, in the event of an insured event-related, the insured person can request indemnity. Insurance coverages that are possible are for outpatient treatment, preventive health check-ups, mental health, special diagnostics, outpatient rehabilitation, and hospitalization.

The **insurance period** is the period of time specified in the insurance contract, during which the insurance coverage agreed with the insurance contract is in effect and on the basis of which the insurance payments are calculated. If the insured person receives insurance coverage for the duration of the insurance period based on the insurance contract, then the insurance coverage applies to them from the time they join the insurance contract until the end of the insurance period unless the policyholder stops offering them insurance coverage under the insurance contract earlier.

The **insurance premium** is the fee agreed in the insurance contract and paid by the policyholder or, if applicable, a close relative for insurance coverage.

An **insurance policy** is a document that confirms the conclusion and validity of an insurance contract and is issued by an insurance agent to the policyholder after the conclusion of the insurance contract, amendment, or extension of the insurance period.

The **insured object** is the health of the insured person and the risk of incurring costs related to the provision of health services necessary to maintain it, that is, the insurance risk.

The **insured person** is the employee referred to as the insured person in the insurance contract or their close relative. On the basis of the insurance contract, the health insurance risk related to the insured person as a third party is insured. If the policyholder excludes an employee from the insurance contract, it is assumed that this person is no longer an insured person.

The **insurer** is AS LHV Kindlustus (registration code 14973611, address Tartu mnt 2, Tallinn, 10145 Harju county).

The **policyholder** is a legal entity that wishes to provide health insurance to its employees and, if applicable, the close relatives of its employees and undertakes the obligation to pay the insurance premiums unless the insured person pays the insurance premiums themselves.

The **policy** is a document in a form that enables written reproduction of the conclusion of the insurance contract and is issued by the insurance agent to the policyholder.

The **health care provider** is the health care provider Confido and its cooperation partners or another health service provider operating on the territory of Estonia.

The **sum insured** is the maximum sum specified in the insurance contract, which is indemnified for all insured events per insured person during the insurance period. The sum insured is reduced by the benefits paid out.

Insured event and insurance coverage

1. The insured event is the use of healthcare services (including the purchase of glasses) by the insured person during the insurance coverage valid for them and to the extent agreed in the insurance contract. The insurance benefit is paid out if the insured event meets the following conditions:

1.1. the healthcare service is related to the insured person's insurance coverage;

1.2. it meets the volume and conditions agreed upon in the insurance contract;

1.3. the healthcare service has been provided during the insurance period;

1.4. health care service has been provided by health care providers operating in the Republic of Estonia who have a professional certificate for the provision of the corresponding service or an activity license prescribed by legislation (visible in the information system of the Health Administration Information System. or on the website of the Estonian Qualifications Authority);

1.5. the physician's referral (referral letter, digital referral letter, entry in the medical record, occupational health physician's decision) was issued before the performance of a test, examination, or treatment procedure of the insured person, and the referral was made less than a year ago (except for the occupational health physician's decision);

1.6. the healthcare service has been provided using such medical technology or methodology, the use of which is allowed in Estonia for the treatment of people;

1.7. is not excluded based on the insurance conditions.

2. The insurance agent would pay the insurance indemnity to the insured person if the costs were borne by the insured person themselves or to the health care provider if the health care provider has provided health services to the insured person or borne related costs. If the insurance agent pays the insurance indemnity to the health care provider, the insured person loses the right to the insurance indemnity.

3. Outpatient treatment insurance coverage

3.1. Outpatient treatment is a non-stationary health care service in which the insured person's visit to the health care provider is limited to a few hours.

3.2. The following costs are indemnified without a physician's referral:

- health care provider's, including the family doctor, appointment and consultation fee;
- remote consultation.

3.3. The following costs are indemnified only upon referral by a physician:

- tests,
- examinations,
- treatment procedures.

3.4. The following are not covered under the insurance cover of insurance cover for outpatient treatment:

- services, including dental care, mental health, special diagnostics, preventive treatment, outpatient rehabilitation, and hospital care insurance coverage;
- employee health check-up (provided in the Occupational Health and Safety Act);
- the cost related to the general exclusions referred to in clauses 10 -11.

4. Preventive health check-up insurance coverage

4.1. A preventive health check-up is a physician's appointment and consultation, health examination, examination package, or test for which there is no medical indication and which the physician performs at the request and choice of the insured person to check their health condition, prevent diseases, or issue a health certificate.

4.2. The following costs are indemnified without a physician's referral:

- health examination to monitor a chronic or pre-existing illness;
- regular preventive appointments and consultation with a gynecologist;
- regular preventive appointments and consultation with an andrologist;
- vaccination;
- tests and examinations, including an examination package;
- birthmark examination, including by Dermtest;
- STD tests;
- Covid-19 test;
- extending the validity of a prescription;
- optometrist consultations, including issuing a prescription for glasses;
- purchase of glasses once during the insurance period if the visual acuity has changed during the insurance period;
- health certificate, examinations necessary for its issuance.

4.3. On the basis of preventive health check-up insurance, the following are not indemnified:

- services included outpatient care, dental care, mental health, special diagnostics, outpatient rehabilitation, and hospital care insurance coverage;
- purchase of glasses without optical lenses (including blue light glasses);
- purchase of sunglasses with optical lenses;
- the cost of glasses cases and glasses cleaning and preservation products;
- the cost related to the general exclusions referred to in clauses 10-11.

5. Mental health insurance coverage

5.1. Without a physician's referral, the appointment and consultation fees of the following healthcare providers are indemnified:

- psychologist,
- psychotherapist,
- psychiatrist,
- clinical psychologist,
- mental health nurse.

5.2. The cost of mental health examinations is indemnified only upon referral by a physician.

5.3. On the basis of mental health insurance coverage, couple and family counseling and therapy is not indemnified.

6. Insurance coverage for special diagnostics

6.1. The costs of the following procedures are indemnified only upon the doctor's referral:

- digital tomography;
- magnetic resonance examination;
- specific diagnostic technologies, e.g., gastroscopy and colonoscopy;
- ultrasound;
- x-ray;
- computed tomography;
- colposcopy.

7. Outpatient rehabilitation insurance coverage

7.1. Outpatient rehabilitation is a healthcare service aimed at restoring or maintaining impaired functions.

7.2. Only when referred by a physician the following procedures and appointment and consultation fees of healthcare providers are indemnified:

- physiotherapy, including apparatus physiotherapy;
- therapeutic massage;
- manual therapy;
- chiropractic;
- speech therapists.

7.3. The following are not indemnity under outpatient rehabilitation insurance coverage:

- sports club and swimming pool passes, sports practice sessions, etc.;
- the cost related to the general exclusions referred to in clauses 10-11.

8. Hospital treatment insurance coverage

8.1. Hospital treatment is a healthcare service, the provision of which requires the stay of the insured person in a hospital. The insured person is obliged to consult with the insurance agent before using hospital treatment services.

8.2. Day treatment is a health care service in which the insured person needs to be monitored in a hospital bed for a few hours due to treatment or examinations but is not left in the hospital overnight.

8.3. The insurance agent indemnifies the costs of the paid services of both inpatient treatment and day treatment.

8.4. The following costs are indemnified only upon referral by a physician:

- inpatient stay;
- surgery;
- physician's consultation;
- tests, examinations, and treatment procedures in the hospital;
- vitamins and drugs prescribed and consumed in the hospital;
- treatment under conditions of enhanced service for up to 10 days, if the medical institution provides such services.

8.5. The following are not indemnified on the basis of hospital treatment insurance coverage:

- services, including outpatient care, dental care, mental health, special diagnostics, preventive treatment, and outpatient rehabilitation insurance coverage;
- the stay of a close relative with the insured person in a hospital;
- pre- and post-operative outpatient appointment and consultation, procedure, test, and examination;
- the cost related to the general exclusions referred to in clauses 10-11.

9. Dental insurance coverage

9.1. The following costs are reimbursed without a physician's referral:

- dentist's appointment and consultation fee, including preparation of a treatment plan;
- oral hygiene services;
- outpatient surgical and dental services;
- local anesthesia;
- costs related to prosthetics, crowns, and implants.

9.2. The following are not indemnified on the basis of hospital treatment insurance coverage:

- cosmetic and aesthetic surgery and procedure of teeth and oral cavity;
- cosmetic whitening of teeth;
- orthodontics;
- aligners and other orthodontic devices not related to dental treatment (e.g., snoring, sports, and bruxism aligners);
- installation and removal of dental decorations;
- the cost related to the general exclusions referred to in clauses 10-11.

Exclusions

10. The insurance agent does not reimburse the cost related to the following cases:

10.1. services not provided;

10.2. cases related to an epidemic or pandemic or a state of emergency in the country, except for cases related to Covid-19;

10.3. if the insured person has caused damage to their health intentionally, including a suicide attempt, self-harm, or endangering their health;

10.4. a case that occurred as a result of self-treatment and a case related to the use of a drug that was not recommended or prescribed by a physician;

10.5. Cases caused by the consumption of alcohol, narcotics, or psychotropic substances;

10.6. a case that occurred when the insured person committed an act punishable pursuant to the criminal procedure, was detained by law enforcement bodies or was imprisoned

in a custodian facility.

11. The insurance agent does not reimburse the costs of services, procedures, appointments, consultations, examinations, and diagnostics related to the following specialists referred to below:

11.1. services of a coach, dietitian, occupational therapist, geneticist, hypnotist, narcologist, rehabilitation specialist, sexual pathologist, sports doctor, a trichologist, technical orthopedist and prosthetist, and nutritionist;

11.2. cosmetic and aesthetic services, including cosmetic and plastic surgery (including benign skin tumor removal and treatment, aesthetic dermatology, surgical treatment of obesity, weight loss program, skin laser treatment, including ELOS technology, radio wave treatment, pedicure and manicure services);

11.3. vision correction surgery using laser technology;

11.4. organ transplant surgery,

11.5. consultation, treatment, surgery, and sclerotherapy related to varicose veins;

11.6. genetic tests and research;

11.7. sleep research and treatment;

11.8. treatment of sexually transmitted diseases, including HIV and AIDS;

11.9. purchase of medical aids (including contact lenses, orthopedic products, e.g., corset, orthosis, crutches, fixator, cast, medical stockings, orthopedic insoles and shoes, hygiene kit);

11.10. endoprosthetic services;

11.11. mandatory medical examination of the employee resulting from the law;

11.12. immunoglobulin therapy, blood plasma and hyaluronic acid therapy (e.g., PRP injections), barotherapy, orthokine therapy, and intraocular injection;

11.13. alternative and complementary medicine services (including acupuncture, light therapy, sound therapy, aromatherapy, reflexology, iris examination, bioresonance diagnostics, electropuncture, homeopathy, and biofeedback method);

11.14. services related to family planning and childbirth (including detection of pregnancy and fetus, prescription of contraceptives, infertility treatment, artificial insemination, abortion without medical indication, sperm analysis, vasectomy, and laparoscopic operations to remove fallopian tubes and appendages);

11.15. treatment of congenital pathology, degenerative disease (including Alzheimer's disease, Parkinson's disease, multiple sclerosis), and mental illness;

11.16. vacuum, cryo, Thai and aroma massage, massage of the prostate, or gynecological massage;

11.17. printing of medical examination documents and other medical documents as a separate service;

11.18. palliative care and social care;

11.19. costs of medicines, vitamins, and nutritional supplements;

11.20. training, lectures, and courses;

11.21. convenience services, including home visits and transportation.

Health insurance contract and its conclusion, amendments, and termination

12. The policyholder enters into an insurance contract with the aim of insuring insurance risks related to their employees and, if applicable, the close relatives of their employees in order to protect the health of employees and the close relatives of their employees and thereby increase the employees' working capacity and productivity (insurance interest).

13. The policyholder selects the appropriate insurance coverage for the employees and, if applicable, for the close relatives of their employees in cooperation with the insurance agent. The insurance coverages covered by the insurance, the sum insured, indemnity limits, and insurance premiums are specified in the insurance policy and in the terms and conditions.

14. To add an employee to the insurance contract as an insured person, the policyholder submits an application to the insurance agent with the following information: employee's name, social security number/date of birth and e-mail address, choice of insurance cover, insurance period.

15. By transmitting data to the insurance agent, the policyholder confirms that they are the authorized person to transmit the employees' data, that the employees agree to the transmission of their data, and to their inclusion in the insurance contract as insured persons under the terms of the insurance contract.

16. A close relative is added to the insurance contract through an employee insured by the policyholder, and the addition to the insurance contract is confirmed by the close relative themselves.

17. The insurance agent has the right to refuse to include the employee or their close relative as an insured person in the insurance contract if the person has provided false information or previously committed insurance fraud or failure to pay insurance premiums, or is not suitable to be an insured person for other compelling reasons.

18. If an insured person is added to the insurance contract, the insurance agent provides the policyholder with the insurance policy, the information document, the terms and conditions, and, if necessary, other relevant information proving the insurance coverage. The insurance agent, using the contact details of the insured person, forward the insurance card and, if necessary, relevant information to the insured person.

19. The policyholder is obliged to keep the list of insured persons up to date.

20. The insurance contract is deemed concluded, and the rights and obligations arising from the insurance contract come into force at the moment of payment of the insurance premium but not earlier than the first date of the insurance period.

21. The selected insurance cover applies to the insured person during the entire insurance period. During the insurance period, the policyholder has the right to exclude the insured employee from the insurance contract if the policyholder has terminated the employment or other service relationship with this person. Amendments to the insurance contract are made twice a month, taking into account the date when the employment or other service relationship with the employee was terminated and the date when the policyholder notified the insurance agent of the employee's exclusion from the insurance contract. It is possible to exclude the employee's close relative from

the insurance contract during its validity only in exceptional cases and by agreement with the insurance agent.

22. The insurance contract is concluded for an indefinite period, and the insurance period is one year.

23. No later than 30 (thirty) days before the end of the current insurance period, the policyholder submits a new application to the insurance agent, on the basis of which the insurance agent draws up a new insurance policy for the next insurance period and forwards it to the policyholder. If the policyholder does not submit a new application by the specified deadline, the insurance agent will draw up an insurance policy based on the latest information known to the insurance agent and forward it to the policyholder.

24. The terms of the insurance contract can be changed and/or supplemented (including termination) only with the written agreement of the insurance agent and the policyholder, which is formalized as an annex to the insurance contract. Regardless of this, the insurance agent has the right to unilaterally review and change the terms of the insurance contract in the following cases:

24.1. The insurance agent may unilaterally and without prior notice change the terms of the insurance contract to be more favorable to the policyholder, including reducing insurance premiums and increasing insurance coverage and indemnity limits.

24.2. The insurance agent may unilaterally increase insurance payments for the current insurance period and/or reduce the scope of insurance coverage, including reducing the volume of reimbursed health services and insurance amounts and indemnity limits if this is due to a change in the following circumstances:

- a fact independent of the contracting parties, which is specified in the insurance contract as the basis for calculating the insurance premium;
- the average life expectancy of insured persons;
- the frequency of use of the insurance agent's performance obligation by the insured person according to the rate of this insurance premium;
- scope of state reimbursement for health insurance services;
- provider fees for the use of health services;
- legislation concerning healthcare management.

25. The insurance agent may unilaterally change the documents of the insurance contract with the aim of specifying the conditions of the insurance contract to the extent that it is not dealt with in clause 24.2.

26. Amendments to the insurance contract will not take effect until at least one month has passed after notifying the policyholder of the amendment.

27. The insurance agent notifies the policyholder of changes to the insurance contract in accordance with the terms and conditions.

28. The policyholder has the right to cancel the insurance contract by giving at least three months' notice to the insurance agent, so that the contract terminates at the end of the year.

29. The insurance agent has the right to cancel the insurance contract on a regular basis in cases provided by law.

30. The insurance agent has the right to cancel the insurance contract exceptionally for the following reasons:

30.1. the policyholder has not fulfilled the insurance contract by the term specified in the terms and conditions, i.e., has not paid the first or subsequent insurance installments;

30.2. the policyholder or the insured person significantly violates the insurance contract and does not remedy the violation within the deadline set for this purpose;

30.3. the policyholder has been declared bankrupt.

31. The insurance agent may cancel the insurance contract in an emergency within one month of becoming aware of the violation.

Insurance payments and the consequences of not paying them

32. Insurance premiums for the employee as an insured person are paid by the policyholder. The policyholder pays the insurance premiums in quarterly installments.

33. The insurance premium payment date is the day the insurance premium is received in the insurance agent's bank account.

34. An insurance agent issues invoices to receive insurance payments. If applicable, the insurance agent issues e-invoices through an e-invoicing operator.

35. If the policyholder pays insurance premiums on the basis of an insurance policy issued for the current insurance period, the parties to the contract consider this as the policyholder's acceptance of the insurance contract. If the insurance policy differs from the insurance offer, the information and agreements provided in the insurance policy are considered valid and correct.

36. Insurance premiums must be paid for each insured person based on the insurance cover chosen for him.

37. Insurance premiums must be paid for the insured person's entire insurance period unless the insurance coverage is terminated based on the conditions before the end of the insurance period. If the policyholder terminates the employment or other service relationship with the insured person, the policyholder's obligation to pay the insurance premium also ends from the quarter following the termination of the employment or other service relationship with the employee; if the policyholder notifies the insurance agent of the employee's exclusion from the insurance contract. The policyholder will not be reimbursed for the insurance premium paid until the end of the quarter. The policyholder and the employee may agree that the insured person with whom the employment or other service relationship was terminated will be covered until the end of the insurance period (provided that the policyholder has paid insurance premiums for this) or that the policyholder will pay the following insurance premiums for this person even after the termination of the employment relationship.

38. A close relative of the insured employee pays the insurance premiums for insurance coverage on behalf of the policyholder themselves unless otherwise agreed with the policyholder. The insurance premium must be paid at once for the entire insurance period. The insurance agent connects the employee to the close relative's insurance contract after the close relative has paid the premium.

39. If an employee is added to the contract as an insured person during the current insurance period, their indemnity limit and insurance premium are calculated based on the following proportion:

- during the first quarter after the conclusion of the insurance contract – 100% of the insurance premium and indemnity limit;
- during the second quarter after the conclusion of the insurance contract - 75% of the insurance premium and indemnity limit;
- during the third quarter after the conclusion of the insurance contract – 50% of the insurance premium and indemnity limit;
- during the fourth quarter after the conclusion of the insurance contract - 25% of the insurance premium and indemnity limit.

40. The invoice payment term is indicated on the policy and on the invoice. If the invoice is not paid by the deadline, the insurance agent has the right to demand from the recipient of the invoice a late fee of 0.05% (zero point zero five percent) of the unpaid amount by the deadline for each day of delay in payment.

41. Insurance premiums will not be reduced due to the taxes that apply to them, and they will be paid additionally as a result.

42. If the policyholder has not paid the insurance premium or its first installment within 14 (fourteen) days after concluding the insurance contract, the insurance agent may withdraw from the contract until the payment is made. If the insurance agent does not file a lawsuit to collect the insurance premium within three months from the date the payment becomes due, it is assumed that they have withdrawn from the contract. If the insurance premium that has become due or its first installment has not been paid by the time the insured event occurs, the insurance agent is released from their performance obligation.

43. If the policyholder does not pay the second or next installment of the insurance premium by the deadline, the insurance agent will give them a new deadline for payment. If the policyholder does not pay the installment by the new deadline and the insured event occurs after the new installment payment deadline, the insurance agent is released from the obligation to perform and also has the right to cancel the insurance contract.

Rights and obligations of the contracting parties

44. Obligation to provide information

44.1. When concluding an insurance contract, the policyholder and the insured person must provide the insurance agent with all the information required by them, which is necessary for concluding and executing the insurance contract.

45. Rights and obligations of the policyholder

45.1. The policyholder has the right to:

- receive information about the insurance contract from the insurance agent;
- to file a complaint to the insurance agent regarding the performance of the insurance contract in accordance with the procedure stipulated in the terms and conditions.

45.2. The policyholder is obliged to:

- inform the insured person of the conclusion of the insurance contract in his favor and introduce him to the insurance contract, including insurance coverage and conditions, as well as explain to him the rights and obligations arising from the insurance contract;

- pay insurance premiums in the amount and by the term indicated in the insurance contract;
- keep the data of the insured persons up to date and immediately notify the insurance agent of their change and provide new data;
- to ensure that the insured persons give their consent to transfer their personal data to the insurance agent for the conclusion and execution of the insurance contract and to add themselves to the insurance contract as insured persons. The consent must be provided at least in a form that allows reproduction and is available to the insurance agent upon their request.

46. Rights and obligations of the insured person

46.1. The Insured Person has the right to:

- to receive information and advice about the trust agreement concluded in relation to them;
- receive the services agreed upon in the insurance contract concluded for them;
- receive insurance indemnity for the services agreed upon in the insurance contract concluded against them, for which they have paid themselves;
- receive a reasoned written decision from the insurance agent on the refusal to pay the insurance indemnity in full or in part.

46.2. The insured person has an obligation to:

- pay insurance premiums to the extent that the policyholder does not have to pay based on the conditions;
- take care of maintaining their health, follow the instructions of the attending physician in case of illness, and not increase the risk situations related to oneself;
- not to allow third parties to use their insurance coverage;
- before receiving a service covered by insurance coverage from the health care provider, submit an identity document to the health care provider;
- monitor the extent of the insurance benefit, if necessary, also contact the insurance agent for information so as not to exceed the insurance amount or limit specified in the insurance contract;
- comply with the conditions and obligations prescribed by any other document of the insurance contract, including the conditions of insurance coverage.

47. Rights and obligations of an insurance agent

47.1. The insurance agent has the right to:

- receive information about the insured person from state authorities or the register of debtors if the insurance agent deems it necessary;
- process the insured person's personal data in accordance with the applicable legislation.

47.2. The insurance agent has the obligation:

- forward the information and documents of the insurance contract about the insured persons to the policyholder;
- submit invoices for insurance payments to the policyholder or insured person by the deadline;
- collect necessary information from the policyholder to conclude an insurance contract and to add employees and their close relatives to the insurance contract;
- in the event of an insured event to ensure efficient and quick damage handling;

- pay insurance indemnity based on the terms and conditions of the insurance contract in the event of an insured event;
- at the request of the insured person, inform them of the amount of the remaining insurance amount or limit;
- at the policyholder's request, issue them the data and copies of documents that affect the policyholder's rights and obligations arising from the insurance contract if such activity does not contradict the requirements arising from legislation;
- at the policyholder's request, to issue replacement policies and copies of declarations of intent submitted by the policyholder in a form that enables written reproduction.

Payment and recovery of insurance indemnity

48. In the event of damage, the insured person is obliged to consult a physician as soon as possible, comply with their prescriptions and do everything possible to prevent the increase of injuries caused by the insured event, as well as to notify the insurance agent in writing of the need for treatment in order to receive a letter of guarantee from them in case the insured person is provided with a service other than the contractual partner of Confido Health Plan.

49. If the insured person paid the invoice presented by the health care provider themselves in order to receive insurance indemnity, they submit the following documents as soon as possible, no later than within 30 (thirty) days from receiving the service, by authenticating themselves at www.tervisehalendus.eeor, if authentication is not possible, by sending the following documents to the e-mail address kahjud@tervisehalendus.ee:

    - application for indemnity;
    - documents proving the cost of healthcare services with the following information: details of the heath care provider, details of the service recipient, name of the service, price, and date of provision;
    - a certificate issued by an optometrist or ophthalmologist regarding the change in visual acuity during the insurance period, a document proving the cost of buying glasses;
    - medical documents proving the physician's referral (referral letter, digital referral letter, entry in the medical record, occupational health physician's decision);
    - other documents required by the insurance agent regarding the services provided to the insured person in order to clarify the circumstances related to the insured event or to determine the amount of insurance indemnity to be paid.

50. If the insured person has not paid for health services themselves, the health care provider submits data and documents to the insurance agent in order to receive insurance indemnity based on the data volume agreed between the health care provider and the insurance agent.

51. The insurance agent pays the employee health check-up indemnity to the policyholder or the health care provider who provided the employee health check-up service.

52. If several insured events occur during the same insurance period, the insurance agent pays indemnity for all insured events covered by the respective insurance coverage, but not more than the insured amount specified in the insurance coverage.

53. If the insured person has received a complaint from the insurance agent, they are obliged to return to the insurance agent within 10 (ten) working days at the latest the sums that the insurance agent has paid to the policyholder, health care provider, or directly to the insured person for the health services provided to the insured person:

53.1. in case of exceeding the insurance amount specified in the insurance contract;

53.2. in case of exceeding the limit specified in the insurance contract, including the number of paid services;

53.3. to the extent of payments that are not stipulated in the insurance contract;

53.4. in case of expiry of the insurance contract for any reason;

53.5. in case the insured person commits fraud or has received insurance compensation for other unjustified reasons.

Release of the insurance agent from performance obligations

54. The insurance agent has the right to refuse the payment of the insurance benefit if the policyholder or the insured person does not fulfill any obligation provided for in the legislation or the insurance contract, either intentionally (including for criminal purposes) or due to gross negligence.

55. The insurance agent has the right to refuse the payment of the insurance benefit if the policyholder and/or the insured person does not comply with the written orders of the insurance agent, refuses to cooperate, or avoids it.

56. The insurance agent has the right to refuse payment of the insurance indemnity in the event that the policyholder and/or the insured person prevents the insurance agent from ascertaining the circumstances, does not contribute to it, or provides misleading information or documents, as well as in the event that the policyholder and/or the insured person acts in a manner aimed at obtaining unfounded or higher insurance indemnity or part thereof.

57. The insurance agent may reduce the insurance indemnity by up to 50% (fifty percent) in the event that the policyholder or the insured person, due to negligence, does not fulfill any condition stipulated in legislation or the insurance contract.

Processing of personal data

58. The insurer and the insurance agent process the data of the policyholder and the insured persons, including special types of personal data, in accordance with legislation and the principles of processing customer data of the insurer and the insurance agent, which are available on the insurer's website at https://www.lhv.ee/et/kliendiandmete-tootlemise-pohimotted and on the insurance agent's website at https://terviselahendus.ee//confido_privaatsuspoliitika.

59. If the insurer or insurance agent deems it necessary, they have the right to receive information about the policyholder and the insured person from state authorities and the register of debtors.

Other terms and conditions

60. Priority of insurance contract documents

If there are contradictions in the documents of the insurance contract, the terms of the insurance coverage and the corresponding special conditions prevail for the parties to the contract.

61. Transmission of notices

The parties to the contract transmit all notifications related to the insurance contract through authorized persons and contact persons.

62. Submitting complaints about the activities of the insurance agent

62.1. If it is relevant, the policyholder and the insured person have the right to file a complaint about the activities of the insurance agent in connection with the improper fulfillment of the obligations arising from the insurance contract.

62.2. The complainant shall provide at least the following information in the complaint:

- information about the complainant:
  - in the case of a private person, their first and last name, address, telephone number, and e-mail address (if any);
  - in the case of a legal entity, its name, registration code, address, telephone number, and e-mail address (if any);
- the date on which the complaint was lodged;
- an overview of the circumstances and reasons for dissatisfaction with as clear and comprehensive a description as possible; if possible, documents proving the circumstances referred to in the complaint are attached.

62.3. The complaint can be sent to the postal address or e-mail address of the insurance agent.

62.4. The insurance agent sends a reasoned written response to the complainant within 30 (thirty) days from the day of the complaint. If it is not possible to resolve the complaint within 30 (thirty) days due to its complexity or for other reasons, the insurance agent will inform the complainant of the reasons for the extension of the procedure and the new deadline for responding in a form that allows for written resubmission. The insurance agent may not extend this period beyond four months from the date of the complaint.

62.5. If applicable, the policyholder, the insured person, and the beneficiary have the right to ask the insurance agent for additional information about the procedure for handling complaints.

62.6. Complaints processing is free of charge for the complainant.

63. Applicable law

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

64. Settlement of disputes

64.1. Disputes arising from insurance contracts are attempted to be resolved by agreement between the parties.

64.2. If an agreement is not possible, disputes arising from the insurance contract will be settled in court on the basis of the legislation of the Republic of Estonia.

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

64.4. If disagreements cannot be resolved, the parties to the insurance contract have the right to apply for the resolution of the dispute:

- To the conciliation body operating at the Estonian Insurance Association (phone 667 1800, e-mail address lepitus@eksl.ee, address Mustamäe tee 46, 10621 Tallinn);
- in case of violation of consumer rights, to the Consumer Protection and Technical Regulatory Agency (phone 620 1707, e-mail address info@ttja.ee, address Sõle 23a, 10614 Tallinn);
- in case of data protection disputes, to the Data Protection Inspectorate (phone 562 02341, e-mail address info@aki.ee, address Tatari 39, 10134 Tallinn).

64.5. The policyholder has the right to file a complaint about the activities of the insurer and the insurance agent to the Financial Supervision Authority (phone 668 0500, e-mail address info@fi.ee, address Sakala 4, 15030 Tallinn).