GENERAL TERMS AND CONDITIONS OF CONFIDO HEALTH PLAN PARTNERS

Valid from 01.10.2023

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The general terms and conditions of the cooperation partner of the Confido Health Solution (hereinafter "**terms and conditions**") describe the principles and conditions of health insurance offered by LHV Kindlustus AS (hereinafter the "**insurer**") within the framework of the Confido Health Plan. If you would like to receive additional information about the conditions, please contact Terviskindlustusagent OÜ (hereafter **insurance agent**, kindlustus@confido.ee, tel. 602 6795) or the insurance provider AS LHV Kindlustus (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, 10138, Tallinn, Harju County) itself or through its cooperation partners or other service providers offers its health services for employees (and, if applicable, also their close relatives) within the limits of the agreed health insurance risk.

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 insurance indemnity paid.

A co-policyholder is an insured person.

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 person named as a co-policyholder in the insurance contract. On the basis of the insurance contract, the health insurance risk related to the insured person is insured.

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

The insurer is AS LHV Kindlustus (registration code 14973611, address Tartu mnt 2, 10145,

Tallinn, Harju county).

Insurance cover is the cover chosen by the policyholder when concluding an insurance contract, to the extent to which a person can be insured, and in the case of an insurance event related to which the insured person can apply for insurance indemnity.

An insurance contract is a contract between the policyholder and the insurer, which enables the insured person to voluntarily join the health insurance plan. The insurance contract consists of the insured person's application, conditions, insurance offers, insurance policy, information sheet, and other documents certifying the agreements concluded between the insured person, the policyholder, and the insurance agent.

An insurance premium is the fee paid by the policyholder for insurance coverage agreed upon in the insurance contract. The policyholder and the insured person agree that the insured person pays the insurance premium to the insurance agent on behalf of the policyholder.

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.

An insurance policy is a document that confirms the conclusion and validity of an insurance contract. Insured persons are added to the insurance policy concluded by the policyholder on the basis of their own application.

The sum insured is the largest 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 paid-out insurance indemnities.

The policyholder is Terviskindlustusagent OÜ, which has concluded an insurance contract with the insurer.

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.

A deductible is 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.

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

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 healthcare service provider is Confido and its cooperation partner or another healthcare service provider operating in the territory of Estonia.

An authorized person is a person authorized by the insurance agent and the policyholder to exchange data with the cooperation partner in connection with the conclusion and execution of the insurance contract, including the transmission of encrypted data.

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. meets the volume and conditions agreed with the insurance contract;

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

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

1.4. the health care service has been provided by a service provider operating in the Republic of Estonia, who has a corresponding activity license or valid professional certificate for the provision of this service. The activity license can be checked on the website of the Estonian Health Board, and the professional certificate is available on the website of the Estonian Qualifications Authority;

1.5. 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;

1.6. physician's referral (referral letter, digital referral letter, entry in the medical record, occupational health physician's decision, prescription) is issued to a specific healthcare service before receiving the healthcare service. The term of validity of the referral is considered to be one year from the date of issuance of the document, with the exception of the referral made by the occupational health physician, which is valid as stated in the decision but not more than three years.

2. Insurance indemnity is paid by the insurance agent to the insured person if the costs were borne by the insured person themselves and to the healthcare service provider if the healthcare service provider has provided healthcare 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 benefit.

3. Outpatient treatment insurance coverage

3.1. Outpatient treatment is a healthcare service in which the insured person's visit to the healthcare provider is limited to a few hours.

3.2. On the basis of outpatient treatment insurance coverage, the following expenses are indemnified without a physician's referral:

- the appointment and consultation fee of the family physician and a medical specialist, and their related nurse;
- remote consultation fee.

3.3. On the basis of outpatient treatment insurance coverage, the following costs are indemnified only upon referral by a physician:

- tests;
- examinations;
- treatment procedures.

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

- costs related to dental treatment, mental health, special diagnostics, preventive health checkup, outpatient rehabilitation, and hospital treatment and services included in additional insurance coverage;
- the cost related to the general exclusions referred to in clauses 14 and 15.

4. Preventive health checkup insurance coverage

4.1. A preventive health check-up is a health care service for which there is no medical indication and which is performed by the health care service provider at the request and choice of the insured person in order to check their health condition, prevent diseases or issue a health certificate.

4.2. On the basis of preventive health checkup insurance coverage, the following expenses are indemnified without a doctor's referral:

- medical checkup to monitor and treat a chronic disease or one that occurred before the conclusion of the insurance contract;
- preventive appointment and consultation with a gynecologist without a medical indication;
- preventive appointment and consultation with an andrologist without a medical indication;
- vaccination;
- tests, examinations, examination packages, and audits (including birthmark examination, Dermtest, sports medicine examinations, and stress test) and related appointments and consultations;
- tests (including STD test, Covid-19 test) and related appointments and consultations;
- appointment and consultation related to issuing a prescription and extending the validity period;
- appointment and consultation with an optometrist and ophthalmologist in connection with issuing a prescription for glasses or fixing visual acuity;
- a paid health certificate (for example, to apply for a gun license, driver's license, or food handling) and the examinations necessary for its issuance.

4.3. The following costs are not reimbursed under preventive health check-up insurance coverage:

- costs related to outpatient treatment, dental treatment, mental health, special diagnostics, outpatient rehabilitation, hospital treatment, and services included in additional insurance coverage ;
- the cost related to the general exclusions referred to in clauses 14 and 15.

5. Mental health insurance coverage

5.1. On the basis of mental health insurance coverage, the costs of the appointment and consultation fees of the following healthcare providers are indemnified without a

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

5.2. On the basis of mental health insurance coverage, the cost of mental health examinations is reimbursed only when referred by a physician.

5.3. On the basis of mental health insurance coverage, the following costs are not reimbursed:

- couple and family counseling and therapy;
- costs related to outpatient treatment, dental treatment, preventive health checkups, outpatient rehabilitation, hospital treatment, and services included in additional insurance coverage;
- the cost related to the general exclusions referred to in clauses 14 and 15.

6. Insurance coverage for special diagnostics

6.1. On the basis of insurance coverage for special diagnostics, the costs of the following procedures are indemnified only upon referral by a physician:

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

6.2. If the special diagnostic procedure, together with the physician's appointment and consultation fee, is reflected as one service on the document certifying the cost, 50% of the costs are included under outpatient insurance coverage and 50% of the costs under special diagnostic insurance coverage.

6.3. The following costs are not reimbursed under the special diagnostics insurance coverage:

- costs related to outpatient treatment, dental treatment, mental health, outpatient rehabilitation, hospital treatment, and services included in additional insurance coverage;

7. Outpatient rehabilitation insurance coverage

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

7.2. On the basis of outpatient rehabilitation insurance coverage, the following procedures and the appointment and consultation fees of healthcare providers are reimbursed only upon referral by a physician:

- rehabilitation psysician;
- physiotherapy, including apparatus physiotherapy;
- therapeutic massage;
- manual therapy;
- chiropractic care;
- speech therapist.

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

- inpatient rehabilitation;
- passes for sports clubs, spas, and swimming pools;
- sports practices;
- costs related to outpatient treatment, dental treatment, mental health, special diagnostics, preventive health checkup, and services included in additional insurance coverage;
- the cost related to the general exclusions referred to in clauses 14 and 15.

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. Day treatment is a healthcare 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 kept in the hospital overnight.

8.2. Before hospitalization, the insured person is obliged to coordinate it with the insurance agent.

8.3. On the basis of hospital treatment insurance coverage, the following costs of both daily and

24-hour treatment are reimbursed only upon referral by a physician:

8.4. On the basis of hospital treatment insurance coverage, the following costs are indemnified only upon referral by a physician:

- bed day fee;
- the cost of hospitalization (including surgery, minor surgery);
- physician's consultation in the hospital;
- tests, examinations, and treatment procedures in the hospital;
- drugs prescribed and consumed in the context of hospital treatment;
- treatment under enhanced service conditions for up to 10 days if the treatment facility provides these services.

8.5. The following costs are not reimbursed under the hospital treatment insurance coverage:

- the stay of a relative or loved one with the insured person in the hospital;
- inpatient rehabilitation;
- costs related to outpatient treatment, dental treatment, mental health, special diagnostics, preventive health checkup, outpatient rehabilitation, and services included in additional insurance coverage;
- the cost related to the general exclusions referred to in clauses 14 and 15.

9. Dental care insurance coverage

9.1. On the basis of dental care insurance coverage, the following expenses are indemnified without a physician's referral:

- dentist's visit and consultation fee;
- dental care;
- oral hygiene services;
- outpatient surgical and dental services;
- local anesthesia;
- root and gum treatment;
- costs related to prosthetics, crowns, and implants.

9.2. The following are not indemnified on the basis of dental care insurance coverage:

- cosmetic and aesthetic surgery and procedure of the teeth and oral cavity (including teeth whitening, dental decorations, aesthetic laminates, and prostheses);
- orthodontics;
- aligners and other orthodontic devices not related to dental treatment (e.g., snoring, sports, and bruxism aligners);
- products to be purchased (including toothpaste, mouthwash, toothbrush);
- costs related to outpatient treatment, mental health, special diagnostics, preventive health checkup, outpatient rehabilitation, hospital treatment, and services included in additional insurance coverage;
- the cost related to the general exclusions referred to in clauses 14 and 15.

Additional insurance coverages

10. Prescription drugs

10.1. On the basis of prescription drug insurance coverage, the following expenses are reimbursed only on the basis of a physician's prescription:

- purchase of a prescription drug if the prescription drug is entered in the European Medicines Agency register, and the cost of the prescription drug is greater than 10 euros.

10.2. The following costs are not reimbursed under prescription drug insurance coverage:

- vaccines;
- antidepressants, sedatives, stimulants;
- sleeping pills;
- contraceptive drugs and devices;
- tests (including Covid-19 and pregnancy tests)
- food supplements;
- vitamins;
- obesity-related drugs;
- medical devices (including syringes, blood pressure monitors, glucometers, and hearing aids);
- the cost related to the general exclusions referred to in clauses 14 and 15.

11. **Orthopedic aids**

11.1. Under the insurance coverage of orthopedic aids, the following expenses are reimbursed only on the basis of a physician's prescription:

- rental or purchase of aids necessary for rehabilitation (orthoses, orthopedic insoles, crutches, wheelchairs, support bandages).

11.2. The cost of one aid of the same type during the insurance period is reimbursed.

12. **Optics**

12.1. The following expenses are reimbursed based on the optics insurance coverage:

- the purchase of glasses or contact lenses if the visual acuity has changed during the current insurance period, and the previous document certifying the visual acuity, which is the basis of the change, was issued no more than three years ago.

12.2. The purchase of one pair of glasses or contact lenses during the insurance period is reimbursed.

12.3. The following costs are not reimbursed under the optics insurance coverage:

- purchase of glasses without optical lenses (including blue light glasses);
- purchase of sunglasses with optical lenses;
- cost related to eyeglass cases and eyeglass cleaning and preservation products.

13. **Pregnancy and maternity**

13.1. On the basis of pregnancy and maternity insurance coverage, the following medically indicated expenses are reimbursed based on a physician's referral:

- pregnancy period and pregnancy-related tests, examinations, and procedures;
- the cost of a paid postpartum ward.

Exclusions

14. **The insurer does not reimburse the cost related to the following cases:**

14.1. services not provided, including services reflected in advance invoices;

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

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

14.4. 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;

14.5. cases caused by the consumption of alcohol, narcotics, or psychotropic substances;

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

15. **The insurer does not reimburse any costs related to the services, procedures, visits, consultations, examinations, and diagnostics mentioned below and related to the following specialists:**

15.1. services of a coach, dietitian, occupational therapist, geneticist, hypnotist, narcologist, rehabilitation specialist, trichologist, technical orthopedist and prosthetist, and nutritionist;

15.2. cosmetic and aesthetic services, cosmetic and plastic surgery (including benign skin tumor removal and treatment, aesthetic dermatology, cryotherapy, obesity treatment, weight loss program, skin laser treatment, ELOS technology and radio wave treatment services, pedicure and manicure services, including therapeutic and therapeutic manicure, treatment of ingrown nails and fungal treatment, acne and pimple treatment);

15.3. surgery or procedure to correct visual acuity, dry eye treatment using laser technology;

15.4. organ transplant surgery,

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

15.6. genetic tests and studies, food intolerance and sensitivity tests (except for studies related to additional protection described in clause 13);

15.7. sleep study and treatment;

15.8. treatment of sexually transmitted diseases (including HIV and AIDS);

15.9. purchase of medical aids (including orthopedic products such as corsets, orthosis, crutches, fixator, plaster, medical stockings, orthopedic insoles and shoes, and hygiene kit) (except for aids related to additional protection described in clause 11);

15.10. endoprosthetic services;

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

15.12. immunoglobulin therapy, blood plasma, and hyaluronic acid therapy and intra-articular injections (including PRP injections, Kenalog, Synisc), barotherapy, orthokine therapy, and intraocular injection;

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

15.14. 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 for the patency of the fallopian tubes and removal of appendages), except for studies related to additional protection described in clause 13, analyzes and procedures;

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

15.16. vacuum massage, cryo, Thai and aroma massage, prostate or gynecological massage;

15.17. printing, saving of certificates, documents, etc., as a separate service;

15.18. palliative care and social care;

15.19. the cost and expenses of smartphone applications, including their monthly fees;

15.20. drugs, vitamins, and nutritional supplements and procedures with drugs (including infusion therapy), except prescription drugs related to the additional protection described in clause 10;

15.21. training, lectures, and courses (including sexual counseling);

15.22. convenience services, including home visits and transportation.

Health insurance contract and conclusion, amendment, and termination thereof

16. The insurer and the policyholder enter into an insurance contract with the aim of ensuring the health insurance risks of the insured persons related to the policyholder's cooperation partner. If the insured person submits an application to join the insurance contract after reviewing the pre-contractual information, based on this, the insured person's insurance interest is deemed to have been established.

17. The insured person chooses the appropriate insurance coverage in cooperation with the insurance agent and the policyholder. Insurance coverage, insurance amounts, indemnity limits, and insurance premiums are specified in the insurance offer, confirmation letter, and terms and conditions.

18. To add an insured person to the insurance contract, the insured person submits an application to the insurance agent with their desire to join, along with the following information: affiliation with the cooperation partner, first and last name, social security code or date of birth, e-mail address, phone number and choice of insurance coverage.

19. The policyholder has the right to refuse to include the 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.

20. 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 certifying the insurance coverage.

21. 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 start date of the insurance period.

22. The selected insurance cover applies to the insured person during the entire insurance period. The insured person can be excluded from the insurance contract during its validity only in exceptional cases and by written agreement with the insurer and the policyholder.

23. The insurance contract is concluded for a fixed term, and the insurance period is one year unless otherwise stated in the insurance policy. The insurance contract is concluded between the insurer and the policyholder, who is a legal entity, which is why the insurance contract is not automatically extended for the policyholder and insured persons at the end of the insurance period.

24. The terms and conditions of the insurance contract can be changed and/or supplemented (including termination) only by written agreement with the insurer, 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 and conditions of the insurance contract in

the following cases:

24.1. The insurer may unilaterally and without notice change the terms of the insurance contract to be more favourable to the policyholder and/or the insured person, including reducing insurance premiums and increasing insurance coverage and indemnity limits.

24.2. The insurer may unilaterally increase the insurance premiums for the current insurance period and/or reduce the scope of insurance coverage, including reducing the volume of indemnified healthcare 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;
- healthcare provider's fees for the use of healthcare services;
- legislation concerning healthcare management.

25. The insurer 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 addressed in clause 24.2.

26. Amendments to the insurance contract do not enter into force until at least one month has passed after notifying the policyholder and the insured person of the respective amendment.

27. The insurer informs the policyholder and the insured person of changes to the insurance contract in accordance with the procedure specified in the terms and conditions.

28. The insurer has the right to cancel the insurance contract exceptionally for the following reasons:

28.1. The policyholder and/or the insured person has not fulfilled the insurance contract by the term specified in the conditions, including not having paid the first or subsequent insurance installment;

28.2. The policyholder and/or the insured person significantly violate the insurance contract and do not remedy the violation within the term given for that purpose.

29. The insurer may cancel the insurance contract in an extraordinary manner within one month of becoming aware of the violation.

Insurance payments and the consequences of not paying them

30. The insured person pays the insurance premiums for insurance coverage themselves unless otherwise agreed with the policyholder. The insured person generally pays the insurance premium for the entire insurance period at the same time according to the selected insurance coverage unless otherwise stated in the insurance offer and/or insurance policy.

31. In order to receive the insurance payment, the insurer issues an invoice to the policyholder and the insured person through the insurance agent. If it is relevant, the insurer issues a payment link via the insurance agent or an e-invoice via an invoice operator.

32. If the insured person is added to the insurance contract during the current insurance period, their compensation 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.

33. The invoice payment term is indicated on the invoice. If the invoice is not paid by the due date, the insurer has the right to demand from the recipient of the invoice a late payment of up to 0.066% of the amount not paid by the due date for each day of delay in payment.

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

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

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

Rights and obligations of the contracting parties

37. Obligation to provide information

37.1. When concluding an insurance contract, the policyholder and the insured person must provide the insurance agent with all the required information necessary for concluding and executing the insurance contract.

38. Rights and obligations of the policyholder

38.1. The policyholder has the right to:

- receive information about the insurance contract from the insurer;
- submit a complaint to the insurance provider in connection with the performance of the insurance contract in accordance with the provisions of the terms and conditions.

38.2. The policyholder has an obligation to:

- introduce the insured person to the insurance contract, including insurance coverage and terms and conditions, as well as explain to them 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 inform the insurer and the insurance agent of their change and provide new data;
- to ensure that the insured persons provide their consent to transfer their personal data to the insurer and to the insurance agent in order to include themselves as insured persons in the insurance contract. The consent must be provided at least in a form that allows reproduction and is available to the insurance agent upon their request.

39. Rights and obligations of the insured person

39.1. The insured person has the right to:

- receive information and advice about the insurance contract;
- receive agreed healthcare services;
- receive insurance indemnity for agreed services 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.

39.2. The insured person has an obligation to:

- pay insurance premiums for the policyholder as indicated on the invoice and by the due date;
- 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;
- submit their identity document to the health care provider before receiving the service covered by the insurance coverage;
- monitor the extent of the insurance indemnity, 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.

40. Rights and obligations of the insurer and/or insurance agent

40.1. The insurer and/or 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.

40.2. The insurer and/or the insurance agent has an obligation to:

- transmit the insurance contract information and documents to the insured person;
- submit the insurance premium invoice to the policyholder and/or the insured person by the due date;
- collect information from the insured persons, which is necessary for concluding an 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;
- notify the insured person of the remaining insurance amount or limit;
- at the request of the insured person, issue data and copies of documents that affect the insured person's rights and obligations arising from the insurance contract if such activity does not contradict the requirements arising from legislation;
- at the request of the policyholder and/or the insured person to issue replacement

policies and copies of declarations of intent submitted by the policyholder/insured person in a form that enables written reproduction.

Payment and recovery of insurance compensation

41. In the event of damage, the insured person is obliged to consult a physician as soon as possible to comply with their prescriptions and to do everything possible to prevent an increase in injuries caused by the insured event.

42. 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 https://portal.terviselahendus.ee/ or, if authentication is not possible, by sending the following documents to the e-mail address kahjud@terviselahendus.ee:

- physician's appointment - a document proving the cost (invoice or receipt);
- studies and analyses (including special diagnostic) - a document proving the cost (invoice or receipt) and a document proving the physician's referral (referral letter, epicrisis, or occupational health physician's decision);
- examinations and tests of preventive health checkups - a document proving the cost;
- optics - certificate(s) of the change in visual acuity (certificate of previous acuity, up to three years old, and certificate of fixed visual acuity recorded during the insurance period) and a document proving the cost of buying glasses or contact lenses;
- dental care - a document proving the cost;
- outpatient rehabilitation - a document proving the cost and a document proving the physician's referral;
- hospitalization – a document proving the cost and a document proving the physician's referral;
- prescription drugs and orthopedic aids - a document proving the cost and a doctor's prescription;
- other documents are required by the insurer and/or insurance agent regarding the services provided to the insured person in order to clarify the circumstances related to the insured event and/or to determine the amount of insurance compensation to be paid.

43. The document proving the cost (invoice or payment receipt) must have the following information: name of healthcare service provider, name of the service recipient, name of service, price, and date of service provision. If the invoice does not show whether it has been paid for, the insured person must also provide a payment receipt or bank statement.

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

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

46. If the insured person has received a claim from the insurer and/or agent in connection with health care services unjustly indemnified to him, the insured person is obliged to return the insurance indemnity to the insurer within 10 (ten) working days at the latest, which the insurer has paid to the health care service provider or directly to the insured person in the course of indemnification:

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

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

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

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

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

Release of the insurer from the performance obligation

47. 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.

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

49. The insurer has the right to refuse payment of the insurance compensation in the event that the policyholder and/or the insured person prevents the insurer 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 that aims to obtain unfounded insurance indemnity or insurance indemnity or a part thereof is higher than the prescribed amount.

50. The insurer may reduce the insurance indemnity by up to 50% (fifty percent) if the policyholder or the insured person fails to fulfill any condition stipulated in legislation or the insurance contract due to negligence.

Processing of personal data

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

52. 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

53. 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.

54. Transmission of notices

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

55. Submission of complaints about the activities of the insurer and insurance agent

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

55.2. 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, including documents proving the circumstances referred to in the complaint.

55.3. Complaints can be submitted to the postal address or e-mail address of the insurer and/or agent.

55.4. The insurer and/or agent shall send a reasoned written response to the complainant within 30 (thirty) days from the day of receipt 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.

55.5. If applicable, the policyholder and the insured person have the right to ask the insurer and/or agent for additional information about the complaint-handling procedure.

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

56. Applicable law

Legal acts in force in the Republic of Estonia apply to the regulation of relations arising from the insurance contract.

57. Settlement of disputes

57.1. Disputes arising from the insurance contract are tried to be resolved by agreement of the contracting parties.

57.2. 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.

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

57.4. 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).

57.5. The policyholder and the insured person have the right to submit a complaint about the activities of the insurer and/or insurance agent to the Financial Supervision Authority (phone 668 0500, e-mail address info@fi.ee, address Sakala 4, 15030 Tallinn.