SPECIAL TERMS AND CONDITIONS OF ERGO HEALTH INSURANCE FOR RESIDENTS

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Valid from 01 November 2017

The insurer is ERGO Life Insurance SE (registered in Lithuania), which offers services in Estonia through ERGO Life Insurance SE's Estonian branch (hereinafter also: the Insurer).

These ERGO Health Insurance terms and conditions apply to health insurance contracts signed at ERGO Life Insurance SE's Estonian branch with the residents of the Republic of Estonia.

In any matters not resolved by the terms and conditions, the parties to the insurance contract shall be guided by the general terms and conditions of health insurance contracts of ERGO Life Insurance SE's Estonian branch, the Law of Obligations Act, and other legislation.

1. Insured person

The insured person is a natural person named in the insurance contract, who is also a resident of the Republic of Estonia. The age of an insured person can be 3 to 60 years at the time of concluding the contract.

2. Insurance Contract validity. Insurance period.

2.1. The insurance contract is concluded without a term.
2.2. The insurance period is one year.
2.3. The start and end dates of the insurance period are stated in the insurance policy.
2.4. Unless the parties express their wish to end the insurance contract before the end of the insurance period, the Insurer shall issue a new policy for the next insurance period.

3. Insured event. Waiting period.

3.1. **Health insurance package Mini (or Health Mini)** is applied to persons insured in the national system.
In the case of Health Mini, an insured event is an illness, accident or another event stated in the insurance contract of the insured person occurring during the insurance period and after the end of waiting period, due to which the insured person has approached a health care institution or a doctor for medical care and has received medically indicated health care or prophylactic tests in the amount and conditions provided for in the insurance contract.

3.2. **Health insurance package Midi (or Health Midi)** is applied to persons insured in the national system.
In the case of Health Midi, in addition to the conditions stated in Section 3.1, an insured event also includes a critical condition that is listed in the annex List and Description of Critical Illnesses, which occurs during the insurance period and after the end of waiting period and complies with the criteria described in the annex.

3.3. **Health insurance package Maksi (or Health Maksi)** is applied to persons uninsured in the national system. In addition to conditions stated in Sections 3.1 and 3.2, Health Maksi also includes the cost of medications registered in Estonia or the European Union and prescribed by a doctor during the insurance period and after the end of waiting period, in accordance with the terms and conditions established in Section 7.8. of these special conditions.

3.4. Every event that has happened with the insured person and is in compliance with the definition of an insured event is counted as a separate insured event.

3.5. **The waiting period** is a period of time counted from the conclusion of the insurance contract, wherein insurance compensation will not be paid for insured events occurring during that period.

The waiting period is only applied to the following health services:

Health service/ Package	Health Mini/Midi	Health Maksi
Ambulatory care	14 days	30 days
Dental care	14 days	30 days
Prophylactic examinations	14 days	30 days
Prescription medications	14 days	30 days
In-patient indemnity	3 months	30 days
Critical illnesses	3 months	3 months

3.6. No waiting time shall be applied in the case of accidents having occurred during the period of validity of the insurance contract or renewal of the contract with the same insurance cover for the new insurance period.

4. Insured risk and the influencing circumstances thereof

4.1. Insured risk may be increased by the insured person's habits, hobbies, area of activity and previous illnesses, due to which the probability of an insured event occurring or the costs related to an insured event are increased.
4.2. In the case of a larger insurable risk, the Insurer has the right to increase the insurance premium or to refuse to conclude the contract.
4.3. The insurable risk shall be assessed by the Insurer on the basis of the request submitted by the insured person and, if necessary, on the basis of additionally presented medical documents or a medical examination.
4.4. The expenses of evaluating the insured risk will be covered by the Insurer.

5. Scope of the insurance coverage

5.1. The insurance cover shall apply to:
5.1.1. Outpatient and prophylactic health services provided in Estonia;
5.1.2. In-patient services, dental care, and health services involving critical illnesses and the cost of prescription medication provided in Estonia, Latvia and Lithuania.

6. Sum insured Limit and amount of indemnity

6.1. The sum insured is the amount established in the insurance contract in which the Insurer shall pay the insurance indemnity upon an insured event.
6.2. The indemnity limit for medical treatment expenses is the maximum sum paid by the Insurer in the event of the occurrence an insured event during the insurance period per each type of indemnity, set out in the offer and the policy.

6.3. The indemnity rate for medical costs is the % of the medical costs per each type of indemnity stated in the offer and the policy; the part that exceeds the indemnity rate shall be covered by the insured person in case of an insured event.

6.4. Following payment of the insurance indemnity, the sum insured shall decrease by the amount of paid indemnity of the respective type of insurance indemnity.

7. Insurance coverage

The types of insurance coverage provided by Health Mini, Midi, and Maksi are as follows:

7.1. Outpatient family and specialist doctor services

7.1.1. **Health Mini and Health Midi**
The Insurer shall compensate for the following costs that are not covered by national health insurance:
• the patient's appointment fee;
• physician's paid appointment;
• paid examinations designated by the physician, diagnostics, analyses (except food intolerance and allergy tests) and treatment procedures;
• pregnancy monitoring, including examinations and tests during pregnancy.

7.1.2. **Health Maksi**
The Insurer shall cover the following expenses:
• the patient's appointment fee;
• physician's appointment, including paid;
• examinations designated by the physician, diagnostics, analyses (including food intolerance and allergy tests) and treatment procedures;
• pregnancy monitoring, including medically indicated routine examinations and tests within the limits of the sum insured stated in the offer.

7.1.3. The maximum limit and rate of indemnity for services provided by a family physician and specialised medical care is stipulated in the offer and the insurance policy. Patient's appointment fee will be compensated in full by the Insurer and without applying the indemnity rate.

7.1.4. **The exceptions in family physician and specialist medical care** in addition to the provisions of the General Terms and Conditions of Medical Insurance Contracts are:
• health services provided by a nutritionist, homeopath, addiction specialist, clinical immunologist, orthopaedist-prosthetist;
• immunotherapy, sclerotherapy, and barotherapy;
• vaccination, except if separately agreed upon in the insurance contract;
• prescription medication, except if specifically agreed upon in the insurance contract;
• rehabilitation and rehabilitation physician services, except in cases stated in Sections 7.5.1. and 7.9.3. of these terms and conditions.

7.2. In-patient treatment

7.2.1. The Insurer shall compensate for the costs related to planned or unplanned inpatient or outpatient treatment of first-time illnesses of the insured person for the first time during the period of validity of the insurance contract.

7.2.2. **Health Mini and Health Midi**
The Insurer shall compensate for the following inpatient costs uncovered by national health insurance:
• in-patient-fees;
• additional costs for a paid hospital room for one or two people or after delivery;
• second opinion on the diagnosis or suggested treatment regimen;
• paid inpatient care services.

7.2.3. **Health Maksi**
The Insurer shall cover the following expenses:
• in-patient-fees;
• additional costs for general or paid hospital room after delivery;
• an examination of the sick person, organization of health surveys, determination of diagnosis and preparation of a health plan;
• deciding on treatment;
• compiling medical documentation;
• taking care of and nursing the patient;
• catering and administering medicinal products in hospital;
• diagnostic examinations;
• in-patient and out-patient surgeries;
• intensive care;
• second opinion on the diagnosis or suggested treatment regimen;
• reasonable costs on urgent in-patient care related to aggravation of chronic illnesses diagnosed before the conclusion of the contract. Costs are considered reasonable if they are related to health services that are provided at a hospital, upon sudden aggravation of the health condition of the sick person, when absence of emergency medical care would have posed a danger to the life of the insured person or caused a serious impairment to bodily functions or a disability.

7.2.4. The maximum limit and rate of indemnity for services provided at a hospital is stipulated in the offer and the insurance policy.

7.2.5. In addition to the provisions of clause 7 of the General Terms and Conditions of Medical Insurance Contracts, **Health Mini and Health Midi Hospital Insurance Cover shall not apply and the Insurer shall not pay any indemnity in the following cases:**
• surgeries on veins and gynaecological illnesses;
• examination of penetrability of fallopian tubes;
• laparoscopic surgeries and laparoscopic surgeries for removal of adhesion's;
• surgeries correcting eye refraction;
• plastic surgeries;
• organ and tissue transplants (except the insurance cover for critical illnesses referred to in Section 7.9);
• cancer treatment (chemotherapy, radiation therapy, hematological therapy) (except the insurance cover for critical illnesses referred to in Section 7.9);
• palliative care;
• cardiovascular surgeries;
• materials used at surgeries, tissue replacements and additional materials (implants, prostheses, retina devices, orthoses, hygiene and cosmetic products);
• costs related to close relatives staying in hospital, except costs for post-natal paid hospital room;
• midwifery costs.

7.2.6 In addition to the provisions of clause 7 of the General Terms and Conditions of Medical Insurance Contracts, **Health Maksi Hospital Insurance Cover shall not apply and the Insurer shall not pay any indemnity in the following cases:**
• gynecological surgeries, examination of penetrability of fallopian tubes;
• laparoscopic surgeries and laparoscopic surgeries for removal of adhesion's;
• surgeries correcting eye refraction;
• plastic surgeries;
• costs related to close relatives staying in hospital, except costs for post-natal family hospital room;
• midwifery costs.

7.3. Prophylactic examinations

7.3.1. The Insurer shall compensate for the costs of medical examinations and diagnostic examinations not substantiated by medical indication when they:
• determine the health status of the client and help to discover symptoms that could indicate imminent health issues;
• enable advice to be giving regarding the shaping of the client's lifestyle and habits with the intention of maintaining or improving health;
• are necessary for issuing medical certificates in relation to issuing of documentation (work permit, driver's licence, etc.);
• are necessary for occupational health checks;

• are necessary for monitoring chronic illnesses or illnesses developed before the conclusion of the insurance contract (incl. for issuing prescriptions);
• are related to family planning or contraceptives (incl. for issuing prescriptions).

7.3.2. The indemnity limit of prophylactic examinations and the indemnity rate is stated in the offer and the policy.

7.4. Dental care services

7.4.1. Dental treatment is a health care service that is provided to ambulatory patients by a dentist for the purpose of diagnosing, treating and preventing soft and hard tissue diseases, defects, traumas and congenital development disorders.

7.4.2. The Insurer shall compensate for the following dental treatment services:
• dentist's outpatient appointment;
• oral health promotion and disease prevention;
• consultations, drawing up of a treatment plan;
• treatment procedures, including dental treatment, fillings, cleaning, repairs of bridges and fillings;
• fitting dentures, repairing dentures;
• compiling medical documentation and assessing the patient's work ability;
• examinations necessary for diagnosing dental diseases and oral tissue diseases.

7.4.3. The indemnity limit of dental care services and the indemnity rate is stated in the offer and the policy.

7.4.4. In addition to the provisions of clause 7 of the General Terms and Conditions of Medical Insurance Contracts, **Dental Care Insurance Cover shall not apply and the Insurer shall not pay any indemnity for:**
• teeth whitening;
• orthodontic treatment with braces;
• cosmetic operations on teeth and mouth cavity.

7.5. Rehabilitation and aid equipment after an accident

7.5.1. The Insurer shall compensate for the following necessary rehabilitation costs after an accident for up to 3 months after the end of active in-patient treatment:
• rehabilitation, rehabilitation services;
• osteopathy, chiropractic, manual therapy;
• electric therapy, massage, bath treatments, corrective-gymnastic therapy.

7.5.2. The Insurer shall cover the following costs for aid equipment necessary after an accident:
• wheelchair, orthopaedic shoes and aids, support equipment, hearing aid and joint prosthesis;
• support bandages, metal plates for osteosynthesis.

7.5.3. The indemnity limit and rate for rehabilitation and aid equipment after an accident are stated in the offer and the policy.

7.6. Dental care after an accident

7.6.1. The Insurer shall compensate for the repairs of teeth damaged in an accident and the plastic surgery and prosthesis costs for fixing a jaw and teeth.

7.6.2. The indemnity limit and rate for dental treatment necessary after an accident is stated in the policy.

7.7. Insurance protection exceptions in case of an accident

In addition to the provisions of clause 7 of the General Terms and Conditions of Medical Insurance Contracts, the following cases shall not be deemed insurance events under the terms and conditions of accident insurance cover, and shall not be compensated:

7.7.1. stroke, epilepsy attack or some other spasm attacks that involve the entire body of the insured person, except when such damage or seizures are caused by an event covered by accident insurance;

7.7.2. minor injuries of skin or mucus membrane by which the infection can enter the body immediately or some time later, except in cases of rabies and tetanus;

7.7.3. intoxication caused by solids or liquids voluntarily administered orally, including food poisoning;

7.7.4. abdominal hernia, except when it is caused by an accident related to this insurance;

7.7.5. vertebrate spine disc damage, internal organ and brain haemorrhages, except when they are caused by an accident related to this insurance.

7.8. Prescription medications

7.8.1. In case of prescription medicine insurance cover, the insurer shall compensate for the costs of medications prescribed by a physician and registered in Estonia or other EU countries during the insurance period and after the end of waiting period.

7.8.2. **The exceptions to the prescription medication insurance cover** are costs on food additives, vitamins and diet mixes.

7.8.3. The indemnity limit of prescription medications and the indemnity rate is stated in the offer and the policy.

7.9. Medical treatment expenses for critical illnesses

7.9.1. Critical illness insured events include the unexpected and unforeseeable acute illness of the insured person or any other event that has occurred for the first time during the insurance period and after the end of the waiting period, is included in the List and Description of Critical Illnesses in the annex to the insurance terms and conditions and is in compliance with the criteria described thereof.

7.9.2. The need for treatment or surgery involving a critical illness must be confirmed by a health care specialist with the right to work as a physician.

7.9.3. The following surgeries and illnesses shall be deemed critical under these terms and conditions:
• Active tuberculosis
• Alzheimer's disease that appears before 65 years of age
• Aplastic anaemia
• Bacterial meningitis
• Crohn's disease
• Organ or bone marrow transplant
• Idiopathic Parkinson's disease before 65 years of age
• Hepatic insufficiency
• Multiple sclerosis
• Malign tumour
• Stroke
• Coronary artery bypass grafting
• Acute chronic renal insufficiency
• Heart surgery
• Acute myocardial infarction

Detailed description of critical illnesses is provided in annex List and Description of Critical Illnesses to these terms and conditions. If an insured person develops a critical illness, the Insurer shall compensate for the medically justified costs within the limits of the sum insured which was agreed upon in the insurance contract, which is not covered by national health insurance and which is related to the:

• planned or emergency ambulatory or inpatient treatment of the critical illness;
• medications prescribed during treatment;
• rehabilitation.

The sum insured shall be paid for a maximum of 18 months from the end of the calendar month of diagnosing the critical illness or until the sum insured is paid.

7.9.4. In case several critical illnesses develop during the insurance period, the obligation of the Insurer is limited to the sum insured.

7.9.5. If the Insurer has paid out the entire sum insured, the next period's insurance protection will not extend to the critical illness on which the treatment costs are already paid.

7.9.6. The Insurer will not cover the costs if the insured person is diagnosed with a critical condition during the waiting period or before the insurance protection enters into force (they were examined etc.).

7.9.7. The Insurer shall cover the costs based on the payment documentation issued by the respective medical establishment or pharmacy, either directly to the establishment or to the insured person. When the cost of medical services exceed the sum agreed with the Insurer or the average market price of the service, the insured person shall cover the price difference.

8. Instructions in case of insured event

8.1. In the case of injury an insured person may visit a contractual partner of the Insurer or the nearest family doctor or specialised medical care or licensed medical institution providing in-patient treatment in order to receive medical treatment.

When visiting the contractual partners of the Insurer, an insured person will receive care within the same working day in case of acute illness and at the first opportunity in case of a planned visit. Information on the contractual partners of the Insurer is presented on the Insurer's web page: https://www.ergo.ee/erakliendile/ravikindlustus.

8.2. In addition to the provisions of clause 5.2 of the General Conditions of Health Insurance Contracts, an insured person shall:

8.2.1. turn to a licenced physician at the first opportunity, follow the physician's instructions and do everything they can to prevent an increase of injuries caused by the accident;

8.2.2. in case of bodily harm by third person(s), notify the police either personally or via other people;

8.2.3. in order to receive a guarantee statement from the Insurer, an insured person shall notify the Insurer of the need for treatment in writing.

9. Terms and conditions for receiving insurance indemnity:

Within three months, an insured person shall submit to the Insurer:

9.1. an indemnity application;
9.2. an extract of the medical records or health card;
9.3. documentation verifying the costs related to health care services;
9.4. in case of critical illness treatment costs, a copy of the prescription with the code RKH-10 for critical illnesses together with documentation verifying payment;
9.5. copy of the prescription in case of compensation for prescription medicines;
9.6. in case of an accident, a verification of the accident being registered in police if such registration is required.