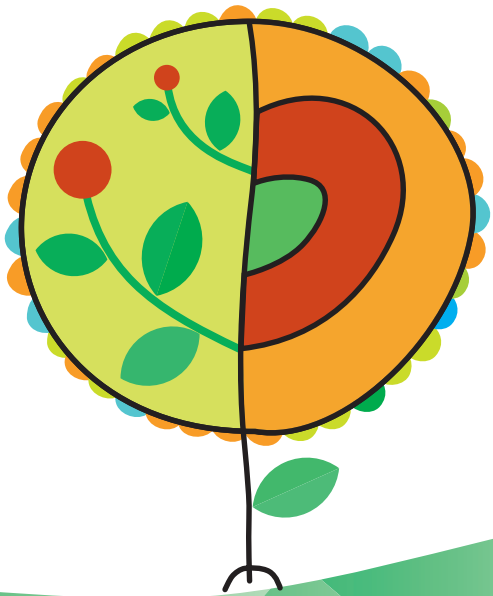
Estonian
Health Insurance
Fund

For Your Health

Handbook 2013



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DEAR READER!

In your hands you are holding the Estonian Health Insurance Fund's annual handbook "For Your Health". In the handbook, we have collected a selection of the most pressing issues related to health insurance and Estonian health care system. This year's handbook gives an in-depth overview of the operation of the medical system and talk about the services included in the health insurance package. We also write about discount medicinal products, discuss how the Health Insurance Fund contributes to monitoring children's health, and take a closer look at the e-services offered by the Health Insurance Fund. We also cover insurance and the present and future possibilities of treatment in the European Union.

We hope that in this booklet, you will find answers to some of your most pressing questions.

Insurance like any other – how, what and how much does health insurance give?

Health insurance is a type of insurance like any other. In case of home insurance and motor insurance, individuals pay contributions so that expenses regardless of the amount would be covered in the event of an accident. It is the same with health insurance. People pay health insurance contributions and if they are taken ill, insurance will cover their medical costs. Insurance is necessary, because there is a considerable risk of falling ill, while health services, medicinal products etc. are expensive. All in all, falling ill may prove to be very costly.

A solidarity-based health insurance scheme is valid in Estonia. This means that in addition to playing for personal health insurance, 13% of a working person's gross wages also covers the insurance of those who do not pay health insurance contributions themselves. This group includes children, pensioners, mothers raising children under the age of three at home, unemployed individuals and pregnant women. All Estonian citizens with health insurance receive similar medical care, whether or not they pay health insurance contributions.

Only 46% of the people with health insurance finance the system. The rest do not contribute to the system, but take advantage of the services. The funds of the system are constantly used to treat all people in need; no one owns a personal account.

Health insurance is managed by the Health Insurance Fund. The Health Insurance Fund mainly finances medical care provided to insured individuals. The fund also finances medicinal products distributed at a discount; compensates for the purchase of medical equipment for people covered by health insurance; pays various benefits; engages in health promotion, etc.

Health insurance is characterised by two dimensions. The scope of an insurance package shows how many services and other benefits the health insurance fund shall finance. The depth of the package explains the extent to which the services and other benefits shall be covered. Sometimes, people mistakenly assume that the health insurance fund covers all costs connected with medical services. The health insurance fund does indeed cover most services to the full. However, some medicinal products and services are partially paid for by the patient.

What are the selection criteria for the services to be compensated?

Proposals to amend the list of health services are mostly made by the representatives of health professionals' associations. Medical professionals can assess new services, metho-dologies and technologies, as well as the effect of these on patients. Assessments of whether medical services are evidence-based can be made by medical specialists recommended by the University of Tartu Faculty of Medicine or the State Agency of Medicines. Cost-effective-ness is mainly assessed by the Health Insurance Fund, and the necessity of the services to the society is assessed by the Ministry of Social Affairs.

The new service must be more effective than the existing ones. Costs must also be considered – whether the positive effect costs more or less than an alternative; whether it enhances the quality of life or if it can save the life of a patient. The choice is made by considering the criteria and financial possibilities. The Advisory Board of the Health Insurance Fund submits a written opinion and makes a proposal to the Minister of Social Affairs for the new list to be submitted to the Government of Estonia for authorisation.

The Health Insurance Fund and health professionals' associations continue to work on the services excluded from the list in order to include them in the list in the future if possible.

How does a medicinal product beco-me a discount medicinal product?

Medicinal products are manufactured and marketed by private operators. The State Agency of Medicines decides whether the medicinal product is of sufficient quality, and authorises its marketing. Many medicinal products are expensive and the support of the Health Insurance Fund is required to cover the cost.

To receive discount on a medicinal product, the manufacturer of medical products submits an application to either the Health Insurance Fund or the Ministry of Social Affairs. The manufacturer describes the characteristics and uses of the medicinal product and justifies the cost of the medicinal product. The State Agency of Medicines makes an assessment on the medical part of the application. The Health Insurance Fund analyses the economic aspects of the application and considers whether the cost of the medicinal product is justified.

The services and amounts that the Health Insurance Fund covers are determined by three legal acts that are constantly being amended:

- **The list of health care services** includes health services paid for by the Health Insurance Fund.
- **The list of medicinal products** includes medicinal products compensated for by the Health Insurance Fund and the level of benefits.
- **The list of medical equipment** includes equipment compensated for by the Health Insurance Fund and the terms and conditions of compensation.

Before including a new service or medicinal product in the health insurance package, four general criteria are analysed, namely whether:

- the service, medicinal product or medical device is medically effective enough;
- its effect on the patient's health and the cost of its compensation are appropriately balanced;
- there are other possibilities to achieve the same goal;
- the Health Insurance Fund is able to cover the additional cost.

Thus, the list does not include all existing medicinal products, equipment or services.

Next, both the application and forward estimates are considered by the medicinal products committee which then makes a recommendation. The recommendation is often conditional. The manufacturer of medical products and the Ministry of Social Affairs enter into negations, e.g. over the price of the medicinal product. If an agreement is reached, the product is inscribed on the list of medicinal products of the Health Insurance Fund. When the new list takes effect (once each quarter) the Health Insurance Fund begins to compensate the cost of the medicinal product to people.

Including medical equipment in the list is carried out similarly to medicinal products, and their purchase is compensated on the basis of a medical device card issued by a doctor.

In addition to paying for services, the Health Insurance Fund also makes financial compensations to individuals covered by health insurance. Please read the article "Compensations" on page 11 for additional information.

Health insurance

Health insurance is required for the Health Insurance Fund to pay for medical treatment expenses. People not covered by health insurance must pay for medical treatment expenses themselves, whereas treatment may be very expensive. All permanent residents of Estonia, as well as people who stay here under a temporary residence permit or right of residence and who have paid their social tax or whose social tax has been paid for, are entitled to health insurance. Also, the state ensures the right of health insurance to children under the age of 19, pupils and students, conscripts, pregnant women, the unemployed, individuals on parental leave, dependent spouses, pensioners, carers of disabled individuals and people who have entered into a voluntary insurance agreement with the Health Insurance Fund. How can people receive health insurance coverage?

EMPLOYED ADULTS

The people whose social tax is paid for them or who pay their own social tax are:

- employees **with contracts of employment**;
- people receiving remuneration or service fee **on the basis of a contract under the law of obligations**;
- members of the **management and control body** of a legal person;
- self-employed persons and spouses involved in their activity.

In order to commence, terminate and suspend health insurance, the **employer** needs to submit the required documents to the Health Insurance Fund. Data on self-employed persons and their spouses participating in their activity are submitted by the **Estonian Tax and Customs Board**. If a self-employed person employs individuals on the basis of a contract of employment or a contract under the law of obligations, and is obliged to pay social tax for these individuals, the self-employed person must submit the documents for the commencement, termination and suspension of the health insurance of the employees to the Health Insurance Fund himself/herself.

Insurance data must be submitted to the Health Insurance Fund within seven calendar days after the contract has entered into force or the self-employed person has been entered in the commercial register. Who must be notified of the termination of an employment relationship? The notification must be entered in the commercial register ten calendar days as of the termination of an employment contract or the termination of the activity of the self-employed person. Health insurance is valid for **two months** after the termination thereof.

Employers can submit data to the Health Insurance Fund and view information about the health insurance of their employees in the Company Registration Portal.

CHILDREN

Children of up to 19 years of age, whose permanent residence is Estonia according to the population register, are covered by health insurance. Health insurance is valid until the day the child turns 19.

PUPILS AND STUDENTS

Right to state health insurance is entitled to

- **basic school pupils** up to the age of 21;
- **upper secondary school pupils**, who are under the age of 24 at the time of entrance;
- individuals without basic education who study at a **vocational school** and have passed the age of compulsory school attendance, and pupils studying at a **vocational school** on the basis of basic or secondary education;
- **students**, including distance-learning students, who are permanent residents of Estonia.

Health insurance is valid for the whole standard period of study and for **three months** after graduating from the educational institution. If a pupil has not completed the study programme during the standard period of study (except for medical reasons) or he/she is expulsed from school, his/her health insurance is terminated **one month** after the end of the standard period of study or his/her exmatriculation. Health insurance is suspended for the duration of academic leave, except if

the academic leave is taken for medical reasons.

Data on pupils and students are submitted to the Health Insurance Fund by the **Estonian Ministry of Education and Research**.

In order to continue receiving Estonian health insurance while studying abroad, pupils and students must submit documents certifying their studies in a foreign country to the Health Insurance Fund. Health insurance is formalised on the basis of these documents for a maximum period of **12 months**. Therefore, certification of studying abroad must be delivered to the Health Insurance Fund **each academic year**.

UNEMPLOYED INDIVIDUALS

The right to receive state health insurance cover becomes valid through the Estonian Unemployment Insurance Fund to:

- individuals receiving unemployment insurance benefit – as of the day the right to receive benefit becomes valid;
- individuals receiving unemployment allowance – as of the day the right to receive allowance becomes valid;
- the unemployed not receiving unemployment allowance – as of the 31st day of being registered as unemployed;
- the unemployed who are undergoing practical training, work exercise or a minimum of 80 hours of employment training and do not receive unemployment allowance – as of the first day of participation;
- non-working individuals, who have participated in eliminating the consequences of a nuclear disaster – as of the day of submitting the application.

People do not need to submit documents to the Health Insurance Fund themselves in order to receive health insurance. The data needed to commence, terminate or suspend health insurance is **submitted by the Unemployment Insurance Fund**.

When the period of being registered as unemployed with the Unemployment Insurance Fund ends, the health insurance will continue to be valid for **another month**. As an exception, the health insurance of people receiving unemployment insurance benefit is terminated **after two months**.

Please find additional information on regis-tering as an unemployed person, unemployment benefits and allowances, as well as applications and the required forms on the Unemployment Insurance Fund website at **www.tootukassa.ee** or from the agencies of the Unemployment Insurance Fund.

CONSCRIPTS

In order to receive health insurance, data on the conscripts are submitted to the Health Insurance Fund by the **Defence Resources Office**. Health insurance is valid for **one month** after the compulsory military service has ended.

PREGNANT WOMEN

If a pregnant woman did not have health insurance before becoming pregnant, she needs to submit an identity document and a certificate issued by the midwife on the detection of pregancy to the customer service office of the Health Insurance Fund to receive health insurance. The insurance is terminated **three months** after the date of birth estimated by a medical professional.

PARENTS

Individuals raising a child under the age of 3 on **parental leave**, be it the monther, the father or a guardian, are covered by insurance.

The following are also eligible for health insurance:

- one non-working parent living in Estonia, who is raising three or more children under the age of 19, at least one of whom is under eight years of age;
- one parent, guardian or carer living in Estonia, who has entered into a foster care contract, and who is raising seven or more children under the age of 19 living in Estonia.

Data for receiving health insurance are submitted to the Health Insurance Fund by the **Estonian National Social Insurance Board**.

DEPENDENT SPOUSES

Dependent spouse who has less than five years left until old-age pension

State health insurance is entitled to the dependent spouse of an insured person in a legal marriage, who has less than **five years** left until his/her old-age pension. In order to receive health insurance, the candidate must **submit an application to the Health Insurance Fund**. The insurance is terminated when the dependent person reaches retirement age, the marriage is divorced or the maintenance provider is no longer insured. In general, when the dependent person reaches retirement age, the insurance continues as the insurance of an old-age pensioner.

DEPENDENT SPOUSE WHO RAISES CHILDREN

State health insurance is also available to the dependent spouse of an insured person in a legal marriage, who is raising:

- at least one child under the age of eight,
- an eight-year-old child until finishing the first grade,
- at least three children under the age of 16.

In this case, the maintenance provider must be insured as an employee, a person receiving wages or service fees on the basis of a contract under the law of obligations, as a member of the management body of a legal person, or as a self-employed person.

In order to receive health insurance, documents must be **submitted to the Estonian National Social Insurance Board** which will communicate the data required to formalise the insurance to the Health Insurance Fund. Please find additional information about the documents by calling the Estonian National Social Insurance Board at **16106** or visiting **www.ensib.ee**.

If the conditions required for insurance are no longer met, the Social Insurance Board communicates the data required to terminate the insurance to the Health Insurance Fund.

PENSIONERS

All individuals receiving state pension awarded in Estonia are covered by insurance. The data required to receive insurance are submitted to the Health Insurance Fund **by the Social Insurance Board**.

CARERS OF DISABLED INDIVIDUALS

State health insurance is also available to individuals whose social tax on the disabled person's maintenance allowance is paid by the rural municipality government or city government. Data communicated by the local government in order to receive insurance are submitted to the Health Insurance Fund **by the Ministry of Social Affairs**.

VOLUNTARY INSURANCE

If you do not belong to any of the groups above, you can enter into a so-called voluntary insurance contract with the Health Insurance Fund.

Individuals eligible to enter into the contract are:

- individuals who have been covered by insurance through an employer for a minimum of 12 months during the previous two years; who have been covered by insurance as individuals receiving wages or service fees on the basis of a contract unter the law of obligations; as a member of a management and control body of a legal person; as a self-employed person; as a pupil or a student;
- individuals receiving pension from a foreign country, in whose case previous health insurance from Estonia is not required.

These people may enter into contract in order to insure themselves or their dependents. In general, a voluntary insurance contract is entered into for a term of one year. Insurance contributions are calculated by multiplying the average Estonian gross wages disclosed by Statistics Estonia by 0.13. The sum of insurance contribution for 2013 is €109 per month, €327 per quarter, and €1,308 per year. Insurance contributions are usually paid once per quarter. The contract may be entered into via e-mail; by sending a digitally signed application to the customer service office of the Health Insurance Fund; or at the customer service offices of the Health Insurance Fund.

Please find additional information on receiving health insurance coverage in the Member States of the European Union in the article "Living and travelling in other EU Member States – right to travel insurance", page 20.

How can you check if you are covered by health insurance?

You can find information on your health insurance in the Estonian State Portal at **www.eesti.ee** or by calling the Health Insurance Fund helpline **16363** (Mon–Fri 8:30 AM–4:30 PM, calling from abroad at +372 669 6630).

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Health care administration – how does the medical system operate?

In order to use medical services through the Health Insurance Fund, a person needs needs to be covered by health insurance.

Each year, the Health Insurance Fund enters into contracts with family physicians and medical institutions, determining the extent to which the Health Insurance Fund shall pay for services rendered to patients covered by health insurance, and what kind of services and to what extent the Health Insurance Fund shall purchase.

Medical institutions are responsible for organising the activity of medical service providers and using the money paid by the Health Insurance Fund. Their ability to manage their organisation is of utmost importance.

How is receiving health care organised?

On average, Estonian residents visit a doctor 7.5 times per year. They use the services of a family physician approximately 4.4 times. Medical specialists are visited 3.1 times.

Which doctor to turn to and how fast help is received depends on the nature and severity of the health problem. In Estonia, health care is divided to three levels: first contact care or care provided by the family physician; care provided by a medical specialist; and nursing care. In case of the need for urgent health care, patients may consult the emergency department themselves or call the ambulance.

FIRST LEVEL: CARE PROVIDED BY THE FAMILY PHYSICIAN

Every person has the right to choose a family physician. Otherwise, the family physician is assigned by the Health Board, notifying the Health Insurance Fund.

The first adviser of the patient is usually a family nurse or a family physician. Therefore, health care provided by the family physician is also called first contact care. Family nurses and family physicians can solve most health issues. The main functions of a family nurse include advising patients, teaching them about the prevention of diseases, and monitoring chronically ill patients. The main functions of a family physician include the diagnosis and treatment of diseases. He/she assigns tests, refers the patient to a medical specialist, etc.

In 2012

- 4,523,318 family physician consultations
- 592,690 family nurse consultations
- 973,882 people visited the family nurse or family physician
- The Health Insurance Fund paid €70,212,000 for health care provided by family physicians

Patients with an acute illness must receive an appointment with their family nurse or family physician on the same day. In case of chronic illnesses and other health issues that do not require immediate intervention, the family physican will see the patients within five business days. Medical certificates, e.g. for driving licences or children's camps are issued by the physician within 15 days. Patients can also ask for advice and help by phone or via e-mail.

How much is paid by the patient?

Visits with the family physicians are free of charge for patients covered by health insurance. Family physicians may not charge visitation fees or other fees, e.g. for disposable plastic slippers, office supplies, rent, etc. Physicians are also not entitled to ask for so-called voluntary donations for the visit. The exceptions are individuals not covered by health insurance. When paying the fee, we recommend you ask for a receipt and send it to the Health Insurance Fund. The Health Insurance Fund can oblige the family physician to return the sum paid.

Family physicians can charge up to €5 for a home visit regardless of how many patients he/she checks during a single visit. Home visits are free of charge for pregnant women and children under the age of two.

Advisory line of the family physician 1220

The advisory line of the family physician 1220 provides medical advice on simpler concerns relating to health, instructions on first

How much does the Health Insurance Fund pay the family physician?

Type of fee	Amount of fee	What does it cover
Basic sum	€912.23 per month	Rent of rooms and home visits
Capitation fee	€2.57–5.53 for each patient in the practice list, depending on the age of the patient	Wages of the family practice employees Costs of consultation procedures
Study fund	29–37% of the capitation fee, depending on how active the family physicians are in treating their patients	Studies on patients
Distance fee	€133.65–382.94 per month	Transportation expenses of family physicians working in rural areas
Additional fees	€1,082.42 per month	Expenses of a second family nurse
Additional fees for the quality system	Up to €3,834.7 per year	Additional fee through the quality system

aid, and information on issues related to the organisation of medical care. The aim of the family physician advisory line is to make help more accessible when the family physician is not available or when the concern does not seem serious enough to visit the family physician. The advisory line is open 24 hours a day in both Estonian and Russian. The line is also open on national holidays and weekends. Calling is not a replacement for the consulation of a family physician. In case of a more serious concern relating to health, the patient is advised to consult with the family physician. Urgent and emergency calls are redirected to the alarm centre.

SECOND LEVEL: SPECIALISED MEDICAL CARE

If the family physician decides that a patient's concern relating to health requires intervention from a medical specialist of a narrower field, he/she shall issue the respective referral. Without a referral, patients are free to visit eye and skin specialists, gynecologists and psychiatrists.

Medical specialist can be visited all over Estonia. A resident of Tallinn may visit a specialist in Tartu, a resident of Saaremaa can visit a medical specialist in Tallinn, etc. It must be checked whether the medical specialist is a con-tractual partner of the Health Insurance Fund (information is provided on the Health Insurance Fund website). Otherwise, the Health Insurance Fund will not pay for the visit or the following procedures.

Specialised medical care is divided in three – out-patient treatment, day care surgery and procedures, and in-patient medical treatment. Out-patient treatment means performing physical examinations of patients and certain procedures (blood tests, cardiogram, etc.) on the spot, as well as possible treatment later at home. Out-patients do not stay at the hospital for longer. Day care surgery and procedures include surgical procedures that do not require patients to stay at the hospital for longer either. In-house health care is provided to patients at the hospital and they need to stay at the hospital overnight or for a longer period.

Access to a medical specialist

Individuals requiring specialised medical care are placed on a waiting list according to the severity of their medical problems. In case of serious problems, patients can see the medical specialist sooner. The Health Insurance Fund has laid down periods of time within which the patient must be able to visit the specialist. The maximum waiting period for an out-patient visit is six weeks, while in case of a scheduled in-patient visit and procedures of day care surgery, the waiting time is up to eight months. The waiting time may be prolonged if a person chooses the medical specialist or medical institution himself/herself; medical institutions lack specialists and other resources (equipment, rooms); the patient is waiting for a repeat consultation; the Health Insurance Fund lacks money, etc.

How much is paid by the person, how much by the Health Insurance Fund?

Patients are charged up to €5 for a consultation with a medical specialist, since specialised medical care is very expensive. The fee is a

motivation to prevent people from visiting medical specialists without a reason. The Health Insurance Fund pays an additional €15.32 for each visit. Costs of procedures and studies are added. One medical case may cost from a few euros up to tens of thousands of euros.

It is prohibited to charge visit fees from pregnant women, children under the age of 2, and when in-patient service must be provided immediately after providing emergency out-patient specialised medical care.

Medical institutions may charge up to €2.5 per an in-patient day. In one medical case, fee may be charged for up to 10 in-patient days or up to €25. The Health Insurance Fund also pays extra for in-patient days. The amount of the fee depends on the illness. Patients cannot be charged in-patient fees for intensive care and for providing in-patient medical care to pregnant women or minors.

In 2012

- 3,162,649 specialised medical cases (appointment + before and after procedures within a single medical case)
- 795,581 people used specialised medical care
- The Health Insurance Fund paid €450,472 for specalised medical care

THIRD LEVEL: NURSING CARE

Nursing care is required by patients who find it hard to cope independently due to a chronic illness, a disability or other similar reasons. These patients are mostly elderly. Nursing care enables to achieve and preserve their best possible ability to cope.

In case of in-patient nursing care, the patient must stay at the hospital. Home nursing and supportive home therapy of cancer patients or out-patient nursing care is provided at the patients' homes. Medical professionals issue referrals for nursing care.

How much does it cost?

In case of in-patient nursing care, patients pay 15% of the in-patient fee or €6.87 per day and €209.54 per month on average. The Health

Insurance Fund pays medical institutions approximately €38.91 or approximately €1,186.76 per month for each day of nursing care. Similarly to specialised medical care, in-patient days also cost €2.50 per day in case of nursing care or a maximum of €25 per one stay at the hospital.

In total, the Health Insurance Fund spent €17,538,000 on financing nursing care in 2012.

Services of out-patient nursing care, including the home nursing service, are still free of charge to patients and paid for by the Health Insurance Fund. The procedures performed during a home nursing visit include, for example, preparing a nursing care plan, advising, basic nursing care of patients, and performing medical procedures and certain laboratory studies.

EMERGENCY MEDICAL CARE

Anyone experiencing a serious and urgent health problem outside the reception time of a family physician can go to the emergency reception department or so-called EMO of a larger hospital. All individuals in need are helped according to the severity of the health problem and the urgency of need for medical care. The second option in case of urgent problems is to call the ambulance at 112. Emergency medical care is not funded from the Health Insurance Fund, but from the state budget.

EMO is also entitled to charge visit fees of up to €5, except in the cases where a medical specialist assesses the patient's health problem as requiring emergency care.

Which benefits are provided by Health Insurance Fund?

Benefit for temporary incapacity for work is financial compensation paid under the certificate of incapacity for work to employees who do are not receiving their income. Paying this type of benefit depends on the type of certificate of incapacity for work, as well as on the reason for the incapacity for work.

How are benefits for temporary incapacity for work calculated?

Calculations of the Health Insurance Fund are based on the data of the Estonian Tax and Customs Board on social tax calculated for the beneficiary or social tax paid in the previous calendar year.

The employer calculates sickness benefit on the basis of the employee's average wages of the last six months.

When calculating the benefit, the average income of a calendar day is equal to the quotient of income calculated on the basis of social tax calculated or paid for the employee during the calendar year preceeding the start date of leave marked on the certificate of incapicity for work and the figure 365.

In order to calculate the sum of benefit, a percentage of benefit rate is calculated from daily income, and the percentage is multiplied by the number of days subject to benefitting (see examples of calculation). The benefit rates differ according to the different reasons for leave. Income tax is withheld on the benefit.

After the benefit has been received, the beneficiary can view the information that served as the basis for the calculations in the Estonian State Portal **www.eesti.ee**.

Sickness benefit

Who receive the benefit? Working individuals who are insured through their employer or contractual partner under the law of obligations, as a member of the management and control body of a legal person or as a self-employed person.

How much is paid? The sum of sickness benefit is calculated on the basis of the reason for leave given on the certificate of incapacity for work. Table 2 provides information on who pays the sickness benefit, from which day, and in which amount.

How to apply? Take the certificate of incapacity for work to your employer, who will deliver it to the Health Insurance Fund. Self-employed persons deliver the certificate to the Health Insurance Fund themselves.

When will the money be received? The employer pays the benefit on the pay day or within 30 days as of receiving the certificate of incapacity for work. The Health Insurance Fund pays the benefit within 30 days as of receiving a certificate of incapacity for work if it is formalised as required.

Maternity benefit

Who receive the benefit? Working pregnant women after going on pregnancy leave. Non-working pregnant women receive parental benefit after the child is born from the Estonian National Social Insurance Board (www.ensib.ee, helpline 16106).

How much is paid? 100% of the average daily income for 140 days, which is calculated on the basis of the social tax of the previous year.

How to apply? Submit the certificate for maternity leave to the employer, who will deliver it to the Health Insurance Fund. Self-employed persons must bring or send the certificate to the Health Insurance Fund themselves.

When will the money be received? 30 days after the certificate for maternity leave reaches the Health Insurance Fund.

Care allowance

Who receive the benefit? Working individuals who are nursing a child or a family member at home.

How much is paid? 80% of the average daily income, which is calculated on the social tax of the previous calendar year, as of the first day. The number of benefit days is different, as shown in Table 2. The certificate for care leave can be valid for longer than there are benefit days.

How to apply? Take the certificate for care leave to the employer, who will deliver it to the Health Insurance Fund. Self-employed persons must bring or send the certificate to the Health Insurance Fund themselves.

When will the money be received? 30 days after the certificate for care leave reaches the Health Insurance Fund.

Adoption benefit

Who receive the benefit? Working adoptive parents of a child under the age of 10 for 70 calendar days as of the date when the court judgement for adoption enters into force.

How much is paid? 100% of the average daily income, calculated on the social tax of the previus calendar year.

How to apply? The child's family physician issues a certificate for adoption leave on the basis of the court judgement. The certificate must be taken to the employer, who will deliver it to the Health Insurance Fund. Self-employed persons must bring or send the certificate to the Health Insurance Fund themselves.

When will the money be received? 30 days after the certificate for adoption leave reaches the Health Insurance Fund.

Table: Benefits for incapacity for work, arrangement and rate of payments

Reason for dismissal from work	Number of reason	Type of certificate	Procedure of compensation	Duration of benefit payments
Illness	1	Certificate for sick leave	The employer pays the benefit as of the 4th day of illness up to the 8th day of illness. The Health Insurance Fund pays as of the 9th day of illness ; the benefit rate is 70%	Up to 182 days, up to 240 days in case of tuberculosis
Domestic injury	3	Certificate for sick leave	The employer pays the benefit as of the 4th day of illness up to the 8th day of illness. The Health Insurance Fund pays as of the 9th day of illness ; the benefit rate is 70%	Up to 182 days
Traffic injury Complication/illness caused by a traffic injury	4 18	Certificate for sick leave	The employer pays the benefit as of the 4th day of illness up to the 8th day of illness. The Health Insurance Fund pays as of the 9th day of illness ; the benefit rate is 70%	Up to 182 days
Quarantine	10	Certificate for sick leave	The employer pays the benefit as of the 4th day of illness up to the 7th day of illness; the benefit rate is 70%	Up to 7 days
Occupational diseases	2	Certificate for sick leave	The Health Insurance Fund pays as of the 2nd day of illness; the benefit rate is 100%	Up to 182 days

Occupational accident Occupational traffic accident Complication/illness caused by an occupational accident	5 6 7	Certificate for sick leave	The Health Insurance Fund pays as of the 2nd day of illness; the benefit rate is 100%	Up to 182 days
Injury received when protecting the interests of the state or society or when preventing a crime	8	Certificate for sick leave	The Health Insurance Fund pays as of the 2nd day of illness; the benefit rate is 100%	Up to 182 days
Transfer to another position	17	Certificate for sick leave	The Health Insurance Fund compensates the wage difference related to transfer to less strenuous work to the rate of 100%. If the person is dismissed due to lack of less strenuous work, he/she is paid as of the 2nd day; the benefit rate is 70%. The benefit can only be received in case of pregnancy up to the pregnancy and maternity leave	Up to the pregnancy and maternity leave
Illness or injury during pregnancy	19	Certificate for sick leave	The Health Insurance Fund pays as of the 2nd day of illness; the benefit rate is 70%	Up to 182 days
Nursing a child under the age of 12 years	14	Care allowance	The Health Insurance Fund pays as of the 1st day of illness; the benefit rate is 80%	Up to 14 days
Nursing an ill family member at home	12	Care allowance	The Health Insurance Fund pays as of the 1st day of illness; the benefit rate is 80%	Up to 7 days
Nursing a child under the age of 3 or a disabled child under the age of 16 during the mother's illness or providing delivery assistance	13	Care allowance	The Health Insurance Fund pays as of the 1st day of illness; the benefit rate is 80%	Up to 10 days
Pregnancy and maternity leave	15	Certificate for maternity leave	The Health Insurance Fund pays as of the 1st day of illness; the benefit rate is 100%	140 days
Adoption leave of an adoptive parent of a child under the age of 10	16	Certificate for adoption leave	The Health Insurance Fund pays as of the 1st day of illness; the benefit rate is 100%	70 days

You can find additional information on sickness benefits in the Estonian State Portal at www.eesti.ee or by calling the Health Insurance Fund helpline at 16363 (Mon–Fri 8:30 AM–4:30 PM, calling from abroad at +372 669 6630).

Dental care benefit

The objective of dental care benefit is to compensate expenses made on dental care.

Who receive the benefit? Individuals over 63 years of age; individuals receiving pension for incapacity for work or old-age pension; pregnant women; mothers of children under one year of age; and individuals who have an increased need for dental care services.

How much will be paid? Individuals over 63 years of age and individuals receiving pension for incapacity for work or old age pension receive up to €19.18 per year; pregnant women, mothers of children under one year of age, and individuals who have an increased need for dental care services* receive up to €28.77 per year.

How to apply? Submit an application along with the document issued by the dentist, certifying payment for the service to the Health Insurance Fund. The service may be provided both in Estonia and abroad. Pregnant women and individuals who have an increased need for dental care must add a medical certificate.

When will the money be received? Six months after the correct documents have reached the Health Insurance Fund at the latest.

NB! * Benefit can be applied for by individuals who have an increased need for dental care as a result of the following health services:

- surgical and radiation therapy of tumours in the head-neck area;
- surgical treatment of cleft lip, alveolus and palate and other anomalies;
- surgical treatment of traumas to the facial bones of the skull;
- procedure (endoscopy, anesthesia etc.) that has resulted in trauma;
- transplant of tissue and organs or preparation for transplant;
- hospital treatment of extensive inflammations (abscess, phlegmon) in the head-neck area.

Dental care benefit rates

Beneficiary	In order to receive the benefit, submit the following documents to the Health Insurance Fund	Amount of benefit per year
Person receiving pension for incapacity for work or old age pension Insured individuals over 63 years of age	Application Document certifying payment for the dental care service	€19.18
Pregnant woman	Application Document certifying payment for the dental care service Document certifying pregnancy	€28.77
Mother of child under one year of age	Application (include the child's personal identification code and name) Document certifying payment for the dental care service	
Individuals who have an increased need for dental care*	Application Document certifying payment for the dental care service Medical certificate certifying the increased need for dental care service	

Denture benefit

The objective of the denture benefit is to compensate for expenses people have made on dentures. The benefit is paid to the elderly, because they use the prosthetic dentistry service the most.

Who receive the benefit? Individuals over 63 years of age, individuals receiving pension for incapacity for work or old age pension.

How much will be paid? Up to €255.65 within three years.

How to apply? There are two possibilities:

- submit an application to the maker of the prothesis, applying for the costs in the amount of the benefit to be transferred directly to the maker of the prothesis.
- submit an application along with the document certifying payment to the Health Insurance Fund.

When will the money be received? If the application is submitted to the Health Insurance Fund, money will be received within 90 days after the application and invoice have reached the Health Insurance Fund.

Supplementary benefit for pharmaceuticals

The supplementary benefit for pharmaceuticals helps to compensate for expenses made on medicinal products mainly by those individuals covered by medical insurance, whose treatment plan includes expensive medicinal products; who suffer from chronic conditions and, consequently, need to use medicinal products for a long time or who have to use several medicinal products simultaneously.

Who receive the benefit? Individuals covered by health insurance who pay more than €384 for discount prescriptions per calendar year.

How much will be paid? It depends on the sum spent on medicinal products; up to €1,300.

How to apply? Submit an application to the Health Insurance Fund or in the Estonian State Portal at eesti.ee. The application must be submitted only once. It can already be done before spending the 384 euros. The Health Insurance Fund shall keep count of the sum spent of prescription medicinal products.

When will the money be received? The benefit is paid in January, April, July and October. After submitting the application, the Health Insurance Fund will check whether the applicant has had the right to reiceive benefit during the two previous years. If they have, the ensured will receive benefit for those two years as well.

Benefit for medicinal products related to heterogenous fertilisation

Who receive the benefit? Women under 40 years of age (incl.) covered by health insurance, who

- have medical reasons for heterogenous fertilisation and/or embryo transfer;
- have undergone the procedure; and
- who have purchased medicinal products required for the procedure that are included in the list of Estonian Health Insurance Fund.

The benefit may be received for any number of times. Supplementary benefit for pharmaceuticals can also be received for medicinal products purchased at a discount.

How much will be paid? Up to €639.12 per procedure. Benefit can be received only once per prescription. In calculating the benefit, the cost-sharing by the discount medicinal product patient. (€3.19 in case of a 50% discount medicinal product; €1.27 in case of medicinal products that are discounted to the extent of 75%–100%.)

How to apply? Submit the application to the Health Insurance Fund by registered mail if sending by post or with a digital signature. The Health Insurance Fund receives data on the medicinal products from its own database.

NB! After each procedure of heterogeneous fertilisation and/or embryo transfer procedure, a new application must be submitted to the Health Insurance Fund.

When will the money be received? Payments are made once per quarter – on the 20th of February, May, August and November.

In order to receive benefit for medicinal products in case the patient pays for the procedure on her own or the procedure is performed in a foreign country, the application must be accompanied by the patient's summary on the blank of the medical institution including data on the medical institution, service necessity and the time of performing the procedure.

Discount medicinal products – ask for additional information about medicinal products from your physician or pharmacist

What are discount medicinal products and how are discount rates calculated?

Nowadays, medicinal products are very expensive and a part of their cost is thus covered by the Health Insurance Fund. The Health Insurance Fund covers a part of the medicinal products entered into the list of discount medicinal products. A discount rate of 50, 75, 90 or 100% applies to these medicinal products. The higher rate is applied to primary medicine needed for patients of severe and/or chronic illnesses and certain groups of the population, such as pensioners receiveing old age pension or pension for incapacity for work.

In 2012, the Health Insurance Fund paid 99 million euros for discount medicinal products prescribed to patients of the Health Insurance Fund, while the patients paid 48 million euros for the medicinal products. The sum paid by the patient depends on the reference price. What is the reference price and how to calculate the price of a medicinal product?

Story of a patient: *Jüri had taken diabetes for an extended period of time. One day, buying medicine again from the pharmacy, he was in for a big surprise: for two boxes of medicinal product that had cost 12.96, he had to pay 45.60 a few months later. The product that had been on sale for a long time had suddenly become significantly more expensive. Why?*

There are many reasons why prices are changed, but the most frequent reason is that the reference prices of discount medicinal products change.

What is a reference price and why does it change?

Reference prices are laid down when there are several medicinal products with a similar effect but different prices on the market. The reference price is calculated on the basis of more affordable medicinal products that contain the same active substances (see Figure "Reference Price Development"). Since the function, safety and quality of the medicinal products are the same, it is not justified to pay significantly more for one medicinal product than another similar product.

What is the active substance?

- Medicinal products consist of several substances – active substances and excipients.
- Active substances have the effect. Excipients hold the medicinal product together, create a suitable form, give colour, shape, taste etc.

What is an active substance-based prescription?

- All medical professionals are obliged to issue active substance-based prescriptions. The medical professional writes down the name of the active substance, not the commercial name of the product. This enables the patient to choose the most affordable option among the medicinal products containing the same active substance.
- In rare cases, the medical professional can write the commercial name of a medicinal product on the prescription. There must be a medical reason for doing so. In this case, the patient does not have a choice at the pharmacy and he or she has to pay for the medicinal product shown on the prescription.

The Health Insurance Fund benefits are also calculated on the basis of the reference price. If a patient buys a medicinal product that exceeds the reference price, he/she has to cover the difference.

The reference price of a medicinal product changes when a new medicinal product containing the same active substance appears on the market or when a manufacturer lowers the price. The Ministry of Social Affairs updates the reference prices and the list of discount medicinal products once per quarter. In Jüri's case, a new and more affordable medicinal product containing the same active substance was introduced to the market. Thefore, the Ministry of Social Affairs determined a new reference price. Since Jüri bought a medicinal product that was much more expensive than the reference price, he had to cover the difference himself.

How could a patient avoid situations like that?

Patients should ask their family physicians for prescriptions based on the active substances, since then they can ask to see the choice of medicinal products at the pharmacy and choose the medicinal product best suited for their circumstances.

Discount rates of medicinal products

100% discount

- This discount rate is used to compensate for especially expensive medicinal products, which are often used to treat serious illnesses and illnesses that cause incapacity for work.

The patient has to pay 1 euros and 27 cents for each prescrption. This is called the cost-sharing base rate. The rest is paid by the Health Insurance Fund. If a reference price is laid down for the medicinal product, but the medicinal product exceeds the price, the patient shall cover both the base rate and the difference.

Children under the age of 4 years are eligible for a 100% discount on medicinal products included in the list of discount medicinal products.

90%, 75% and 50% discount rate

The list of medicinal products discounted to the extent of 75% often includes medicinal products taken for a long time that therefore burden the budget, e.g. medicinal products to treat blood pressure and cardiac insufficiency.

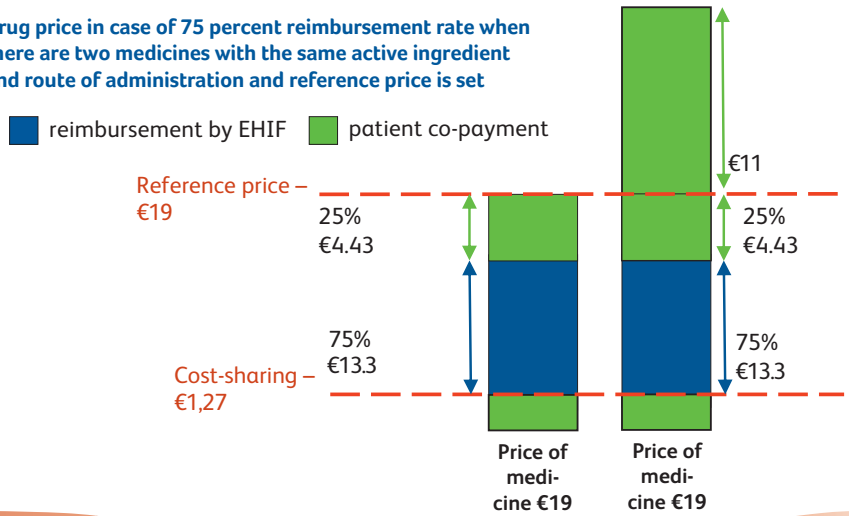
Additional discounts are available to children aged 4–16 and individuals receiving pension for incapacity for work or old age pension. They receive a 90% discount on medicinal products with a regular discount of 75%.

In addition to the base rate of €1.27, the patients pay 25% or 10% of the difference between the price of the medicinal product and the base rate, depending on the discount percentage of the medicinal product. The Health Insurance Fund pays the rest to the extent of 75% or 90%, respectively. It must be noted here that if a reference price has been laid down for the medicinal product, the patient has to cover the difference.

Certain prescription medicinal products are compensated to the extent of 50%. Often, these medicinal products are for short-term treatment and do not require more substantial state support, e.g. antibiotics that are taken as a short course of medical treatment. It must be noted that the base rate is also higher in case of such medicinal products – €3.19. The difference is covered by the patient to the full extent.

To avoid excess expenses, please ask a physician for a prescription based on the active substance and demand for the most affordable medicinal product at the pharmacy!

Drug price in case of 75 percent reimbursement rate when there are two medicines with the same active ingredient and route of administration and reference price is set



Services to support the health development of children

At what age should a child be checked by a physician or a nurse?

In order to regularly monitor children's health, medical professionals have specified regular medical checks for children. These serve to observe children's growth and development, hearing, vision and speech. Information is provided on infectuous diseases and vaccinations. In addition, medical checks are used to help to develop children's healthy eating and exercise habits and to advise the family.

The first seven years with a family physician

Healthy babies undergo prophylactic monitoring once a month during the first year; three visits have to be made to the family nurse during the first year. During these visits, babies are weighed and measured. The nurse's tasks also include teaching the parents how to feed the baby and care for him/her, avoid accidents etc. Visits with the pediatrician are not intended for healthy babies. If necessary, the family physician refers the child to a medial specialist.

Children of 6–7 years have to visit the family physician for a pre-school health check. The doctor assesses the child's development and school readiness. Vision, hearing and speech development are checked as well. The health check should be performed in the spring before school starts. This means that there is time to get a pair of glasses before school, for example.

Teeth should be looked after from early on

Hygiene at home keeps teeth in good condition; the fist visit to the dentist should be made at the age of 3. Teeth need regular checks since the first teeth cut. The most important thing is to give the child a good experience at the dentist's office – the parent could support the child during visits, so that he/she felt comfortable at the dentist's later. School nurses also refer children to preventive checks at the ages of 7, 9 and 12. If a child needs dental care, it should take place at the family's awareness and consent. It should also be found out whether the dentist has a contract with the Health Insurance Fund, for only then is the service free of charge for the parent.

Studies have shown that if teeth are strong and healthy at the end of teenage years, they will not need treatment for decades.

Recommended times for a child's medical checks:

Age/grade of the child	Doctor	Nurse*	Dentist	Eye specialist
1 week (home visit)	x	x		
2 weeks	x			
1 month	x			
2 months		x		
3 months	x			
4.5 months		x		
6 months	x			
7 months		x		
9 months	x			
12 months	x			
18 months	x			
2 years		x		
3 years	x		x	x
4 years		x		
5 years	x			
6–7 years	x		x (6 years)	
7–8 years / I		x	x (7 years)	
8–9 years / II	x			
9–10 years / III		x	x (9 years)	
11–12 years / V	x		x (12 years)	
13–14 years / VII		x	x (14 years)	
15–16 years / IX	x		x (15 years)	
17–18 years / XI		x		

Health support at shcool

After being admitted at school, parents must submit an officially authenticated statement of the pupil's medical record. It contains data on earliler vaccinations, chronic illnesses, the medicinal products used, but also allergies to medicine and food. The information is essential to monitoring the child's health at school, but also in adjusting the study load and lifestyle.

When starting school, parents are asked to give consent for the provision of health care services at the school in general, and for health checks in the I, III, VII and IX grade.

Patients may be eximened and provided health care services only on their or their representatives' consent. In case of primary shcool, the choice must definitely be made by the parents. The family may specify the situations when parents need to be contacted regardless of the child's standpoint.

Written and oral consent are equally valid. The school nurse needs to ask for written consent from the parent before each vaccination. This helps to eliminate possible contraindications.

If no health care is provided in school, the child's treatment is prescribed and coordinated by the family physician or medical specialist. If the child has fallen ill at school, the school nurse needs to provide first aid and notify the parents. The school nurse does not assign medical examinations or write absence notes to ill children at school – the family physician has to be visited in this respect. The nurse must be notified of the child's allergy or other diseases. This is essential to provide relevant help fast.

In small schools, the nurse is not always present, but the reception times and telephone number need to be available. If a child moves to boarding school facilities, it is advisable to register the child on the practice list of the local family physician. The school nurse can refer children registered in the area to the family physician at any time.

Materials help to remember

The Health Insurance Fund has supported the publishing of materials that facilitate monitoring children's health. Child's Health Journal and Pupil's Health Journal have been published so far. The publications have been written by qualified specialists. When a child is born or when he/she starts school, every family should receive the materials from the hospital, the family physician or school.

It is good to write down the child's height and development and health data in the journals from birth to the end of basic school. In addition, there are growth diagrams; instructions on dental hygiene; information on the development of hearing, vision and speech; diet-related advice; the composition of the home medicine cabinet; instructions on more frequent illnesses; and the vaccination guide.

Dietary advice only addresses those food products that doctors have unanimously approved. The published instruction materials have also been collected on the website ravijuhend.ee.

Living and travelling in other EU Member States – right to travel insurance

The European health insurance card (hereinafter referred to as the EHI card) allows people to receive health care in another Member State of the European Union, as well as in Norway, Iceland, Liechtenstein and Switzerland (hereinafter reffered to as a Member State) on equal conditions to the insured population of the country of stay. The need for health care must have appeared in the country of stay; it is not valid if someone goes to another country to receive medical treatment. The need for medical treatment must be medically justified. When using health care services, the patients must pay the local co-insurance fee rates (visitation fee, in-patient fee, percentage of the cost of the service etc.). The EHI card does not give the right to free health care. The card can be used only in state medical institutions or institutions that have a contract with the local health insurance fund.

TOURISM

Travellers need to see a doctor sometimes as well. When falling ill in a EU Member State, you are entitled to receive equal health care to the individuals insured in that country. The doctor needs to take into account the length of your stay in the country and assess the scope of necessary treatment. The service may be limited to first aid an a recommendation to visit your family physician back home. Sometimes, hospital treatment or even special transportation back home is required. While the EHI card covers health care and medicinal product expenses, transportation costs or co-insurance costs, which may become fairly substantial in case of long hospital treament, are not compensated on the basis of the EHI card. We strongly recommend you to insure yourself with travel insurance to be able to cover these costs. Travel insturance also includes visits with private doctors, which are not covered by the EHI card. We especially recommend getting travel insurance when staying in holiday resort areas. Instead of state medical institution, tourists are often directed to private doctors, whose services are not compensated by the Estonian Health Insurance Fund.

- Portable documents – documents certifying the rights of individuals moving within the EU, which are given to the person. These documents are equal and will replace certain e-forms in the future.
- The portable focument S1 – equal to E-forms E106, E109 and E121.
- At any time, a person can be covered by health insurance in one Member State only. If you go to work or live in another EU Member State, make sure that you do not have health insurance cover in several countries.

In order to be insured when travelling outside the EU, we recommend getting travel insurance.

Example. *Tourist Jaanus ended up in a Swedish hospital with a serious health problem. He needed complex surgery that could not be performed on the spot. There was a choice between taking Jaanus to another Swedish hospital by plane or directly to Estonia. Jaanus was brought to Estonia. For hospital treatment, Jaanus only paid the in-patient fee. The rest was compensated by the Health Insurance Fund, because Jaanus had the EHI card. Unfortunately, Jaanus had not organised for travel insurance. Therefore, he had to pay several thousand euros for the air transport.*

STUDYING

In most cases, pupils and students are covered by the health insurance of their home country. For example, as a student from Estonia studying in France, you will still be covered by the health insurance of the Estonian Health Insurance Fund. In order to continue receiving health insurance, you will need to submit a certificate of studying at the specific university each year. In order to certify your health insurance, you will need to present the EHI card when visiting a doctor and you will need to explain how long and for what purpose you are staying in the country. This way, the doctor will be able to assess if the provided service is necessary or if it can wait until summer holidays, for example, when you will return to your home country.

Example. *Maire is studying at a university in Germany. In the winter, she contracted tonsillitis and visited the local doctor, who prescribed*

medicine. The doctor thought that it would be appropriate to remove the tonsils. Maire planned to return to Estonia in early summer. Thus, it was more sensible to wait to return home and not operate in Germany.

SHORT-TERM BUSINESS TRIP

In case of business trips lasting from a few days up to a year, the EHI card must definitely be present. Just like in the student's example, the doctor will also need to consider the fact that you are staying in the country for a longer time in case of a business trip, whereas you may require more services than regular tourists. Nevertheless, the EHI card does not cover planned and scheduled treatment, i.e. targeted treatment in a foreign country. In order to receive such treatment, you will have to return to Estonia.

Example. *Elise's employer sent her on an 8-month business trip to Belgium. Elise is diabetic. The test strips of a glucometer bought from Estonia ran out while being in Belgium. Since Elise did not plan to return to Estonia before the end of the business trip, the local doctor prescribed Elise the necessary amount of test strips on two more occasions. Since she had the European health insurance card with her, she was remunerated some of the money when she approached the local health insurance fund.*

LONG-TERM BUSINESS TRIP

If you are sent to work in a foreign country for more than a year, you must take a respective certificate from the Ministry of Social Affairs. On the basis of that certificate, you will need to take form E106 (S1) from the Estonian Health Insurance Fund. On the basis of that form, you will be entitled to receive various forms of medical treatment (including targeted medical treatment) in another EU Member State. Financial benefits, including benefit for incapacity for work, maternity benefit, care allowance and adoption benefit will be paid by the Estonian Health Insurance Fund according to Estonian rules and regulations. The form has to be registered in the state of residence.

Example. *Toomas's employer sent him on a business trip to Finland. The Estonian Health Insurance Fund issued him form E106, which he registered in Finland. Toomas caught the flu and as a complication, he also got pneumonia. He needed a few days of hospital treatment. Toomas only paid co-insurance fees for the treatment and medicine, as if he was insured in Finland, but he submitted the certificate for sick leave to his Estonian employer.*

LIVING IN ANOTHER EU MEMBER STATE

People working in Estonia, who return to their country of residence at least once per week, or so-called border area workers, and people who are on parental leave in Estonia, also have the right to receive various types of medical treatment in another Member State of the EU. In order to certify the right in the country of residence, they need to submit form E106 (S1), which is issued by the Estonian Health Insurance Fund on the basis of the applicant's application.

Example. *Ville lives in Helsinki, but he works in Tallinn on business days. He returns to Finland every weekend. Ville approached the Estonian Health Insurance Fund requesting for form E106m and registered it in Finland. When it became evident that Ville needed an operation and a few weeks of recuperation, he decided to have the operation in Finland. Since form 106 gives the right to receive any kind of medical treatment in the country of residence, he only had to pay the co-insurance fee valid in Finland.*

When moving to another EU Member State, pensioners are entitled to health insurance on the basis of form E121 (S1). People on a long-term business trip and border area workers are entitled to insurance in their country of residence on the basis of form E106 (S1). In order for your rights to be valid under these forms, they need to be registered in the country of your residence!

PENSIONERS GOING TO LIVE IN ANOTHER MEMBER STATE

People receiving the old age pension, pension for incapacity for work or survivor's penion, and want to go to live in another Member State, have the right to receive any kind of medical treatment, including targeted treatment, equally with the local residents. In order to certify the right in another country, you will ask for form E121 (S1 in some countries) from the Health Insurance Fund. The Health Insurance Fund shall issue the form if you have notified the population register of your new address and if you are not insured in Estonia on some other grounds, for example as an employee.

Example: *Maire receives old age pension from Estonia. Her son's family moved to Sweden a few years ago. Maire left her part-time job in a library*

and decided to move in with her son and grandchildren. Maire notified the population register of her new address and applied for form E121 from the Health Insurance Fund. She registered it in Sweden and she visits the doctor there like Swedish pensioners do.

THE PATIENTS' RIGHTS IN EU MEMBER STATES ARE INCREASING

By 25 October 2013 at the latest, all Member States of the European Union are obliged to transpose a directive that regulates increasing the patients' rights in EU Member States. The three main objectives of the directive are:

- to specify the patients' right to receive health care services in another Member State;
- to help ensure the safety and quality of cross-border health care services;
- to promote cross-border cooperation in health care.

People covered by insurance (hereinafter referred to as patients) from the Estonian Health Insurance Fund (hereinafter referred to as the Health Insurance Fund) get important added value thanks to the directive: patients can go abroad to get treatment and apply for benefit for it from the Health Insurance Fund. The Health Insurance Fund shall cover the cost of only those health care services that the patient is entitled to receive at the cost of the Health Insurance Fund in Estonia as well. In Estonia, the paid services, e.g. dental care for adults or services not indicated for the patient, are not compensated.

The Health Insurance Fund pays for services on the basis of the Estonian, not the foreign price list of health care services. If the cost of the service received abroad exceeds the sum included in the list of the Estonian Health Insurance Fund, the patient has to cover the difference himself/herself. He/she will also pay for co-insurance fees, travel and other costs that would not be compensated in Estonia in case of a similar service.

The directive does not involve long-term care services; the availability and distribution of organs for the purposes of organ transplant; or national vaccination programmes. As pointed out above, the directive will also not involve the health care services that are neither provided nor complensated for in Estonia. In the case of such services, the existing procedure, by which the patient has to apply for a prior authorisation from the Health Insurance Fund in order to receive a health care service abroad, will continue to be applied. Please find additional information on planned foreign treatment on the webpage of the Health Insurance Fund.

The principle that patients who temporarily stay in another Member State receive the necessary health care on equal conditions with the insured people of that country under the EHI card, will also continue to be applied.

Please find the Estonian text of the patients' rights directive and additional information on your rights in the European Union, as well as links to application forms on the website of the Health Insurance Fund.

E-services of the Health Insurance Fund

The Health Insurance Fund offers a lot of information in cooperation with the State Portal eesti.ee. Use your ID-card or a bank link to check your data. You can view your personal data, study the medicinal product or medical equipment prescriptions issued to you, and observe the proceedings of the benefint for incapacity for work.

YOUR PERSONAL DATA – you can check and change your contact details and bank account data and view your insurance area. You can see if the postal address forwarded to the Health Insurance Fund by the population register is correct.

NB! All payments of unpaid financial benefits are made to the last account specified by the person.

HEALTH INSURANCE AND FAMILY PHYSICIAN – you can check your health insurance, see your insurance area and the data of your family physician.

YOUR BENEFITS FOR INCAPACITY FOR WORK – you will be able to view information on your benefits for incapacity for work, e.g. certificate for sick leave, certificate for care leave or certificate for maternity leave. You will be able to view information as of the time that an employee of the Health Insurance Fund has started to calculate the benefit.

What can you see? The screen displays a type of certificate for incapacity for work, the period of dismissal, the status of the certificate

for incapacity for work (if the doctor has forwarded it), if the Health Insurance Fund will compensate for it or not, if the benefit is being paid or has it already been paid, if the account information is correct or lacking. After payment, you can also see the benefit rate, number of days of incapacity for work, num-ber of compensated days, the average income of calendar day and calendar year, the sum of benefit, income tax and withholding a sum from the benefit on the basis of the bailiff's claim.

The information of three last years is displayed on screen.

YOUR PRESCRIPTIONS – you can view your digital prescription and those paper prescriptions that have been used to buy medicine and update your data in the pharmacy system (the number of the paper prescription is provided in brackets after the digital prescription number).

Among other things you can view: data of the person preparing the prescription, term of validity of the prescription, user instructions of the medicinal product, active substance, name of the medicinal product.

Prescriptions of medical equipment and data on paper prescriptions issued before 28 September 2012 are also stored.

What can you see? The amount bought, balance of the period.

Benefits for pharmaceuticals

If you have spent more than €384 per calendar year on discount medicinal products, you can apply for the supplementary benefit for pharmaceuticals.

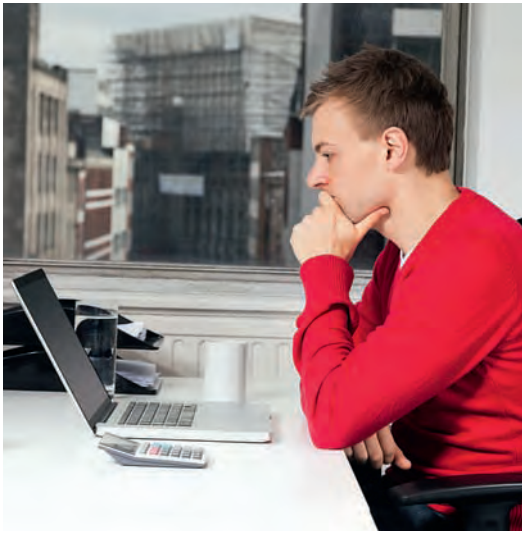
Among other things you can see: the total cost of prescriptions; base rate of compensation; sum to be compensated; sum compensated.

Only the data on discount medicinal products forwarded from pharmacies to the Health Insurance Fund are displayed. These data are updated once per quarter.

The supplementary benefits for pharmaceuticals are calculated only on the basis of discount prescriptions. The base rate of co-insurance (the co-insurance base rates of €1.27 per prescription in case of discounts to the extent of 100%, 90% and 75% and €3.19 in case of a 50% discount are laid down by a regulation of the Minister of Social Affairs), and the reference price of medicinal products or sums exceeding the price shown in the price agreement are not taken into account.

Ordering the European health insurance card (EHI card)

The European health insurance card can be ordered via eesti.ee for people themselves and their children under 19 years. For adults, the card is valid for up to 3 years, for children the card is valid up to 5 years or until the child turns 19. The card is received from the customer service office of the Health Insurance Fund or by post in a regular letter.



If the card has already been issued to you or your children, the card number, term of validity and status are displayed to you on the screen.

Dental care benefit

If you are a person over 63 years of age covered by health insurance, or a person receiving old age pension or pension for incapacity for work, or a pregnant woman, the mother of a child under 1 year of age, or a person with an increased need for dental care service, you can see information about your dental care benefit payments. For the elderly and pensioners, the benefit is €19.18, in other cases it is €28.77.

What can you see: the year and sum to be compensated, limit balance.

Limit for denture benefit

Insured people of more than 63 years of age and people receiving old age pension or pension for incapacity for work can see data on the benefit for their dentures. The amount of benefit is €255.65.

You can see the limit balance of the benefit for dentures or how much benefit you can get. The screen does not display information on the right to get the limit or the term of validity of the limit. You cannot see the time you started using the benefit or how long can you apply for the sum not used as benefit.

What can you see: limit balance.

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FAMILY PRACTITIONER'S ADIVICE 1220

Medical advice 24h (in Estonian and Russian)

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Mo, Tu, Th, Fr 8:30 AM–4:30 PM
We 8:30 AM–6:00 PM

Tartu Department

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