

Standard terms and conditions of a contract for persons considered equal to insured persons

STANDARD TERMS AND CONDITIONS

These standard terms and conditions (hereinafter *standard terms and conditions*) shall be an integral part of the contract to be entered into between the Estonian Health Insurance Fund (hereinafter *Health Insurance Fund*) and the policyholder for the benefit of the policyholder (in this case, hereinafter also *insured person*) or a named third party (hereinafter *insured person*), pursuant to which the insured person is considered equal to the insured person pursuant to the Health Insurance Act (hereinafter *contract*).

1. ENTRY INTO THE CONTRACT AND EMERGENCE OF INSURANCE COVER

1.1. In order to apply for insurance cover, the policyholder shall submit a proper written application to the Health Insurance Fund.

1.2. Upon entering into the contract, the policyholder shall notify the Health Insurance Fund of all known circumstances that may, due to their nature, affect the decision of the Health Insurance Fund to enter into the contract.

1.3. According to subsection 24 (4) of the Health Insurance Act, insurance cover of an insured person shall commence 1 (one) month after the entry into the contract.

1.4. If a contract is entered into during the period when the insured person has compulsory insurance cover pursuant to the Health Insurance Act, the insurance cover pursuant to the insurance cover contract shall commence as of the termination of the currently valid compulsory insurance cover without interruption.

1.5. If a new contract is entered into during the period of validity of the contract entered into previously, the insurance cover pursuant to the new contract shall commence as of the termination of the insurance cover pursuant to the contract entered into previously.

1.6. The Health Insurance Fund shall enter the data of the insured person in the database of the Health Insurance Fund for the emergence of the insurance cover.

2. SCOPE AND LIMITATIONS OF INSURANCE COVER

2.1. As of the emergence of insurance cover, the insured person shall be entitled to apply for the European health insurance card according to the procedure established by the minister responsible for the field pursuant to subsection 21 (3) of the Health Insurance Act.

2.2. Pursuant to subsection 21 (4) of the Health Insurance Act, the insured person must not use their European health insurance card after their insurance cover is suspended or terminated.

2.3. The Health Insurance Fund provides the insured person with health insurance benefits in kind and pays pecuniary health insurance benefits, excl. benefit for temporary incapacity for work, under the terms and conditions and to the extent provided for in the Health Insurance Act.

2.4. The insured person shall not be entitled to require the Health Insurance Fund to compensate for costs incurred by the policyholder on behalf of the insured person or by the insured person themselves in connection with obtaining health services, pharmaceuticals or medicinal devices.

2.5. The Health Insurance Fund shall not compensate the insured person for the additional fee or additional cost-sharing by insured person provided for in Division 6 of Chapter 3 of the Health Insurance Act.

2.6. The insured person shall lose the right to receive the benefits specified in clause 2.3 of the standard terms and conditions if:

2.6.1. Their need for the benefits has arisen as a result of participation in scientific research, including a clinical trial

2.6.2. They fail to follow the medically justified treatment prescribed by a doctor or a family nurse for the prevention of or against the case of disease, excluding in the case provided for in subsection 28 (4) of the Health Insurance Act

2.7. The Health Insurance Fund shall decide on the loss of a right to receive health insurance benefits specified in clause 2.6.2 of the standard terms and conditions in accordance with the procedure provided for in the Administrative Procedure Act and other legislation. The insured person may initiate challenge proceedings with regard to a decision made by the Health Insurance Fund in accordance with the procedure provided for in the Administrative Procedure Act within 10 (ten) calendar days after the receipt of the decision.

3. TERM OF CONTRACT AND INSURANCE PREMIUMS

3.1. The term of the contract shall be 1 (one) to 5 (five) years.

3.2. Insurance cover shall commence at the time provided for in clauses 1.3–1.5 of the standard terms and conditions and shall terminate upon the expiry of the contract.

3.3. The size of an insurance premium payable in a calendar month on the basis of the contract shall be the product of the average gross wages of the previous calendar year as published by Statistics Estonia, multiplied by 0.13 and rounded with the accuracy of 10 (ten) cents. The Health Insurance Fund shall have the right to change the size of an insurance premium payable in a calendar month once a year after Statistics Estonia has published the average gross wages of the previous calendar year.

3.4. The policyholder shall be obligated to pay insurance premiums for the insurance period in advance by 3 (three) months or 1 (one) year. The policyholder shall not have the right to pay insurance premiums by other periods.

3.5. For the payment of the first insurance premium, the Health Insurance Fund shall issue an invoice to the policyholder within 5 (five) calendar days after the entry into the contract. The policyholder shall pay the first insurance premium within 14 (fourteen) calendar days after the entry into the contract.

3.6. Upon payment every three months, the Health Insurance Fund shall issue an invoice to the policyholder for the payment of the next insurance premium at least 14 (fourteen) calendar days before the start of the subsequent three-month period. The due date for the payment of the next insurance premium shall be the calendar day preceding the starting date of the subsequent three-month period specified in the invoice.

3.7. The Health Insurance Fund shall notify the policyholder of changes to the average gross wages of the previous calendar year published by Statistics Estonia and the resulting changes to the size of the insurance premium together with the subsequent invoice to be submitted to the policyholder.

4. EXPIRY, CANCELLATION AND WITHDRAWAL FROM THE CONTRACT

4.1. The contract shall expire on the date agreed upon in the contract or on the day that insurance cover of compulsory insurance arises for the insured person pursuant to the Health Insurance Act or insurance cover in Estonia arises for the insured person pursuant to an international agreement or on other grounds or in the event that the insured person takes up residence abroad. In the event of the death of the insured person, the contract shall expire on the day of the death of the insured person.

4.2. Upon the expiry of the contract, the Health Insurance Fund shall refund the prepaid insurance premium to the policyholder to the bank account specified in the application for the entry into the contract.

4.3. The policyholder shall have the right to withdraw from the contract within 14 calendar days after the entry into the contract by submitting a written application to the Health Insurance Fund. If the insured person has received health insurance benefits specified in clause 2.3 of the standard terms and conditions before withdrawal from the contract, the policyholder shall be obligated to reimburse these to the Health Insurance Fund. If the policyholder has paid the first insurance premium before withdrawal from the contract, the Health Insurance Fund shall return it to the policyholder to the bank account specified in the application for the entry into the contract.

4.4. If the policyholder has failed to timely pay the insurance premium or the first insurance premium within the 14-day deadline provided for in clause 3.5 of the standard terms and conditions, the Health Insurance Fund shall have the right to withdraw from the contract. If the Health Insurance Fund is withdrawing from the contract and the insured person has received health insurance benefits specified in clause 2.3 of the standard terms and conditions before withdrawal from the contract, the policyholder shall be obligated to reimburse these to the Health Insurance Fund.

4.5. If the policyholder has failed to timely pay subsequent insurance premiums, the contract shall be deemed to have been cancelled by the Health Insurance Fund, provided that the Health Insurance Fund has not received the insurance premium by the additional due date specified by the Health Insurance Fund.

4.6. The Health Insurance Fund may withdraw from the contract within one month from the day that the Health Insurance Fund became aware or should have become aware that the policyholder has knowingly failed to notify the Health Insurance Fund of circumstances specified in clause 1.2 of the standard terms and conditions or knowingly submitted to the Health Insurance Fund false information in the application for the entry into the contract.

4.7. If the policyholder materially breaches an obligation prescribed by the contract due to a circumstance arising from them, the Health Insurance Fund may cancel the contract without an advance notice within 1 (one) month after becoming aware of the breach, unless provided otherwise by law.

4.8. The Health Insurance Fund or the policyholder may cancel the contract with good reason, foremost if the cancelling party cannot be reasonably expected to continue the contract until the expiry date of the contract, taking account of all the circumstances and the mutual interest of the parties. The other party shall be notified of the cancellation in writing no later than 30 (thirty) calendar days in advance.

4.9. If the contract is terminated prematurely by cancellation and the insured person has had insurance cover up to the cancellation, the policyholder shall be obligated to pay insurance premiums until the expiry of the contract.

4.10. Expiry of the contract shall terminate the insurance cover.

5. FINAL PROVISIONS

5.1. If the insured person waives the rights granted to them by the contract or if their right expires or is not valid, the policyholder may not appoint a new insured person or require the performance of the obligation pursuant to the contract to them.

5.2. In the cases provided by law, the Health Insurance Fund shall have the right to require the policyholder, insured person, third parties and state and local government authorities to provide data, incl. special categories of personal data and other data, if these data are necessary for the Health Insurance Fund to perform the duties prescribed by law or the contract.

5.3. The policyholder shall promptly notify the Health Insurance Fund of receiving health insurance cover in another European Union Member State, Great Britain, Iceland, Liechtenstein, Norway or Switzerland.

5.4. The policyholder shall promptly notify the Health Insurance Fund of changes to the contact details of the policyholder and the insured person specified in the contract and the bank account specified in the application for the entry into the contract.

5.5. The contract shall be subject to the provisions of the Law of Obligations Act that govern the insurance contract insofar as they are not in contravention of the provisions of the Health Insurance Act. The provisions of the Insurance Activities Act shall not be applicable to the contract.