SPECIAL TERMS AND CONDITIONS OF ERGO BUSINESS HEALTH INSURANCE TI.0174.17

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 Special Terms and Conditions apply to health insurance contracts signed at ERGO Life Insurance SE's Estonian branch.

In any matters not resolved by the terms and conditions, the parties to the insurance contract will 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 an employee of the policyholder or their family member referred to in the insurance contract by their name. The extent of the insurance coverage of family members must be agreed with the insurer separately.

2. Validity of the insurance contract. Insurance period

2.1. The insurance contract is concluded without a fixed 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 will issue a new policy for the next insurance period.
2.5. In order to add insured persons or to terminate the insurance cover during the insurance period, the policyholder sends a written notice to the insurer stating the insured person's:
- first and last name;
- personal ID code;
- start and end date of the insurance cover.

2.5.1. When insured persons are added, the insurance cover will start on the date of the calendar month of submitting a notice of insurance cover, that corresponds to the date of the start of the insurance period.
2.5.2. Insurance cover ends on the last date of the month of filing the notice.
2.5.3. If insured persons are added during the insurance period or insurance cover is terminated, insurance premiums are accounted for the full month.

3. Insured event. Waiting period

3.1. **An insured event** is an illness, accident or another event stated in the insurance contract of the insured person, due to which the insured person has approached a health care institution or a doctor for medical care during the insurance period after the end of the waiting period and has received medically indicated health care or prophylactic tests in the amount and conditions agreed in the insurance contract.
3.1.1. Unlike Clause 7.1.6 of the General Terms and Conditions of Health Insurance, among others, the treatment costs of a chronic illness or trauma diagnosed before the entry into force of the insurance contract are reimbursed in the volume and on the conditions provided in the insurance contract.
3.1.2. An insured event is also the death of an insured person who is a non-resident during the insurance period, as well as the insured person's burial costs in Estonia or costs of sending them to their home country (repatriation), if agreed in the insurance contract.
3.1.3. Every event that has happened to the insured person and is in compliance with the definition of an insured event is counted as a separate insured event.
3.2. **The waiting period** is the period of time starting from signing the insurance contract, as well as the period of time accounted from the date of adding insured persons, wherein insurance indemnity will not be paid for insurance events occurring during that period.
3.2.1. The waiting period is two months and it is only applied for the insurance cover of critical illnesses upon the first conclusion of the insurance contract or when the insured person is first added during the insurance period.
3.2.2. No waiting period is 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 risk circumstances related to their profession and previous illnesses, due to which the probability of an insured event occurring or the costs related to an insured event increase.
4.2. The insurer may request the completion of a health declaration form for the insured person, to evaluate insured risk, if the insured person has become 60 years old or if family members of employees are to be insured. In such a case the insurer may additionally request the submission of medical documents or a medical examination of the insured person.
4.3. In the case of a larger insurable risk, the insurer has the right to increase the insurance premium or to refrain from concluding a contract.
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 applies to the following.
5.1.1. Treatment services provided in Estonia, unless otherwise provided in the contract;
5.1.2. Treatment expenses of critical illnesses in Estonia, Latvia and Lithuania;
5.1.3. Expenses related to repatriation in the case of insurance events that take place in Estonia only.

6. Sum insured. Limit and amount of indemnity for medical expenses

6.1. The sum insured is the amount established in the insurance contract in which the insurer will pay the insurance indemnity upon an insured event that occurs during the insurance period.
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 set out in the offer and the policy.
6.3. The indemnity rate for medical costs is the percentage of the medical costs per each type of indemnity stated in the offer and the policy; the part that exceeds the indemnity rate will be covered by the insured person in the case of an insured event.

6.4. Following the payment of the insurance indemnity, the sum insured for the given insurance period will decrease by the amount of indemnity paid for the respective type of insurance indemnity.

7. Insurance coverage

The insurer and the policyholder may agree on the coverage of the following types of insurance indemnities in the insurance contract in the volume and on the conditions provided in the insurance contract.

- Outpatient general practitioner and specialist doctor services
- Hospitalisation
- Prophylactic examinations
- Dental treatment
- Rehabilitation, equipment or dental treatment following an accident
- Prescription medications
- Rehabilitation indicated by a doctor
- Vaccination
- Ophthalmological aids
- Repatriation of a non-resident
- Post-hospitalisation rehabilitation treatment
- Critical illnesses

7.1. Outpatient general practitioner and specialist doctor services

7.1.1. The insurer reimburses the following costs of outpatient general practitioner's services and specialised medical treatment:
- patient's appointment fee;
- physician's paid appointment;
- examinations designated by the physician, diagnostics, analyses and treatment procedures within the professional competence;
- paid treatment carried out by a specialised doctor or a private clinic;
- monitoring of pregnancy, including routine medical surveys and examinations during pregnancy.

7.1.2. The maximum limit and rate of indemnity for services provided by general practitioner's outpatient care 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.

7.1.3. **The exemptions of general practitioner's outpatient services** and specialised medical care include, in addition to those stated in Clause 7 of the General Terms and Conditions of Health Insurance Contracts:
- health services provided by a nutritionist, homeopath, addiction specialist, clinical immunologist, orthopaedist-prosthetist;
- immunotherapy, sclerotherapy, and barotherapy;
- food intolerance and allergy tests;
- vaccination, except for if separately agreed upon in the insurance contract;
- prescription medication, except for if separately agreed upon in the insurance contract;
- rehabilitation and services of a rehabilitation doctor, except for if separately agreed upon in the insurance contract.

7.2. Hospitalisation

7.2.1. The insurer will compensate for the costs related to planned or unplanned inpatient or outpatient treatment of first-time illnesses of the insured person:
- inpatient fees;
- extra fees for a one- or two-bed hospital room or a paid room after giving birth;
- second opinion on the diagnosis or suggested treatment regimen;
- an examination of the sick person, organisation 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;
- inpatient and outpatient surgeries;
- intensive care.

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

7.2.3. In addition to the provisions of Clause 7 of the General Terms and Conditions of Health Insurance Contracts, the costs of the following treatment services are exempt from the insurance cover for hospital treatment:
- surgery for veins and gynaecological illnesses;
- examination of penetrability of fallopian tubes;
- laparoscopic surgery and laparoscopic surgery for the removal of adhesions;
- surgery correcting eye refraction;
- plastic surgery;
- organ and tissue transplants (except for the insurance cover for critical illnesses referred to in Section 7.13);
- cancer treatment, incl. chemotherapy, radiation therapy, haematological therapy (except for the insurance cover for critical illnesses referred to in Section 7.13);
- materials used in surgery, tissue replacements and additional materials (implants, prostheses, retina devices, orthoses, hygiene and cosmetic products);
- costs related to close relatives staying in hospital, except for the extra costs for a post-natal family hospital room;
- obstetrics;
- paid hospital treatment of a chronic illness or trauma diagnosed before the insurance contract entered into force.

7.3. Prophylactic health examination

7.3.1. In the sense of these terms and conditions, prophylactic health examination is regarded to be a medical examination and diagnostic surveys without medical indications that:
- determine the health status of the insured person and help to discover symptoms that could indicate imminent health issues;
- enable advice to be given regarding the shaping of the insured person's lifestyle and habits with the intention of maintaining or improving their health.

7.3.2. The insurer reimburses prophylactic health inspection which is necessary:
- for issuing medical certifications necessary to apply for documents (e.g. work permit, driver's licence);
- health inspection carried out by an occupational health doctor.

7.3.3. The insurer reimburses the following prophylactic health inspections, if agreed separately in the insurance contract, incl.:
- paid health inspection;
- health inspection necessary for monitoring chronic illnesses or illnesses developed before the conclusion of the insurance contract (incl. for issuing prescriptions);
- health inspection related to family planning or contraceptives (incl. for issuing prescriptions).

7.3.4. The indemnity limit of prophylactic health inspections and the indemnity rate is stated in the offer and the policy.

7.4. Dental care services

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

7.4.2. The insurer will 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;
- compiling medical documentation and assessing the patient's work ability;
- examinations necessary for diagnosing dental diseases and oral tissue diseases.

7.4.3. The insurer will also cover the costs of fitting and repairing dentures, if it has been agreed separately in the insurance contract.

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

7.4.5. In addition to the provisions of Clause 7 of the General Terms and Conditions of Health Insurance Contracts, dental care insurance cover will not apply and the insurer will not pay any indemnity for:
- orthodontic treatment with braces;
- teeth whitening;
- cosmetic surgery on teeth and the oral cavity.

7.5. Rehabilitation and aid equipment after an accident

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

7.5.2. The insurer will 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 treatment following an accident

7.6.1. The insurer will compensate for repairs of teeth damaged in an accident and the plastic surgery and prosthetics costs for the jaw and teeth.

7.6.2. The indemnity limit of dental care following an accident and the indemnity rate is stated in the offer and the policy.

7.7. Exemptions of insurance cover in the case of an accident

In addition to the provisions of Clause 7 of the General Terms and Conditions of Health Insurance Contracts, events caused by the following are not regarded to be insurance events under the terms and conditions of accident insurance cover, and are not be compensated:

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

7.7.2. minor injuries of skin or the mucous membrane by which the infection can enter the body immediately or with a slight delay, except for 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. vertebral 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 the case of prescription medicine insurance cover, the insurer will compensate the costs of medications prescribed by a physician that are registered in Estonia or other European Union countries during the insurance period.

7.8.2. The cost of supplements, vitamins and diet mixes is exempt from insurance cover for prescription medication.

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

7.9. Rehabilitation indicated by a doctor

7.9.1. The insurer reimburses the following costs of rehabilitation services indicated by a doctor:
- rehabilitation services, services of a rehabilitation physician;
- electric therapy, massage, bath treatments, correc-tive-gymnastic therapy;
- osteopathy, chiropractic, manual therapy.

7.9.2. The indemnity limit for the costs of rehabilitation indicated by a doctor have been provided in the offer and the policy.

7.10. Vaccination

The insurer reimburses the cost of vaccinations carried out during the insurance period up to the indemnity limit and indemnity rate stated in the offer and the policy.

7.11. The costs of ophthalmological aids

7.11.1. The insurer reimburses the cost of glasses and contact lenses based on a doctor's prescription issued during the insurance period up to the indemnity limit and indemnity rate stated in the offer and the policy.

7.11.2. The precondition of reimbursing the cost of ophthalmological aids is a verified change in the insured person's vision during the insurance period.

7.11.3. The indemnity limit of ophthalmological aids and the indemnity rate is stated in the offer and the policy.

7.12. Repatriation expenses

7.12.1. If agreed upon separately, the insurer reimburses the costs of transporting a non-resident of an insured person to their permanent country of residence if prescribed so by the doctor.

7.12.2. In the case of the insured person's death, costs of cremation and burial of the insured person in Estonia or transportation of their remains to their home country will be indemnified in the indemnity limit provided in the offer and the policy.

7.12.3. The costs that are reimbursed must be previously agreed with the insurance provider.

7.13. Critical illnesses

7.13.1. 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 after the end of the waiting period during the validity of the insurance cover, 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.

7.13.2. 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.

7.13.3. The following illnesses and surgeries are regarded to be critical illnesses in the sense of these terms and conditions.
- Active tuberculosis
- Alzheimer's disease that appears before 65 years of age
- Aorta surgery
- Aplastic anaemia
- Bacterial meningitis
- Hepatitis C
- Crohn's disease
- Organ or bone marrow transplant
- Benign brain tumour
- Idiopathic Parkinson's disease before 65 years of age
- Human immunodeficiency virus or HIV
- Total loss of a limb or function of a limb
- Total and irreversible damage to hearing in both ears
- Partial or total loss of speech
- Hepatic insufficiency
- Multiple sclerosis
- Malign tumour
- Stroke
- Tick-borne borreliosis or Lyme disease or Lyme borreliosis
- Tick-borne encephalitis
- Coronary artery bypass grafting
- Acute chronic renal insufficiency
- Heart surgery
- Acute myocardial infarction
- 3rd and 4th degree burns.

Detailed description of critical illnesses is provided in the annex List and Description of Critical Illnesses to these terms and conditions.

7.13.4. Upon the conclusion of the insurance contract, the policyholder can choose whether the insurance indemnity for critical illnesses will be paid to the insured person as a single payment or as insurance compensation of treatment costs. The selected type of insurance cover for critical illnesses and its amount are stated in the offer and the policy.

Special features of a single disbursement insurance contract: In the case of critical illness cover with a single payment, a survival period is applied. A survival period is a period of 30 days, which is counted from the date of establishing the diagnosis of a critical illness that constitutes an insured event. If the insured person dies during the survival period, the insurer does not have the obligation to pay the insurance indemnity. In such a case, the insurance cover related to this insured person ends and the insurance premium paid by that policyholder is not refunded. The insurer makes the decision on the payment of the insurance indemnity within 10 business days from the end of the survival period.

7.13.5. Special features of an insurance contract with the compensation of treatment costs. If an insured person develops a critical illness during the insurance period after the end of the waiting period, the insurer will compensate 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 for treatment costs will 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.

7.13.6. In the case that several critical illnesses develop during the insurance period, the obligation of the insurer is limited to the sum insured.

7.13.7. If the insurer has, in relation to the treatment of a critical illness, paid the insured person the whole sum insured, then as the insurance policy is issued for the next insurance period, the insurance will not cover the same critical illness for which treatment costs have been already reimbursed to the insured person.

7.13.8. The insurer will not cover the costs if the insured person is diagnosed with a critical condition before the insurance cover enters into force (they were examined etc.).

7.13.9. The insurer will 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 costs of medical services exceed the sum agreed with the insurer or the average market price of the service, the insured person will cover the price difference themselves.

7.14 Post-hospitalisation rehabilitation treatment

7.14.1 The insurer reimburses the cost of rehabilitation treatment indicated by a doctor and carried out at a rehabilitation centre or a spa following hospital treatment arising from a critical illness, surgery or trauma that constitutes an insured event, incl. the costs of accommodation (except catering), if agreed so in the insurance contract.

7.14.2 The costs of rehabilitation referred to in Clause 7.14.1 are reimbursed for up to one month after the end of active hospital treatment.

7.14.3 The indemnity limit of rehabilitation treatment following hospital treatment and the indemnity rate is stated in the offer and the policy.

8. Instructions in the case of an insured event

8.1. In the case of injury, an insured person may visit a contractual partner of the insurer or the nearest general practitioner or specialised doctor or licensed medical institution providing inpatient treatment in order to receive medical treatment. When visiting the contractual partners of the insurer, the insured person will receive care within the same business day in the case of acute illness and at the first opportunity in the 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 must:

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

8.2.2. report to the police, either themselves or through other persons, any bodily injuries that have been caused to the insured person by a third person or third persons;

8.2.3. report the need for treatment to the insurer in writing to obtain a letter of guarantee from the insurer.

9. Terms and conditions for receiving insurance indemnity

The insured person or the person having the right to claim an insurance indemnity must present the following 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 the case of treatment expenses of a critical illness, along with documents verifying the payment for medications, a copy of the prescription along with the code of the critical illness according to ICD-10;

9.5. copy of the prescription in the case of compensation for prescription medicines;

9.6. in the case of an accident, verification of the accident being registered with the police if such registration is required.