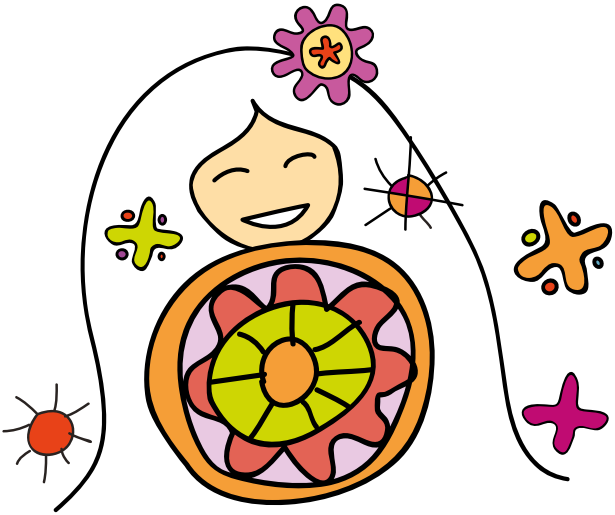
Estonian
Health Insurance
Fund

INFORMATION MANUAL 2016



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Introduction

The Estonian Health Insurance Fund is an institution organizing national health insurance. The purpose of the funds activities is to compensate insured people for the costs of health care, to finance the purchase of medicines and medical appliances and pay for a variety of benefits.

The fund has more than 1.2 million customers. To ensure the availability of health care, subsidized medicines and medical equipment, we work with approximately 3,000 cooperation partners all over Estonia. We are committed to our responsibilities and want to ensure the availability of timely and required health services. An important part of this is each person's awareness of health care facilities and the principles of compensation for services.

You are holding in your hand a manual of the Estonian Health Insurance Fund. We have gathered here the information pertaining to health insurance and the functioning of and the most significant innovations in the health care system.

We will introduce in more detail the health care system in Estonia, including the services offered by the family doctor and the family nurse, the role of the specialized medical care and the policy of reimbursement of discount drugs and medical devices . We will provide a comprehensive overview of what financial benefits are available in the Health Insurance Fund. Also, the manual will include tips on what to do if there is a need for medical care in another European country. In addition, we will also address cancer screening.

Health care is an area that affects us all. We hope that you consider it necessary to examine the information contained in the manual. If additional questions emerge after reading, you can receive answers from the Health Insurance Fund information phone 16 363 (from abroad +372 669 6630).

Wishing you happy and healthy reading

Health insurance

In Estonia is in force a solidary health insurance system. Solidarity in health insurance means that someone's health insurance payments or contribution to the system or access to the necessary assistance does not depend on age, income or health risks. All the medically insured people in Estonia are entitled to the same quality health care, regardless of whether or not they pay the health insurance tax.

Health insurance payments are made by the majority of the working age population, and from the social tax payable from the gross salary of a working person the treatment services also to the population groups in society who currently are not making insurance payments are compensated for. This group includes children, seniors and mothers raising small children at home, also the unemployed and pregnant women. Mutual solidarity includes the young and the old, the rich and the poor and the sicker and the healthier people. Today's working age people use the services relatively little, but health insurance payments paid from their gross wages also cover the health care costs of children and the elderly family members of the taxpayers. Also, today's working-age people will use health care services in the future when they can no longer contribute to the system. The existing funds are used on an ongoing basis to treat all people in need; no one has a personal account.

By its very nature, health insurance is similar to any other type of insurance. In the case of home or motor insurance, a person pays the insurance premium, so that in the event of an accident, they would be ensured with the necessary financial support for covering unexpectedly encountered and often considerable amounts of expenditures. Health insurance works similarly, but with the difference that the person's contribution to the system does not depend on his or her assessed health risk but on whether he or she will pay social security contributions and the size of his or her salary income. Health insurance payments are made from the social tax paid by the working person and if the need arises the cost of health care is covered by the insurance.

Health insurance is necessary for all of us, because no-one is protected against falling ill, but health care services and medications are expensive.

THE HEALTH INSURANCE FUND REIMBURSES THE SERVICES PROVIDED BY A PARTNER

The list of the health care services reimbursed by the Health Insurance Fund is approved by Government Regulation. The list is updated every year. The Health Insurance Fund covers the vast majority of medically related costs, but to some extent is provided a co-payment from the patient. These include, for example for an appointment and per diem charges. Also from the health insurance budget are not covered all the existing health care services, but only those that are included in the list of health services medically indicated for the person.

It must also be kept in mind that the Health Insurance Fund reimburses only the health services, in terms of the provision for which, a contract has been entered into with a treatment facility. On conclusion of the agreement, the right arises for the medical institution for the treatment of patients for the resources of the health insurance funds and the corresponding information must be available in a conspicuous place for all patients. On the other hand, with the conclusion of the agreement obligations arise for the medical institution to adhere to the agreed length of treatment waiting lists, to provide health care services in accordance with international quality standards, etc.

THE FUND SUPPORTS HEALTH PROMOTION AND THE DEVELOPMENT OF HEALTH INSURANCE.

In addition to necessary health services, compensation for medicines and medical equipment and monetary contributions, the Health Insurance Fund is responsible for designing and the establishment of the prices for health services as well as preparation of the list of health care services. The fund is also engaged in disease prevention and health promotion, to that end the fund organizes publicity campaigns and funds various health promotion projects.

The purpose of disease prevention is to detect the person's pre-disease condition as early as possible and to contribute to the prevention of the disease.

Upon disease prevention, the Health Insurance Fund provides for school health care services, early detection examinations of breast and cervical cancer for women, prenatal diagnosis of hereditary diseases and neonatal hearing tests, as well as sexual health counseling of the youth, and the health checks of young athletes. The funded health promotion projects of the Health Insurance Fund include training of education and health professionals on children's health, activities related to children's dental health, campaigns and projects of injury prevention and awareness-raising of people.

In addition, the task of the Health Insurance Fund is to help preparation of the treatment standards and treatment guidelines for various health services, to motivate health care facilities to develop the quality of health services, to check the quality and reasonableness of health services, to arrange execution of external agreements pertaining health insurance and the Health Insurance Fund, to participate in the planning of health care, to comment on the legislation and external agreements related to the Health Insurance Fund and health insurance and to advise on the issues related to health insurance.

Options for obtaining health insurance

Medical expenses of an insured person are paid by the Health Insurance Fund. Without insurance, people would also not be able to receive a discount on medicinal products, or financial compensation and payment for medical services, which can be very expensive. Every permanent resident of Estonia as well as all who stay here on the basis of a temporary residence permit or right of residence, if the social is paid for them, have the right for health insurance. In addition, the state guarantees the right to health insurance for children under the age of 19, pupils and students, conscripts, pregnant women, the unemployed, those on parental leave, dependent spouses, pensioners, the caretakers of disabled people and those who have concluded a voluntary insurance agreement with the Health Insurance Fund.

On January 1, 2016 were amended the provisions of the Health Insurance Act , which govern the insurance coverage terms of the person receiving remuneration or service fees on the basis of the agreement of the member of management and control body or of the agreement under the Law of Obligations Act (LOA)

Receiving the insurance by board members and persons working under an LOA agreement is based on a tax return. **If you are concluding a LOA agreement, please pay attention to the fact**

that for the monthly health insurance to exist it is necessary that the contractor would pay remuneration to you each month and declare the payments on the due date! In doing so, it is important to know that insurance coverage arises if the social tax is declared in one month by one or more payers in the total paid at least to the extent of the minimum obligation of social tax.

For more information on the amendment to the Health Insurance Act see www.haigekassa.ee

WORKING ADULTS

In Estonia, all the insured working people paying the social tax have health insurance. Health insurance is available to all entitled all employees working under an employment contract, the persons receiving remuneration or service fees on the basis of the agreement under the Law of Obligations Act, a member of the management and control bodies of a legal person and sole proprietors and their spouses participating in the activities.

Health insurance is valid for working people, whose social tax is paid for, or who pay social tax for themselves. These are:

- persons employed on the basis of a contract of employment
- recipients of remuneration or service fees on the basis of the agreement under the Law of Obligations Ac;
- Members of the directing body and the controlling body of a legal person;
- Sole proprietors and their spouses participating in their activities.

Employees with a contract employment of over one month are legally entitled to health insurance. The validity of the employee's health insurance must be cared for by the employer. As of 1 July 2014, an employment register was established by the Tax and Customs Board in which the employer is required to register the working data (the start, pause, and termination of employment) of all of their employees. Data for the health insurance of employees or for termination of

insurance will be forwarded to the Health Insurance Fund by the Tax and Customs Board.

However, it may happen that in the event of exchanging a job, the employer forgets to communicate the information of the employee to the register. The fact that the employer has failed to submit the necessary data to the insurance fund may become evident unexpectedly, for instance at the doctor's office when extending one's usual prescription. Thus, when taking up a new position, it makes sense after some time of working **to check the validity of the insurance on one's own**. This can be done in the state portal at www.eesti.ee or by calling the Health Insurance Fund information line 16363.

Health insurance is valid for two months after the termination of the contract of employment.

CHILDREN

All children up to 19 years of age, with their principal place of residence in Estonia, according to the population register, have health insurance. The insurance is valid until the day of their 19th birthday.

PUPILS AND STUDENTS

Health insurance is provided by the state to the following persons during their studies:

- Students acquiring basic education;
- Students acquiring general secondary education;
- Students carrying out formal vocational training;
- Students who are permanent residents of Estonia e.g., doctoral students receiving the support of doctoral studies.

Emergence and termination of health insurance

Details of pupils and students shall be submitted to the Health Insurance Fund by the Ministry of Education and Research, which is responsible for the accuracy and timely reporting of the data submitted.

- The insurance coverage of the student obtaining basic education expires three months after the completion of the educational institution.
- The insurance coverage of the student obtaining general secondary education expires three months after the completion of the educational institution. However, if the student has been expelled from an educational institution within three years after commencing their studies without completion of their studies, the insurance cover terminates one month thereafter.
- **The health insurance of students and persons obtaining vocational education** ends three months after the graduation from the educational institution. If the student has not graduated from the educational institution one year after the end of the standard period of the curriculum or has been expelled or dismissed from the educational institution, his or her health insurance ends one month thereafter.

During the academic leave the health insurance stops, except in the case when the leave has been taken for medical reasons.

The pupils and the students bound for study abroad must, in

order for the Estonian health insurance to continue, submit to the Health Insurance Fund a document certifying the studies abroad. On the basis thereof, health insurance shall be formalized for up to **12 months**. Thus, the certificate of studies shall be delivered to the Health Insurance Fund **each academic year**.

UNEMPLOYED

All unemployed people registered in the Unemployment Insurance Fund also have health insurance:

- Unemployment insurance recipients are covered from the date on which entitlement to the benefit arises;
- Unemployment support recipients are covered from the date on which entitlement to the benefit arises;
- the unemployed who do not receive unemployment benefits, from the 31st day from being registered as unemployed;
- Unemployed people who participate in practical training, work practice, or at least 80 hours in employment training and do not receive the unemployment support from the first day of participation;
- Non-employed persons who have participated in nuclear disaster relief, from the day the application is filed.

The person himself or herself does not have to submit documents to the Health Insurance Fund to obtain health insurance.

Details for the start, termination and suspension of the insurance shall be submitted by the Estonian Unemployment Insurance Fund.

If the registration period in the Estonian Unemployment Insurance Fund has ended, the health insurance is valid for another month. The exception is the recipients of the unemployment benefit whose health insurance will expire in two months.

Information on registering as unemployed, on the unemployment allowances and benefits, and on the applications and the necessary

forms can be obtained from the website of the Unemployment Insurance Fund www.tootukassa.ee or from the offices.

CONSCRIPTS

For obtaining the health insurance, the data of a conscript shall be submitted to the Health Insurance Fund by the **Defence Resources Agency**. The health insurance is still valid for **one month** after completing military service.

PREGNANT WOMEN

If a pregnant woman does not have health insurance, to obtain health insurance she must submit to the customer service office of the Health Insurance Fund a certificate issued by the doctor or midwife about the establishment of pregnancy. The insurance ends **three months** after the expected date of childbirth established by the doctor.

PARENTS

The insured is a person on parental leave raising a child who is less than three years of age, whether it be a mother, father or guardian. Also is insured:

- One non-working parent living in Estonia, who is raising three or more children under the age of 19 living in Estonia, of whom at least one is under 8 years of age;
- One parent, guardian or caregiver residing in Estonia with who has been concluded an agreement for care in the family and who is raising seven or more children under the age of 19 living in Estonia;

The data for obtaining health insurance shall be submitted to the Health Insurance Fund by the **Estonian National Social Insurance Board.**

DEPENDENT SPOUSES

Dependent spouses who have less than 5 years until the retirement age

The dependent spouse of a legally married insured person who has less than **five years** until the pensionable age has the right to state health insurance. For obtaining the insurance, the person wishing insurance must submit **an application to the Health Insurance Fund** The insurance ends when the dependent reaches the pensionable age, gets divorced, or the insurance of the maintenance provider ends.

If the dependent reaches the pensionable age, generally the insurance continues as the insurance of the old-age pensioner.

Dependent spouses who are raising children

The dependent spouse of a legally married insured person who is raising:

- A child of 8 years of age until the completion of the 1st grade;
- an 8-year-old child up to finishing of 1st Grade has the right to state health insurance.
- At least three children under 16 years of age.

In this case the provider of the maintenance must be insured as an employee, a person receiving employment or service fees under the contract of the Law of Obligations Act, a member of a directing or controlling body of a legal person or as a sole proprietor.

For receiving health insurance, the documents shall be submitted to the **Estonian Social Insurance Board**, who will communicate the data necessary to formalize insurance coverage to the Health Insurance Fund. More detailed information on the documents can be obtained from the National Social Insurance Board phone 16106 or at the address www.sotsiaalkindlustusamet.ee.

If the conditions giving the right for health insurance are no longer met, the National Social Insurance Board shall communicate to the Health Insurance Fund the data for termination of the insurance.

PENSIONERS

All the recipients of a pension designated in Estonia are insured. Their data for obtaining health insurance shall be submitted to the Health Insurance Fund by the **Estonian National Social Insurance Board**.

CAREGIVERS OF DISABLED PERSONS

The people for whom the municipal government or the city government pays the social tax for the support of caring for a disabled person also have the right to state health insurance. The data received from the local government for obtaining health insurance shall be submitted to the Health Insurance Fund by the **Estonian National Social Insurance Board.**

VOLUNTARY INSURANCE

If the person does not belong to any of the above groups, it is possible to conclude a voluntary health insurance contract with the Health Insurance Fund. Upon entry into the contract, premiums shall be paid to the Health Insurance Fund.

The following persons are entitled to enter into the contract:

- People, who in two months prior to entering into a contract, have been insured at least 12 months through an employer, as a recipient of employment or service fees under a contract of the Law of Obligations Act, a member of a directing or a controlling body of a legal person, a sole proprietor, a pupil or a student;
- people who have paid for themselves or for whom has been paid social security tax under an contract of employment or contract of service, under the Law of Obligations Act, under the contract of a member of management and control bodies of the legal entity, as a sole proprietor or as a spouse of a sole proprietor in the calendar year preceding the entry into the contract at least twelve times calculated from the monthly rate set with the state budget for the budgetary year;

- Recipients of foreign pensions, in the case of which prior health insurance in Estonia is not required.

These people may enter into a contract to insure either themselves or their dependents. Typically, a voluntary insurance contract is concluded for one year.

You can check the existence of the valid health insurance in the state portal www.eesti.ee, by sending a digitally signed enquiry at info@haigekassa.ee or by calling the Health Insurance Fund information phone 16363 (calling from abroad +372 669 6630).

Health care in Estonia

In Estonia, medical care is divided into three levels: **Primary or family medical care, specialized medical care and nursing care**.

For receiving health care, as a rule, first should be turned to the appointment of the family doctor, by whom patients are guaranteed a quick consultation, the necessary examinations and treatments, and, if necessary, referral to the next level of health care. **In case of a need for emergency medical treatment, one can by themselves go to the accident and emergency medicine department or call an ambulance**.

You can find detailed information about the contract partners providing the services of family medical care, specialized medical care, dental care services (contact data, location, services) in the Health Insurance Fund's website: www.haigekassa.ee

The family doctor and the family nurse

The first contact of a person with health concerns in the health care system is his or her family doctor or family nurse. In the situations needing rapid intervention you must no doubt turn to the ambulance or emergency care department, but in all other cases, the family doctor and his or her team are the primary health consultants. The family doctor is a highly qualified physician who can diagnose and cure for most of the diseases. A family doctor is a highly skilled physician who is able to diagnose and treat most diseases.

You can check the name of your family doctor in the state portal www.eesti.ee or to ask on the Health Insurance Fund information phone 16 363.

The family doctor in cooperation with the family nurse diagnoses and cures most diseases, monitors the child's progress and the

chronically sick, performs minor surgical procedures, directs the patient to studies and takes tests, performs vaccination, binds the wounds and removes stitches and, if necessary, makes home visits, giving advice on care, injury, or acute intoxications and on preventive measures to all persons entered in his or her list.

The family nurse has independent appointments where he or she teaches, advises and guides people in promoting and maintaining health and preventing disease.

The family nurse provides assistance in the event of illness and organizes medical records, in addition, the role of a nurse to monitor people with chronic illnesses. If necessary, the family nurse consults the family doctor or refers the person to the appointment of the family doctor. Everyone has the right to choose their own family doctor. If he fails to do so, the family doctor is designated by the Health Insurance Fund who shall notify the Health Insurance Fund thereof.

A person with an acute illness must be received by the family nurse or family doctor on the same day. In the case of a chronic disease and other concerns not requiring such a rapid intervention, the family doctor receives the patient within five working days.

For registration on the list of the family doctor or for exchanging the family doctor, an application for inclusion in the list must be submitted to the family doctor preferred by the person. The application form can be obtained from the family doctor or the Health Insurance Fund website. Also, newborns must be registered on the list of the family doctor with an application. If the family doctor has not notified of the refusal of including on the list in writing within seven days, the person submitting the application belongs to his or her list the latest as of the first day of the month following the submission of the application. In Estonia, there are approximately 800 family doctors on

whom information can be found on the website of the Health Board at: www. terviseamet.ee.

The family doctor has the right to refuse to accept a person onto their list if the maximum size limit set for the list of the family doctor has been exceeded. In Estonia, the maximum amount of the list of the family doctor is 2000 people (or 2400, if also an assistant doctor works in the doctor's office).

A family doctor's visit is free of charge for the insured. For home visits, the family doctor may charge up to € 5, regardless of how many patients she or he checks during the visit.

Home visits for pregnant women and children under two years of age are free of charge.

Development of the family doctor system and increasing the role of the family doctor and the family nurse in our health care system is an important strategic objective of the Health Insurance Fund.

New options are regularly added to the package of services provided by the family doctor. Since last year, the Health Insurance Fund finances separately the evening and weekend appointments of the family doctor, if the family doctor has the willingness to provide them. By the end of the year 2015, nearly 300 family doctors offered their insured the opportunity to come the doctor's appointment after the end of the workday. In the past year the family doctor received the possibility to refer their patients directly to a speech therapist or clinical psychologists. Since 2016, will be added the opportunity to refer the people of their list directly to the physiotherapist appointment. Previously, for that was a necessary a prior appointment to the rehabilitation doctor.

FAMILY DOCTOR COUNSELING LINE 1220

The family doctor consultation phone 1220 is a nationwide phone, from which one can receive professional medical advice 24 hours a day, in Estonian and Russian.

On the phone 1220, advice can be obtained in case of less serious health problems, instructions for primary care, and, where appropriate, information on the issues related to the organization of health care.

Calling to 1220 can be helpful when:

- your family doctor is not available
- you think that the health problem is not so serious that you need to contact the family doctor
- you are far away from the family doctor (for example, in another county)
- you are abroad and cannot turn to your family doctor right away (when calling from abroad dial +372 6304107)
- you need a consultation in relation to someone else's (child, relative) health matters.

A call to the emergency number 112 should be made in particular if the health problem or accident requires calling an ambulance.

If on calling 1220 it appears that emergency medical care is necessary, the call will be directed to the number of the alarm center for calling the ambulance .

E-CONSULTATION

On the provision of timely and high-quality health care and advice to people, **the cooperation of family doctors with medical specialists is crucial**. To ensure more efficient co-operation, in 2013, for family doctors, was established the possibility through a health information system to consult with a medical specialists for adjustment of the diagnosis of their patients and for determining the treatment. The e-consultation service saves the time of the patients, because one does not always have to go to a medical specialist themselves – **the family doctor consults the medical specialist electronically, and the entire treatment takes place in coordination by the family doctor**. However, if during the e-consultation the medical specialist decides that the patient still needs specialized medical assistance or further examination, the medical specialist is able to invite the patient to the appointment. E-consultancy also improves the speed of the information moving from the family doctor to the medical specialist and allows us to decide better on the basis thereof of how quickly the patient requires specialized medical care.

As of 2016, the Health Insurance Fund finances the e-consultation services on the specialties of urology, endocrinology, pulmonary diseases, rheumatology, ear, nose and throat diseases, pediatrics, neurology, hematology, immunology-allergology, gastroenterology, cardiology, oncology, and orthopedics.

Joining the service is voluntary for the doctor.

PEOPLE WITH CHRONIC DISEASES

With age, there is also the increasing likelihood of developing chronic diseases that require regular monitoring by a health care professional. More and more people both in the world and in Estonia develop

chronic diseases (e.g., cardiovascular diseases, diabetes, respiratory diseases, diseases of the joints, kidney diseases). **The family doctor and the family nurse the first point of contact for all health problems, they are also involved in the early detection and the treatment of the disease and prevention of complications**. If necessary, the family doctor refers the person to the appointment of the medical specialist for the diagnosis and determination of treatment or uses the e-consultation service. In monitoring of chronic disease, the first contact care or the family doctor system plays an important role. As a result, the monitoring of chronic diseases is one of the quality criteria of the family doctors which the Health Insurance Fund monitors in the work of family doctors. This criterion aims to early detection chronic illnesses and effective treatment thereof in order to reduce disease complications and mortality. In order to have a high quality of treatment by family doctors, in interdisciplinary collaboration has been drawn up a number of guidelines for the diagnosis and treatment of diseases (the treatment guidelines can be accessed at www.ravijuhend.ee).

The family nurse expects people with chronic diseases to schedule an appointment at least once a year, then he or she can check the key indicators of health, discuss with the patient his or her ability to cope with the disease and the everyday life and the behavior affecting the progression of the disease.

For some chronic diseases, it is possible to improve a person's quality of life and to postpone the development of complications due to the progression of the disease also by making small changes in the daily life (such as a healthy diet, increasing physical activity, adjustments in the daily schedule). If a person has any new health complaints, the analysis results are not too good or there is a need to make changes to the treatment, the family nurse refers the person with a chronic disease to the appointment of the family doctor. If a person suffering from a chronic illness has not come to the family doctor for a checkup on a regular basis, the family doctor or the family nurse herself or himself may contact the patient. In this case, the patient should

always come to the appointment, so it is possible to control better the chronic disease.

DEVELOPMENT OF CHILDREN'S HEALTH

In order to ensure continuous monitoring of the health of children, the pediatricians, family doctors, family nurses and medical specialists have agreed in the Decree of the Minister of Social Affairs on regular health checks for children. The subjects for monitoring will be the child's growth and development, hearing, vision and speech.

From the family doctor can be obtained information on infectious diseases and vaccination. In addition, assistance will be given to shape the child's healthy nutrition and exercise habits, and advice will be provided in all other on matters of health.

Plan for medical examinations and the time schedule of national vaccinations

Child's age	Appointment	Vaccination against infectious diseases and screening
Postnatal examination	Pediatrician in the maternity hospital	Tuberculosis vaccine, hepatitis B vaccine, first injection. Screening of metabolic diseases and hearing
Week 1	Family nurse	
Week 2	Family doctor	
1 month	Family doctor	Hepatitis B vaccine, second injection
2 months	Family nurse	Rotavirus vaccine, dose 1
3 months	Family doctor	Diphtheria, tetanus, pertussis, polio, Haemophilus infection vaccine first injection Rotavirus vaccine, dose 2
4,5 months	Family nurse	Diphtheria, tetanus, pertussis, polio, Haemophilus infection vaccine second injection Rotavirus vaccine, dose 3
6 months	Family doctor	Diphtheria, tetanus, pertussis, polio, Haemophilus infection vaccine third injection, hepatitis B vaccine, dose 3
7 months	Family nurse	
9 months	Family doctor	Blood tests to rule out anemia
12 months	Family doctor	Measles, mumps, rubella vaccine, first injection
18 months	Family doctor	
2 years	Family nurse	Diphtheria, tetanus, pertussis, polio, Haemophilus infection vaccine, a fourth injection
3 years	Family doctor, ophthalmologist, dentist	
4 years	Family nurse	
5 years	Family doctor	

6–7 years, pre-school check-up	Family doctor, dentist	Diphtheria, tetanus, pertussis, polio vaccine, fifth injection
8–9 years	Family doctor	
9–10 years	Family nurse, dentist	
11–12 years	Family doctor, dentist	Hepatitis B vaccine (1, 2, 3 - a month apart)
13–14 years	Family nurse, dentist	Measles, mumps and rubella vaccine, second injection
15–16 years	Family doctor, dentist	Diphtheria, tetanus, pertussis vaccine, sixth injection
17–18 years	Family nurse	Diphtheria, tetanus, pertussis vaccine, seventh injection

A healthy infant is monitored during the first year of life prophylactically on a monthly basis. Three visits must be made to the family nurse. In these visits, children are weighed and measured. In addition, the nurse's job is to advise the parents on child nutrition, hygiene, care, prevention of accidents and the like. Pediatrician visits are not necessary for healthy infants. If necessary, the family doctor will refer the child to the appointment of a medical specialist such as a neurologist or orthopedist.

With a 6–7-year-old child, pre-school health checks should be passed by the family doctor. The doctor will evaluate the child's development and school readiness. Among other things, the child's vision and auditory acuity and speech development is checked. In case of discrepancies, the doctor may refer the child for additional examination to a speech therapist, or to an ophthalmologist. **It would be recommended to perform health check in good time before the school, in the spring.** Then there will be time to solve the problems. For example, if necessary to acquire glasses or if a child needs extra help or any special conditions, it is possible to arrange

for that in a good time. The project of integration of children with diabetes in school, in which the disease is detected before the school and specialists provide the school staff with the necessary training and support.

DENTAL HEALTH CARE

The teeth should be taken care of already at a young age. Before the first baby teeth break, the infant's mouth should regularly be cleaned. **The first visit to the dentist should take place during the breaking of the child's first tooth, or when the child is about one-year-old**. The primary advice on the mouth health can be obtained already from the midwife or during the child's first year of life, from the family nurse.

Studies have shown that when at the end of adolescence the teeth are strong and healthy, no treatment is needed for several more decades. Thus, with the right hygiene habits of children and with preventive checks, situations can be avoided where in the adult age a large part of savings is absorbed by dental care.

Also, school nurses cooperate with dentists in the referral of children to preventive screening at 7, 9 and 12 years of age. If a child needs

dental treatment, it must surely take place with the knowledge and on the approval of the family.

It should, however, be checked whether the dentist has a contract with the Health Insurance Fund. Only then, the service is free for parents.

Remember!

It is easy to prevent tooth decay when consuming tooth-friendly foods - if you are thirsty, drink water and keep longer breaks between meals, i.e. avoid snacking.

The Health Insurance Fund pays for the dental care of the children and youth under 19 years of age at its contract partners, the contact data of the contract partners can be found at www.haigekassa.ee

SCHOOL HEALTH CARE

For admission to the school, the officially certified transcript of the pupil's health record must be submitted. It must include earlier vaccinations, chronic illnesses, regularly used medications, as well as drug or food allergies. The information is essential for monitoring the health of the child at school, but also for adjustment of the study load and the way of life.

When coming to school, parental consent is asked for the provision of school health care services, in general, including for medical examinations in the 1st, 3rd, 7th and 9th grade.

The concept of consent arises from the Law of Obligations Act. On this basis, the patient can be examined, and healthcare can be provided to him or her only on his or her consent. Equally valid with a written consent is verbal consent. Parental consent is important in situations such as when a student asks for help from the school nurse during the break.

Before each vaccination, the school nurse must ask for a written consent from the parent of the child even if it has already been granted for the child's admission to the school. Parental consent

will help to rule out any contraindications. If the family does not want to vaccinate their children, this must be confirmed in writing.

What kind of health assistance can be obtained from the school?

No treatment takes place at school. The treatment of a sick child is determined and is coordinated by a family doctor or a specialist. If a child has fallen ill at school or a trauma has occurred, the school nurse must give him or her first aid and inform the parents. A school nurse does not designate examinations or treatment, nor can he or she issue a medical excuse for absence. In case of illness, a family doctor should be contacted.

The school nurse can help if for health reasons a pupil needs differences in the organization of study, such as in the period after an illness. The nurse needs to know about the child's allergies or chronic diseases. Only then, it will be possible to provide quick and appropriate assistance.

In small schools, the nurse is not always present, but his or her office hours and the phone number must be available.

The Health Insurance Fund has supported the publication of materials to facilitate the monitoring of children's health.

The following materials have been published **„Child's health journal"** and **„Student's health journal"**.

When the child is born, or when he or she goes to school, each family should receive them from the hospital, the family doctor or the school. The materials are available also at www.haigekassa.ee

Specialized medical care

If the family doctor thinks that the patient's health concern needs an intervention of a narrower specialist, he or she shall issue a referral. Without a referral, a person can turn to a doctor of eye and skin and venereal diseases, gynecologist, and a psychiatrist.

The insured have the right to choose an appropriate medical specialist and the time of appointment in any medical institution who has a contract with the Health Insurance Fund.

The specialized medical care contract partners of the Health Insurance Fund can be found on the Health Insurance Fund homepage www.haigekassa.ee ▶ ***to the person*** ▶ ***medical and nursing care*** ▶ ***Health Insurance Fund contract partners***.

Specialized medical care is divided into three – outpatient, inpatient, and day treatment.

For a medical specialist visit, a medical institution shall be entitled to charge the patient a per visit fee up to five (5) euro, excluding pregnant women, children under 2 years of age and in cases where a person is referred to another doctor of the same medical institution or on provision of emergency medical care if it is followed by hospitalization. During the hospital, the patient may be charged a bed-day fee of 2.50 euro per day, to a maximum of 25 euro per stay in the hospital.

Outpatient treatment is the medical appointment during which time the patient is examined some procedure is performed (blood test, cardiogram, etc.) on site and, if necessary, further treatment is prescribed. The patient does not remain in the hospital for longer.

In case of day care a patient stays in the medical institution for no longer than just the appointment, but will not stay overnight in the hospital.

Inpatient care is provided in a hospital, and the patient has to stay there overnight or longer.

The Supervisory Board of the Health Insurance Fund has set the times during which a person must have access to the doctor or the maximum rates of waiting lists. Setting the maximum rate of waiting lists is based on the principle that **a person must receive adequate health care service at a time when his or her health condition does not deteriorate significantly.**

Those in need of specialized medical treatment will be placed on the waiting list on the basis of the severity of the health problem.

The maximum waiting period of an outpatient visit is six weeks, for a planned hospital admission and day surgery procedures up to eight months.

The waiting time may be extended if a person prefers a certain doctor or a medical institution, the medical institution has few doctors or other resources (equipment, facilities), a patient is waiting for re-appointment, etc.

Nursing care

The goal of the nursing care service is maintaining and possibly improve the patient's state of health and ability to cope, a short- or long-term care and support of a patient in a stable state and, if necessary, discomfort alleviation, preparing a person for a referral to the care institution or for home. Nursing care service is provided according to the needs of the patient, whether at home, in a hospital or in a care institution.

The need for nursing care is decided on by the doctor, and a referral is necessary for obtaining the service.

NURSING CARE IN THE HOSPITAL

Independent inpatient nursing care or provision of nursing care in the hospital is a service for a patient who is in a stable condition and

does not require constant medical care, but who needs the provision of nursing care and medical treatments determined by the doctor to the extent that exceeds the possibilities of home nursing.

Independent inpatient nursing care may be needed after trauma, severe illness, or flaring up of a chronic disease, on alleviating discomfort caused by a serious illness. The need for referral of a patient to a nursing hospital is determined by the family doctor, the medical specialist by themselves or with the nurse.

The co-payment of the patient staying in inpatient nursing care is 15% of the bed-day fee established by the Health Insurance Fund. 85% shall be paid by the Health Insurance Fund for the person with the health insurance coverage. The hospital can charge a separate bed-day fee for the first 10 days spent in the hospital (2.50 euros/ day). Outpatient nursing care services, including home nursing services, are free of charge.

Inpatient nursing care is provided in a nursing hospital or in a nursing care department where the performance of procedures and deciding on the need, therefore, is in the competence of the doctor and the nurse.

The length of the stay in the nursing hospital and the services provided therein will depend on the patient's medical condition and the need for nursing care.

HOME NURSING

Home nursing services are designed for a patient whose conditions does not require a hospital stay but still requires professional medical help. Home nursing care may also be required by a person with reduced mobility who due to the disease-related problems are unable to go to the doctor by themselves - so a home nurse is also

an important link between the family doctor and the doctor providing treatment and those in need.

The need for referral of a patient to home nursing service is decided by the family doctor or a medical specialist. For obtaining the service is necessary a referral on which the doctor indicates the patient's health problems, the needed treatment, and the nurse indicates the need for nursing care.

Home nursing services are free of charge for medically insured people; they are paid for by the Health Insurance Fund.

The procedures carried out during a home nursing visit include, inter alia:

- nursing counseling – teaching of the use of technical aids, instructing and teaching family members and nutritional counseling;
- performance of nursing operations - prevention and treatment of bed sores, blood pressure measurement, the position treatment; bladder catheterization, indwelling catheter care; care and exchange of epicystostomy; stoma care; wound and ulcer treatment; tracheostomy care; insertion and care of peripheral venous line; nasogastric tube insertion; teaching of tube-feeding; performance of inhalations; measuring blood glucose with a glucometer;
- on the basis of the decision of the doctor, performance of medical procedures, removal of sutures from the wound; oxygen therapy; drug administration intramuscularly, intravenously, subcutaneously, orally, rectally, the administration of feed solution; pain treatment; peritoneal dialysis and, if necessary, performance of certain laboratory studies;
- Symptomatic treatment of a cancer patient and alleviation of discomfort.

In the case of issues related to nursing care services, contact your family doctor or Health Insurance Fund information phone 16 363.

Financial compensation

In addition to payment for the health services provided to people, funding of medicines and medical devices, **the Health Insurance Fund also pays a number of monetary benefits**. These include different benefits for incapacity for work, a supplementary benefit for medicinal products and dental care benefits and benefits for artificial insemination.

BENEFITS OF TEMPORARY INCAPACITY FOR WORK

The benefit of temporary incapacity for work is paid on the basis of a certificate of incapacity for work to an employed person who due to a temporary leave from work loses the income subject to social tax. The benefit is paid to the employed person who is insured.

Benefits for incapacity to work is calculated based on the data on the social tax calculated or paid for by the recipient of the benefit for the previous calendar year received from the Tax and Customs Board.

The employer calculates the sickness benefit on the basis of the last six months' average salary.

Information related to payment of the benefit for incapacity for work can be viewed on the state portal www.eesti.ee. There can also be accessed medical data entered by the doctor, one's own bank account number to which the Health Insurance Fund transfers the benefit of incapacity for work and the data used for calculation of the benefit. Additional information is available from the Health Insurance Fund information phone 16363 or by e-mail info@haigekassa.ee

Payment of the benefit will depend on the type of the certificate of incapacity for work and on the cause of incapacity for work:

Reason for temporary release from work	Type of the certificate	Procedure of payment of the benefit	The benefit is paid
Illness	Certificate for sick-leave	The employer pays benefit from the fourth day to the eighth day of the illness. The Health Insurance Fund pays from the ninth day, the benefits rate of 70%.	Up to 182 days (240 days in the case of tuberculosis)
Non-work injury	Certificate for sick-leave	The employer pays benefit from the fourth day to the eighth day of the illness. The Health Insurance Fund pays from the ninth day, the benefits rate of 70%.	Up to 182 days
Traffic injury Complication/ illness caused by a traffic injury	Certificate for sick-leave	The employer pays benefit from the fourth day to the eighth day of the illness. The Health Insurance Fund pays from the ninth day, the benefits rate of 70%.	Up to 182 days
Quarantine	Certificate for sick-leave	The employer pays benefit from the fourth day to the seventh day of the illness, the rate of the benefit is 70%.	Up to 7 days
Occupational illness	Certificate for sick-leave	The employer pays benefit from the second day of the illness, the rate of the benefit is 100%.	Up to 182 days
Occupation-related accident Occupation-related accident in traffic A complication/ illness resulting from an occupational accident	Certificate for sick-leave	The employer pays benefit from the second day of the illness, the rate of the benefit is 100%.	Up to 182 days
Injury in the defense of the state or public interests or in the prevention of crime	Certificate for sick-leave	The employer pays benefit from the second day of the illness, the rate of the benefit is 100%.	Up to 182 days

Transfer to an easier job	Certificate for sick-leave	The Health Insurance Fund reimburses the wage gap resulting from the transfers to an easier job at a rate of 100%. If a person is released due to the absence of a lighter job, the benefit is paid to him or her from the second day, the rate of the compensation being 70%. The benefit can be received only in the event of pregnancy until pregnancy leave and maternity leave.	Until pregnancy leave and maternity leave.
Illness or injury during pregnancy	Certificate for sick-leave	The employer pays benefit from the second day of the illness, the rate of the benefit is 70%.	Up to 182 days
Nursing of an under 12-year-old child	Certificate for care leave	The Health Insurance Fund pays the benefit from the first day of the leave, the benefits rate of 80%. NB! As of 01.07.2015, an insured person is entitled, under the certificate for care leave, to receive care allowance for nursing of a child under 12 years of age up to 60 calendar days if the illness is caused by a malignant tumor and the child's treatment begins in the hospital.	Up to 14 days
Nursing a sick family member at home	Certificate for care leave	The Health Insurance Fund pays the benefit from the first day of the leave, the benefits rate of 80%.	Up to 7 days
Nursing of a child less than three years of age or a disabled child under 16 years of age during the child's mother's illness or during provision of obstetrical care	Certificate for care leave	The Health Insurance Fund pays the benefit from the first day of the leave, the benefits rate of 80%.	Up to 10 days
Pregnancy leave and maternity leave.	Certificate for maternity leave	The Health Insurance Fund pays the benefit from the first day of the leave, the benefits rate of 100%.	140 days
Leave of an adoptive parent of a child of under 12 years of age	Certificate for adoption leave	The Health Insurance Fund pays the benefit from the first day of the leave, the benefits rate of 100%.	70 days
Donation of an organ or hematopoietic stem cells	Certificate for sick-leave	The Health Insurance Fund pays from the 1 day, the benefits rate of 100%.	Up to 182 days

How can the benefits for temporary incapacity for work be obtained?

1. At the end of the leave period, your doctor will issue you an electronic certificate of incapacity for work in his or her computer and submits it to the Health Insurance Fund database;
2. You can view the data submitted by the doctor in the state portal

   www.eesti.ee (***E-services ▶ Residents ▶ Health and Health Protection ▶ Personal benefits of incapacity for work);***
3. In order to know the bank account to which the Health Insurance Fund will make a payment to you, please check your bank account details in the state portal

   www.eesti.ee (***E-services ▶ Residents ▶ Health and Health Protection ▶ My bank account and details in the Health Insurance Fund)***

   or by calling the information telephone 16363;
4. Inform the employer of the termination of the certificate of incapacity for work accordance with the mutual agreement either orally or in writing;
5. The employer shall submit the data of the certificate of incapacity for work via the state portal www.eesti.ee;
6. The benefit of incapacity for shall be paid into your current account within a couple of days after the submission of the employer's data;
7. You can view the data submitted by the doctor in the state portal

   www.eesti.ee (***E-services ▶ Residents ▶ Health and Health Protection ▶ Personal benefits of incapacity for work);***

DENTAL CARE BENEFIT

Who is eligible?

Persons covered by health insurance, at least 63 years of age, the old-age and disability pensioners, pregnant women, mothers of a child less

than one-year-old and people with an increased need for dental care.

The Health Insurance Fund pays insured persons under 19 years of age for dental care. For receiving the free dental care, you must turn to the contract partner of the Health Insurance Fund.

How much is paid?

Pensioners at least 63 years of age receiving a pension for incapacity for work and the old-age pensioners receive 19.18 euros a year; pregnant women, mothers of a child less than one-year-old and people with increased need for dental care* up to 28.77 euros a year.

Submit to the Health Insurance Fund an application together with a document certifying the payment for the service issued by the dentist. The service may be provided in Estonia as well as abroad. Pregnant women and people with an increased need for dental care must enclose a medical certificate.

When is the money received?

Not later than six months after the arrival of the properly prepared documents at the Health Insurance Fund.

NB! *Compensation can be claimed only by the people covered by health insurance for whom has emerged the need for increased dental care as a result of the following health care services (e.g., surgery and radiation therapy of tumors in the head and neck region, surgical treatment of facial skull bone traumas, a procedure during which a trauma has occurred, tissue and organ transplants, etc.). For the exact list, see www.haigekassa.ee

DENTURE BENEFITS

Who is eligible?

Persons covered by health insurance at least 63 years of age, the old-age and disability pensioners.

How much is paid?

During a three-year period up to 255.65 euros.

How do I apply?

There are two possibilities:

a) submit an application to the denture maker, where you apply for payment of the expenses to the extent of the compensation directly to the maker of the denture.
b) Submit an application along with a document certifying the payment to the Health Insurance Fund.

When is the money received?

In the event of submission of an application to the Health Insurance Fund within 90 days after the arrival of the application and the invoice at the Health Insurance Fund.

ADDITIONAL BENEFIT FOR MEDICINAL PRODUCTS

Who is eligible?

The insured person who pays for the discounted prescriptions at least 300 euro in a calendar year.

How much is paid?

Depends on the amount spent on medicinal products.

Discount prescriptions purchased after 01.01.2015 are subject to the following calculation principles:

- If the amount is less than EUR 300, the additional benefit for medicinal products is not paid
- starting from EUR 300-500, 50% benefit is paid for the part exceeding EUR 300
- If the amount exceeds EUR 500, 90% benefit will be paid for the exceeding amount

How do I apply?

You can submit the application through the service of the state portal www.eesti.ee or submit the application to the regional office of the Health Insurance Fund or digitally signed to the address info@haigekassa.ee

When is the money received?

The benefit is payable in January, April, July and October. After submitting your application the Health Insurance Fund verifies whether the applicant has the right for the benefit for the previous two years. If so, the insured person can receive the benefit also for these years. For detailed information about the calculation of the benefit see he state portal www.eesti.ee section “Benefits for medicinal products".

More detailed information on the benefits is available on the Health Insurance Fund website at www.haigekassa.ee, the state portal at www.eesti.ee, or the Health Insurance Fund information phone 16363.

Screening

Disease prevention and early detection will help to increase the quality of human life for many years since the disease detected at the early stages is usually curable and the person maintains the activity and the capacity for work.

A number of disease prevention activities funded by the Health Insurance Fund are integrated with the health care services, and they are offered to individuals throughout the life cycle - such as screenings targeted to pregnant women and newborn children, health checks of children and people with chronic illness carried out by family doctors.

Screenings are medical examinations, which investigate certain age groups of the population or risk groups, who are considered most

at risk of the disease being investigated. Screenings are specially designed for the investigation of the healthy groups of the population with no complaints and no obvious symptoms of the disease.

BREAST CANCER SCREENING

In Estonia, women aged 50-62 years are invited to breast cancer screening at two-year intervals. **In 2016 are invited for breast cancer screening the women born in the years 1956, 1958, 1960, 1962, 1964 and 1966.**

Breast cancer can be detected before cancer has been noticed and has spread in the body. An option for an early detection of breast cancer is a radiological examination of the breast or mammography. Mammography is an examination with the radiation dose safe for the health.

An early detected breast cancer is more treatable, allows the use of breast-sparing surgery techniques and is a prerequisite for the overall healing.

You can find the locations and the schedule of the moving mammography buses at www.haigekassa.ee

CERVICAL CANCER SCREENING

In Estonia, women aged 30-55 years are invited for breast cancer screening at five-year intervals. **In 2016 are invited for cervical cancer screening the women born in the years 1961, 1966, 1971, 1976, 1981 and 1986.**

The main cause of cervical cancer is the human papillomavirus (HPV), which is spread primarily through sexual contact. If a woman is infected with certain types of HPV, it may result in changes in the cervical cells, thereafter precancerous states, and cervical cancer. This process is usually long, lasting even from 10 to 25 years. The cell changes can be detected by cytological (diagnosis by cells) study, known as the PAP study, which is a method for early detection of cervical cell changes recognized around the world. **Regular participation in screening helps detect possible cell changes and precancerous conditions**

in a timely manner when they are treatable.

HOW TO PARTICIPATE IN THE SCREENING?

You will receive an invitation to participate in cancer screening to the address in the population register. In parallel with the invitation sent to your home, an electronic invitation will arrive in your E-health patient portal. However, all invitations may not necessarily reach their destination for one reason or another. The most frequent cause is inaccurate data in the population register.

If your birth year, however, is in the list of this year's recipients of the invitation, and you know that you have not made the relevant tests or studies done over the last 12 months, you do not necessarily have to wait for an invitation. You should simply call to the health care institution most convenient for you. When registering, in particular, the birth year and the validity of the health insurance are checked. When arriving at the screening, bring an identity document with you.

You can find the contact details of the health care institutions carrying out early detection studies of breast and cervical cancer at www.haigekassa.ee

COLON CANCER SCREENING

Colon cancer screening is a screening launched in 2016, where for the first time also men will be screened in addition to women. Colon cancer screening has proven to be an effective way to detect the disease in the initial stages, and when starting the treatment immediately, healing is likely. Colon cancer has slow and gradual progress, but at the same time, it is a relatively common disease (in Estonia, annuallyca 750 new cases are discovered). In Estonia, people aged 60-69 will be subject to screening.

In the second half of 2016 men and women born in 1956 will be invited to take part in colon cancer screening. To participate in the screening, you need to visit your family doctor.

Discount drugs

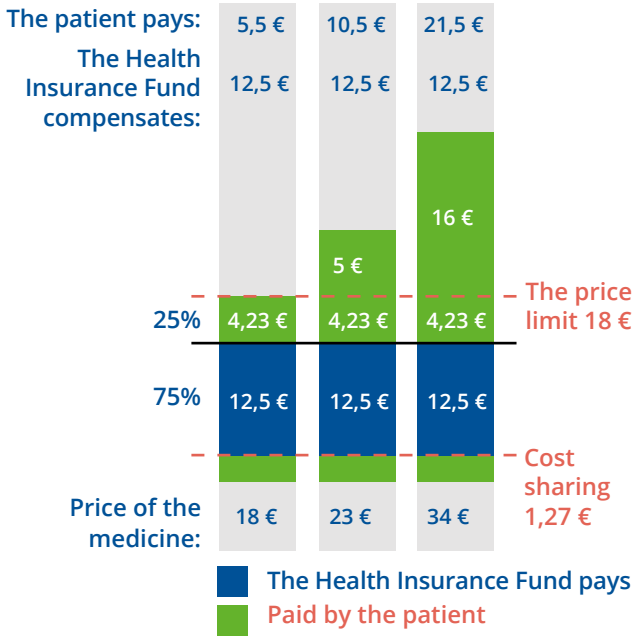
Since medicines are very expensive nowadays, part of the cost thereof is helped to be covered by the Health Insurance Fund. Discounting of medicines or full or partial payment for medicines is one of the means to ensure access to affordable medicines for people and helps to avoid the situation where the patient does not start the necessary treatment due to excessively high price of the medicine.

The Health Insurance Fund pays, to a certain extent, for the medicine the value of which has been previously thoroughly assessed and, consequently, it has been decided to enter into the discount medicines list. For these drugs applies the 50, 75, 90, or 100% discount rate. Higher rates apply to essential medicines necessary for treatment of serious and chronic illnesses, and larger discounts also apply to certain groups of the population (old-age and disability pensioners).

The discount drug list is renewed on a regular basis once a quarter (January 1, April 1, July 1 and October 1). The renewal of the list is notified of on the webpage of the Ministry of Social Affairs http://www.sm.ee/et/ravimid

For any prescription, the person purchasing the medicine should always pay the base rate of co-payment which depending on the prescription discount per cent is approximately 1–3 euro. For the remaining part of the cost of the medicine applies the discount of the Health Insurance Fund according to the set percentages and the patient shall pay as compulsory co-payments the excess remaining from the discount. If a price limit has been set for the medicine and the price of the medicine purchased exceeds the price limit, then in addition to the base rate and the mandatory co-payment, in the pharmacy must be paid the part exceeding the price limit. It can be called avoidable cost sharing, and a choice of the person buying the medicine sometimes allows here a significant financial saving.

MEDICAL PRODUCT PRICE CALCULATION WITH 75% DISCOUNT



*in the cases of children 4 to 16 years of age and insured people over 63 years of age, the entitlement for incapacity to work or old age pension is a 90% discount, which applies to the sale of medicines from the list of 75 % discount.

The patient pays the cost sharing part of 1.27 euros, the 25% of the amount between the limit price or the agreement price and the patient's cost sharing and the amount in excess of the limit price.

The Health Insurance Fund reimburses the 75 % of the amount between the limit price and the patient's cost sharing

WHAT IS THE PRICE LIMIT?

The price limits will be established in the group of the medicinal products with the same active substance and the same method of administration included in the list of discount drugs. On the calculation of the limit prices are grouped first all the packaging of the medicinal products with the same active substance and the same method of administration, the prices of their average daily doses are found, and on the basis of the price of the second-cheapest package the limit prices are calculated for all the packages of the group. On discounting the medicinal product, the Estonian Health Insurance Fund is based on the limit price established for the

You will more information on compensation of the medicinal products at www.haigekassa.ee/et/ravimi-hind

package of the medicinal product, and if a patient has been prescribed or the patient wants to buy a medicinal product, the price of which is higher than the limit price, the patient will cover the gap between the limit price applicable to the package and its selling price.

WHAT IS THE ACTIVE SUBSTANCE BASED PRESCRIPTION?

All doctors have a duty to prescribe active ingredient based prescriptions. On the prescription, the doctor writes the name of the active ingredient, not the trade name of the medicine. It gives people in the pharmacy the opportunity to choose the medicine with the most suitable price among the medicines with the same active ingredient.

The data of all your prescriptions can be verified in the state portal www.eesti.ee in the service Prescriptions.

The doctor can write on the prescription the trade name of a specific medicine only if there is a medical need for that. In this case, the patient does not have options in the pharmacy, he or she must buy the medicine, the name of which is written on the prescription.

WHAT IS THE ORIGINAL MEDICINE AND WHAT IS THE GENERIC MEDICINE?

The journey of a medicine from its inception until it reaches the pharmacy counter is an expensive and lengthy process. Therefore, the company that has invented the medicine and brought it to the market has the right for a patent period or for the right of exclusive selling of the medicine, in order to profit from the original medicine invented by it, and maintain the motivation to continue to develop new medicines. After the end of the patent period, other companies may begin to produce the medicine that contains exactly the same active substance as the original medicine, and is targeted for the treatment of exactly the same diseases. They are called generic medicines; sometimes the

names of copy medicines or the generics are also used.

A generic medicine is as effective as the original medicine because it contains exactly the same active ingredient in the same amount as the original medicine.

In addition to the discount medicine obtained in the pharmacy, the Health Insurance Fund will also pay for the medicines used in the hospital.

Diseases are cured and relieved by the active ingredient, not the trademark!

A medicine consists of the active substances and excipients. The active ingredient is the one that has an impact.

Excipients keep the medicine together, provide a suitable form, the color, shape, taste and the like.

Medical devices

The Health Insurance Fund will compensate to the insured persons such medical devices to be used independently at home, with the help of which is possible to treat illnesses and injuries, or the use of which prevents the progression of the disease.

The medical devices to be compensated for include glucometer test strips necessary for measuring the blood sugar of diabetics, lancets, insulin needles, different stoma care appliances, orthoses, catheters, wound dressings and patches for treatment of different wounds, the devices used for the treatment of sleep disorders and the masks thereof.

The Health Insurance Fund reimburses medical devices either at 90% or 50% discount rate. Accordingly, 10% or 50% of the device price must be paid by the patients themselves.

The doctor providing treatment establishes the need for a medical device and prepares the digital card of the medical device for acquisition thereof on favorable terms. For purchase of the device, the patient must turn to the pharmacy or a seller who has entered

into a contract with the Health Insurance Fund and presents an identity document. If you buy the device for someone else, then it is necessary that the identification code of the person for who you buy the device is included.

The list of medical devices is updated annually on the basis of the proposals of manufacturers and professional associations, and the price agreements concluded with the manufacturers. **For a current list of medical devices, see the Health Insurance Fund website.**

From 1 January 2016, a number of updates will be added to the list of the medical devices of the Health Insurance Fund. Compared with the current list **174 new devices have been added to the new list** In addition, the Health Insurance Fund will compensate the medical devices for three new diagnoses, which previously had no discounts, and will expanding the compensation conditions of the devices already on the list.

From the new year will improve the availability and selection of medical devices for the patients with different stomas, neck traumas, severe ichthyosis, a rare disease *Epidermolysis Bullosat* and for patients needing compression products to treat lymphoedemae.

New medical devices will also be added to the following groups:

- blood glucose meter test strips;
- lancets;
- colostomy, ileostomy, urostomy care devices (stoma rings and bags);
- orthoses for post-trauma and postoperative use;
- would dressings and patches;
- devices used in the treatment of sleep disorders and their masks

Medical care and treatment opportunities in a foreign country

THE REQUIRED MEDICAL TREATMENT WHILE STAYING TEMPORARILY IN ANOTHER EU COUNTRY

When planning a trip to another European Union Member States it makes sense to think in advance about what you need to know, and what to take with you to reduce costs, which may be associated with an unexpected health disorder.

The most important help that must be in the wallet is the European Health Insurance Card. On this basis, the people insured by the Estonian Health Insurance Fund can receive the medical treatment during a temporary stay in another Member State and receive treatment on equal terms with the insured people living in that country. For this, the need for health care has to be incurred during the stay in the other country, and the need for health care must

- **You can easily order your European Health insurance certificate from Internet, using the website of the Estonia Health Insurance Fund www.eesti.ee. The card can be ordered to your home address, and it is free of charge.**
- **The European Health Insurance Card cannot be used when the health insurance has ended. If the health insurance is not valid and the card is still used, pursuant to the Health Insurance Act and the Law of Obligations Act, the Health Insurance Fund has the right to demand compensation for damages.**
- **The European Health Insurance Card is valid for three (3) years and can only be used with an identity document.**
- **If you are traveling outside the European Union, it is advisable to take out travel insurance.**
- **Calling from abroad, the Health Insurance Fund information phone is +372669 6630.**

be medically justified. Whether the medical care is needed, will be decided by the doctor.

The European Health Insurance Card gives the right to the necessary medical care during a stay within the European Union and the European Economic Area and Switzerland. The required medical care is not free – the patient's deductible expenses (visit, hospital charges, etc.) must be paid for according to the tariffs in the country of location.

Deductible expenses shall not be compensated for the patient. Also, the card does not cover the transport costs between countries. Therefore, we recommend on traveling to a foreign country also always take the travel insurance with the protection of the health risks. In the light of the above, the hospital should issue an invoice only for the deductible, which in turn can be submitted to the private insurance provider.

Also be sure to observe that for obtaining health care service, you turn to a state health care institution, and not to private doctors, since the EHIC is accepted only in the health care institutions belonging to the state system.

PLANNED MEDICAL TREATMENT ABROAD

Unlike the need for medical aid caused by an emergency need for treatment in a foreign country, **planned treatment represents a situation where a person goes to another country in order seek treatment there**. The application form is available on the website of the Health Insurance Fund, or in customer service offices. The first option is to apply for the permission of the Health Insurance Fund for covering the cost of treatment in a foreign medical institution (for the criteria of the permission see www.haigekassa.ee). The reimbursement is made in accordance with the rates of the state that provided the treatment. The Health Insurance Fund makes an inquiry to the state where you were treated, and according to information received, shall transfer the reimbursable amount to your bank account.

In the case of a positive decision, the Health Insurance Fund will issue a document confirming the assumption of the payment of the fee and pay the medical costs incurred from abroad.

Another possibility to receive planned medical treatment abroad is **Under the European Union Directive on the free movement of patients**. This means that the patient who is holding a referral to a medical specialist can choose from a health care institution or a doctor from any state system within the European Union, and after treatment to seek compensation from the Health Insurance Fund. An important difference between recourse to a medical specialist on the basis of a referral in Estonia and abroad lies in the fact that **while abroad the entire medical treatment must be paid for by the patient first, and then upon returning home to apply for reimbursement of the cost from the Health Insurance Fund**. It must be kept in mind that the Health Insurance Fund pays only for the health services that the patient would be entitled to receive at the expense of Health Insurance Fund also in Estonia. The reimbursement is not possible in case of health care services that are not provided in or recoverable in Estonia (e.g., dental care for adults) or the services medically not indicated for the person. If the price of the service received from abroad is higher than the price in our list of health care of the Health Insurance Fund, the patient must pay the difference in price themselves. **Also, the patient has to pay for the visit, co-payment fees, and travel expenses**.

For receiving the compensation, an application must be submitted, the form of which is available on the website of the Health Insurance Fund or in the customer service offices, as well as to provide original invoices of the treatment, payment records, referral of the medical specialist and the summary of the treatment protocol.

WORKING IN THE EUROPEAN UNION MEMBER STATES

Posted employee

The employer must pre-register temporary assignments or postings of an employee to a foreign country in the Estonian National Social

Insurance Board. The National Social Insurance Board shall issue a separate certificate A1 for each employee on the (certificate concerning the applicable legislation, indicating the Member States the legislation of which the person is subject to), which is not a basis for obtaining health care services.

An employee whose posting is short-term (less than six months), must order the European Health Insurance Card, which entitles him or her to obtain the necessary health care in the country of posting or destination.

In the case of a long-term posting lasting longer than 6 (six) months, the person or his or her employer can request a form E106 from the Health Insurance Fund. This form entitles the employee to register himself or herself in the health insurance system of the posting country, and after the registration of the form the posted employee **is entitled to receive medical care in the country of assignment under the same conditions as the insured persons there**.

If the family members also take up residence in the foreign country, they should be notified of on the registration of the form, and they will also receive insurance in the country of posting. Medical expenses will be compensated to the country of posting by the Estonian Health Insurance Fund.

You will find the application form on the Health Insurance Fund website

www.haigekassa.ee ▶ ***Forms*** ▶ ***European Union forms*** ▶ ***application for obtaining the Form E106***.

NB! The employer and the person have to fill in different applications!

STUDYING IN THE EUROPEAN UNION MEMBER STATES

In order to continue the Estonian health insurance while studying abroad, a document certifying studies in a foreign country complete with an application for health insurance application must be submitted to the Estonian Health Insurance Fund. The student will obtain the

document certifying studies from his or her educational institution and it must contain the contacts (name, address) of the educational institution; the student information (name and surname, personal identification number); the duration of the study period; the name and the surname of the representative of the educational institution, data of the communication equipment and a signature.

For reimbursement of scheduled treatment abroad by the Health Insurance Fund, there are three options:

- **On the basis of the European health insurance card**
- **On the basis of prior authorization from the Health Insurance Fund (elective medical treatment abroad)**
- **Under the European Union Directive on the free movement of patients**

The school certificate can be submitted to the Health Insurance Fund either by mail or e-mail. It is also possible to submit it in person to the customer service office of the Health Insurance Fund.

HEALTH INSURANCE FUND INFORMATION PHONE 16363

On workdays 8.30 to 16.30, from abroad +372 669 6630

E-mail: info@haigekassa.ee
www.haigekassa.ee

Family doctor advisory phone 1220

Medical advice around the clock in Estonian and Russian

CUSTOMER SERVICES OF THE ESTONIAN HEALTH INSURANCE FUND

Harju Department
Harju County and Tallinn
Lastekodu 48,
10144 Tallinn
Mon, Tue, Thu, Fri 8:30 to 16:30
Wed 8.30–18.00

Pärnu Department
Pärnu, Lääne, Saare, Hiiu and Rapla Counties
Rüütli 40a, 80010 Pärnu NB!
Mailing Address Lai 14,
80010 Pärnu
Mon, Tue, Thu, Fri 8:30 to 16:30,
Wed 8:30 to 18:00

Viru Department
East and West-Viru Counties,
Järva County Nooruse 5,
41597 Jõhvi
Mon, Tue, Thu, Fri 8:30 to 16:30, Wed 8:30 to 18:00

Tartu Department
Tartu, Viljandi, Jõgeva, Võru, Valga and Põlva Counties
Põllu 1a, 50303 Tartu
Mon, Tue, Wed, Thu, Fri 8:30 to 16:30, Thu 8:30 to 18:00

Estonian Health Insurance Fund