Issuer:	Riigikogu
Type:	act
In force from:	01.07.2015
In force until:	31.08.2015
Translation published:	30.06.2015

Health Insurance Act[1]

Passed 19.06.2002
RT I 2002, 62, 377
Entered into force in accordance with § 90

Amended by the following acts

Passed	Published	Entry into force
29.01.2003	RT I 2003, 20, 116	10.03.2003
17.12.2003	RT I 2003, 88, 591	01.01.2004
20.04.2004	RT I 2004, 37, 253	01.05.2004, in part01.08.2004
02.06.2004	RT I 2004, 49, 342	01.07.2004
28.06.2004	RT I 2004, 56, 400	01.08.2004, in part01.01.2005 and 01.04.2005
13.10.2004	RT I 2004, 75, 520	01.12.2004
08.12.2004	RT I 2004, 89, 604	01.04.2005
16.12.2004	RT I 2004, 89, 614	01.01.2005
06.04.2005	RT I 2005, 22, 148	01.01.2006
15.06.2005	RT I 2005, 39, 308	01.01.2006
12.10.2005	RT I 2005, 57, 451	18.11.2005
24.11.2005	RT I 2005, 65, 498	01.01.2006
15.12.2005	RT I 2005, 71, 546	01.01.2006, 01.04.2006
17.05.2006	RT I 2006, 26, 191	01.08.2006
21.12.2006	RT I 2007, 4, 17	29.01.2007
15.02.2007	RT I 2007, 24, 127	01.01.2008
19.12.2007	RT I 2007, 71, 437	01.10.2008
20.12.2007	RT I 2008, 3, 22	01.09.2008
19.06.2008	RT I 2008, 34, 210	01.08.2008
19.06.2008	RT I 2008, 34, 210	01.09.2008
19.06.2008	RT I 2008, 34, 210	01.08.2009
09.12.2008	RT I 2008, 56, 313	01.01.2009
10.12.2008	RT I 2008, 58, 327	02.01.2009
11.12.2008	RT I 2008, 60, 331	01.01.2009
17.12.2008	RT I 2009, 5, 35	01.07.2009
20.02.2009	RT I 2009, 15, 93	01.07.2009
21.05.2009	RT I 2009, 29, 176	01.04.2010, in part19.06.2009 and 01.07.2009
18.06.2009	RT I 2009, 35, 232	01.07.2009
30.09.2009	RT I 2009, 49, 331	01.01.2010, in part01.04.2010
17.12.2009	RT I 2009, 67, 461	01.01.2010
18.03.2010	RT I 2010, 15, 77	18.04.2010, in part01.07.2010
22.04.2010	RT I 2010, 22, 108	01.01.2011, will enter into force on the date specified in the decision of the Council of the European Union regarding the abrogation of the derogation established in favour of the Republic of Estonia on the ground provided for in Article 140(2) of the Treaty on the

		Functioning of the European Union, Decision No. 2010/416/EU of the Council of the European Union of 13 July 2010 (OJ L 196, 28.07.2010, pp. 24-26).
26.01.2011	RT I, 17.02.2011, 1	27.02.2011
07.06.2011	RT I, 10.06.2011, 7	07.06.2011, the words “or insured persons who are at least 65 years of age” in subsection (6) of § 57 of the Health Insurance Act are declared unconstitutional and repealed by a judgment of the Supreme Court en banc.
14.06.2012	RT I, 02.07.2012, 8	01.08.2012
14.06.2012	RT I, 05.07.2012, 14	01.10.2012
13.06.2012	RT I, 06.07.2012, 1	01.04.2013
13.06.2012	RT I, 10.07.2012, 2	01.04.2013
10.10.2012	RT I, 25.10.2012, 1	01.12.2012
20.12.2012	RT I, 31.12.2012, 6	10.01.2013
12.06.2013	RT I, 02.07.2013, 1	01.09.2013, in part01.01.2014
15.11.2013	RT I, 29.11.2013, 1	09.12.2013
18.12.2013	RT I, 10.01.2014, 2	20.01.2014, in part01.01.2015
19.02.2014	RT I, 13.03.2014, 2	23.03.2014, in part01.01.2015, 01.01.2017 and 01.01.2019
26.03.2014	RT I, 16.04.2014, 4	26.04.2014
26.03.2014	RT I, 16.04.2014, 3	01.07.2014
11.06.2014	RT I, 21.06.2014, 8	01.01.2015
19.06.2014	RT I, 29.06.2014, 109	01.07.2014, the ministers’ official titles have been replaced on the basis of subsection 107³ (4) of the Government of the Republic Act.
17.09.2014	RT I, 08.10.2014, 1	18.10.2014, in part01.01.2015
19.11.2014	RT I, 13.12.2014, 1	01.01.2016, in part01.01.2015 and 01.07.2016
29.01.2015	RT I, 26.02.2015, 1	01.03.2015
18.02.2015	RT I, 11.03.2015, 2	21.03.2015, in part01.07.2015 and 01.01.2016
18.02.2015	RT I, 23.03.2015, 1	02.04.2015
18.02.2015	RT I, 23.03.2015, 5	01.07.2015

Chapter 1
GENERAL PROVISIONS

§ 1. Scope of application of Act

(1) This Act regulates solidarity-based health insurance (hereinafter *health insurance*).

(2) In the event of a conflict between this Act and an international agreement ratified by the *Riigikogu*, the provisions of the international agreement apply.

§ 2. Definition, principles and form of health insurance

(1) Health insurance is a system for covering health care expenses incurred to finance the disease prevention and treatment of and purchase of medicinal products and medical devices for insured persons and to pay benefits for temporary incapacity for work and other benefits on the conditions and in accordance with the procedure provided for in this Act.
[RT I 2008, 3, 22 – entry into force 01.09.2008]

(2) Health insurance is based on the solidarity of and limited cost-sharing by insured persons and on the principle that services are provided according to the needs of insured persons, that treatment is equally available in all regions and that health insurance funds are used for their intended purpose.

(3) Health insurance is compulsory insurance, with the exception of the health insurance provided for in §§ 22–24 of this Act.

§ 3. Insurer

(1) For the purposes of health insurance, the insurer is the Estonian Health Insurance Fund (hereinafter *health insurance fund*).

(2) An insured person will choose a regional unit of the health insurance fund and be entered in the list of insured persons of the unit.

(3) Unless otherwise provided by this Act, persons entered in the lists of insured persons of regional units of the health insurance fund have equal rights and equal opportunities to receive health insurance benefits.

§ 4. Health promotion

The health insurance fund participates in financing projects specifically aimed at promoting health to the extent of the amounts prescribed for such purpose in the budget of the health insurance fund and with the approval of the Ministry of Social Affairs.

Chapter 2
CONDITIONS OF INSURANCE

Division 1
Insured Person

§ 5. Insured person

(1) For the purposes of this Act, an insured person is a permanent resident of Estonia or a person residing in Estonia on the basis of a temporary residence permit or the right of residence or a person legally staying and working in Estonia based on a temporary ground for stay for whom a payer of social tax must pay social tax or who pays social tax for themselves in accordance with the procedure, in the amounts and within the time limits provided for in the Social Tax Act, or a person considered equal to such persons on the basis of this Act or on the basis of a contract specified in subsections 22 (1) and (2) of this Act.
[RT I, 23.03.2015, 1 – entry into force 02.04.2015]

(2) The following are insured persons for whom a payer of social tax must pay social tax:
1) persons who work on the basis of an employment contract concluded for a term exceeding one month or for an unspecified term and for whom the employer must pay social tax;
2) officials, active servicemen, members of the *Riigikogu*, the President of the Republic, members of the Government of the Republic, judges, the Chancellor of Justice, the Auditor General, the Public Conciliator, members of councils of local authorities, members of city or rural municipality governments, mayors of rural municipality or city districts for whom the state or the local authority must pay social tax via its agencies;
[RT I, 06.07.2012, 1 – entry into force 01.04.2013]
3) persons for whom the state, local authority or, based on the Creative Persons and Artistic Associations Act, an artistic association (hereinafter *artistic association*) is required to pay social tax under § 6 of the Social Tax Act;
[RT I, 10.01.2014, 2 – entry into force 20.01.2014]
4) members of the management or controlling bodies of legal persons within the meaning of § 9 of the Income Tax Act for whom the legal persons must pay social tax each month on the basis of clause 9 (1) 2) of the Social Tax Act in the amount calculated on the basis of at least the monthly rate established in the state budget for the given budgetary year;
5) persons receiving remuneration or service fees on the basis of a contract for services, a mandate or a contract under the law of obligations for the provision of any other services, which is concluded for a term exceeding one month or for an unspecified term, who are not entered in the commercial register as self-employed persons and for whom the other party to the contract must pay social tax each month on the basis of clause 9 (1) 2) of the Social Tax Act in the amount calculated on the basis of at least the monthly rate established in the state budget for the given budgetary year;
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]
6) persons receiving an unemployment insurance benefit on the basis of the Unemployment Insurance Act for whom the Estonian Unemployment Insurance Fund must pay social tax on the basis of clause 2 (1) 8) of the Social Tax Act.

(3) An insured person who pays social tax for themselves is a person who is entered in the commercial register as a self-employed person or who has been registered with the Tax and Customs Board as a notary, certified translator or enforcement officer and who pays social tax on their business income in accordance with the Social Tax Act.

[RT I, 25.10.2012, 1 – entry into force 01.12.2012]

(3^1) An insured person for whom social tax is paid by a self-employed person registered in the commercial register is their spouse who has been entered in the register of taxable persons as the spouse participating in the activities of the undertaking of the self-employed person on the basis of § 20^2 of the Taxation Act (hereinafter *spouse participating in activities of undertaking of self-employed person*).
[RT I, 02.07.2012, 8 – entry into force 01.08.2012]

(4) The following persons for whom social tax is not paid are considered to be equal to insured persons on the basis of this Act:
1) pregnant women whose pregnancy has been identified by a doctor or a midwife;
[RT I 2009, 29, 176 – entry into force 01.04.2010]
2) persons under 19 years of age;
3) persons who receive a state pension granted in Estonia;
4) persons with up to five years left until attaining the retirement age who are maintained by their spouses who are insured persons;
5) persons acquiring basic or general secondary education, persons acquiring formal vocational education and higher education students who are permanent residents of Estonia and study in an educational institution in Estonia founded and operating on the basis of legislation or in an equivalent educational institution abroad.
[RT I, 23.03.2015, 5 – entry into force 01.07.2015]

Division 2
Duration of Insurance Cover

§ 6. Duration of insurance cover of officials, active servicemen, members of *Riigikogu*, President of Republic, members of Government of Republic, judges, Chancellor of Justice, Auditor General, Public Conciliator, members of councils of local authorities, members of city or rural municipality governments, mayors of rural municipalities or city districts

(1) The insurance cover of the persons specified in clauses 5 (2) 1) and 2) of this Act will commence upon expiry of a waiting period of fourteen days from the date of commencement of work entered in the employment register specified in § 25^1 of the Taxation Act (hereinafter *employment register*).

(2) If the date of commencement of work entered in the employment register remains within the term of validity of the valid insurance cover, the insurance cover will continue on the new ground without interruption.

(3) The insurance cover of the persons specified in clauses 5 (2) 1) and 2) of this Act will terminate two months after the date of termination of work entered in the employment register.

(4) The insurance cover of the persons specified in clauses 5 (2) 1) and 2) of this Act will be suspended two months after the date of commencement of the suspension of work entered in the employment register, except in the case of unpaid leave granted by agreement of the parties, provided that social tax is paid for the person in accordance with the Social Tax Act, and the insurance cover will continue as of the date following the date of termination of the suspension of work entered in the employment register.

(5) Subsection (4) of this section does not apply in the period during which the insured person is entitled to the benefit for temporary incapacity for work.
[RT I, 16.04.2014, 3 – entry into force 01.07.2014]

§ 7. Duration of insurance cover of persons for whom social tax is paid by state, local authority or artistic association

(1) The insurance cover of a person specified in clause 5 (2) 3) of this Act will commence as of the making of an entry on commencement of the insurance cover in the health insurance database. The documents necessary for the person to be entered in the health insurance database must be submitted to the health insurance fund by the agency through which the state or local authority pays social tax for the person or by an artistic association.

(2) The insurance cover of a person specified in clause 5 (2) 3) of this Act will terminate one month after the termination of the obligation of the state, local authority or artistic association to pay social tax for the person. The agency through which the state or the local government paid social tax for the person and the artistic association are required to notify the health insurance fund of termination of the obligation to pay social tax within ten calendar days.
[RT I, 10.01.2014, 2 – entry into force 20.01.2014]

§ 8. Duration of insurance cover of members of management or controlling bodies of legal persons

(1) The insurance cover of a person specified in clause 5 (2) 4) of this Act will commence as of the expiry of a waiting period of fourteen days from the date of commencement of work entered in the employment register.

(2) If the date of commencement of work entered in the employment register remains within the term of validity of the valid insurance cover, the insurance cover will continue on the new ground without interruption.

(3) The insurance cover of a person specified in clauses 5 (2) 4) of this Act will terminate two months after the date of termination of work entered in the employment register.

(4) In the event of failure to pay social tax by the due date, the insurance cover of a person specified in clause 5 (2) 4) of this Act will terminate two months after the due date if the obligation to pay social tax has not been performed as required and in full by such time.

(5) The insurance cover of a person specified in clause 5 (2) 4) of this Act will continue without a waiting period as of the date following the date of receipt of information from the Tax and Customs Board on the full performance of the obligation to pay social tax.
[RT I, 16.04.2014, 3 – entry into force 01.07.2014]

§ 9. Duration of insurance cover of persons receiving remuneration or service fees on basis of contract under law of obligations

(1) The insurance cover of a person specified in clause 5 (2) 5) of this Act will commence as of the expiry of a waiting period of fourteen days from the date of commencement of work entered in the employment register.

(2) If the date of commencement of work entered in the employment register remains within the term of validity of the valid insurance cover, the insurance cover will continue on the new ground without interruption.

(3) The insurance cover of a person specified in clause 5 (2) 5) of this Act will terminate two months after the date of termination of work entered in the employment register.

(4) In the event of failure to pay social tax by the due date, the insurance cover of a person specified in clause 5 (2) 5) of this Act will terminate two months after the due date if the obligation to pay social tax has not been performed as required and in full by such time.

(5) The insurance cover of a person specified in clause 5 (2) 5) of this Act will continue without a waiting period as of the date following the date of receipt of information from the Tax and Customs Board on the full performance of the obligation to pay social tax.
[RT I, 16.04.2014, 3 – entry into force 01.07.2014]

§ 9^{1}. Duration of insurance cover of persons receiving unemployment insurance benefit

(1) The insurance cover of a person specified in clause 5 (2) 6) of this Act will commence as of the making of an entry on commencement of the insurance cover in the health insurance database. The documents necessary for the person to be entered in the health insurance database must be submitted to the health insurance fund by the Estonian Unemployment Fund.

(2) The insurance cover of a person specified in clause 5 (2) 6) of this Act will terminate two months after termination of the obligation of the Estonian Unemployment Fund to pay social tax for the person. The Estonian Unemployment Insurance Fund must notify the health insurance fund of termination of the obligation to pay social tax within ten calendar days.
[RT I 2004, 56, 400 – entry into force 01.08.2004]

§ 10. Duration of insurance cover of self-employed persons entered in register

[RT I 2005, 71, 546 – entry into force 01.04.2006]

(1) The insurance cover of a person specified in subsection 5 (3) of this Act will commence upon expiry of a waiting period of fourteen days calculated as of the entry on the commercial register or the register of taxable persons. The documents necessary for the person to be entered in the health insurance database must be submitted to the health insurance fund by the registrar of the central database of the registration department of Tartu County Court or by the Tax and Customs Board within seven calendar days after the entry in the commercial register or the register of taxable persons.
[RT I, 21.06.2014, 8 – entry into force 01.01.2015]

(2) If the data necessary for an entry on commencement of the insurance cover of a person to be made in the health insurance database are submitted to the health insurance fund during the period of validity of the insurance cover of the person, the insurance cover will continue on the new basis without interruption.
[RT I 2005, 71, 546 – entry into force 01.04.2006]

(3) The insurance cover of a person specified in subsection 5 (3) of this Act will terminate two months after making of the deletion entry in the commercial register or register of taxable persons. The registrar of the central

database of the registration department of Tartu County Court or the Tax and Customs Board must inform the health insurance fund of the termination of the activities of a person specified in subsection 5 (3) of this Act within ten calendar days after making the deletion entry.
[RT I, 21.06.2014, 8 – entry into force 01.01.2015]

(4) The insurance cover will be suspended two months after the entry in the commercial register or register of taxable persons of the suspension of the activities, including seasonal activities of a person specified in subsection 5 (3) of this Act. The registrar of the central database of the registration department of Tartu County Court or the Tax and Customs Board are required to inform the health insurance fund of the termination of the operation of an enterprise or the professional activities of a person within ten calendar days after making the entry on suspension of activities in the commercial register or register of taxable persons.
[RT I, 21.06.2014, 8 – entry into force 01.01.2015]

(5) If a person recommences business activities after their suspension, the registrar of the central database of the registration department of Tartu County Court and the Tax and Customs Board must submit to the health insurance fund the details of recommencement of business activities within ten calendar days. Upon receipt of the data, the insurance cover will continue without a waiting period.
[RT I, 21.06.2014, 8 – entry into force 01.01.2015]

(6) The provisions of subsection (4) of this section do not apply in the event of suspension of engagement in business for a period during which the insured person is entitled to receive the benefit for temporary incapacity for work.
[RT I 2005, 71, 546 – entry into force 01.04.2006]

§ 10[1]. Duration of insurance cover of spouse participating in activities of undertaking of self-employed person

(1) The insurance cover of the spouse participating in the activities of the undertaking of a self-employed person will commence after the passing of the waiting period of fourteen days from the entry in the register of taxable persons. The Tax and Customs Board must submit the documents required for entering the spouse participating in the activities of the undertaking of a self-employed person within seven calendar days after the entry of the spouse participating in the activities of the undertaking of a self-employed person in the register of taxable persons.

(2) If the documents necessary for an entry on commencement of the insurance cover of the spouse participating in the activities of the undertaking of a self-employed person to be made in the health insurance database are submitted to the health insurance fund during the period of validity of the insurance cover of the spouse participating in the activities of the undertaking of the self-employed person, the insurance cover will continue on the new basis without interruption.

(3) The insurance over of the spouse participating in the activities of the undertaking of a self-employed person will terminate two months after making a deletion entry regarding the spouse in the register of taxable persons or after making a deletion entry regarding the self-employed person in the commercial register.

(4) The insurance cover of the spouse participating in the activities of the undertaking of a self-employed person will be suspended after two months have passed from the suspension of the activities of the self-employed person, including after making an entry on the suspension of seasonal activities in the commercial register.

(5) As of the receipt of data on the recommencement of the activities of a self-employed person, the insurance cover of the spouse participating in the activities of the undertaking of the self-employed person will continue without a waiting period.

(6) Subsection (4) of this section does not apply in the event of suspension of the activities of a self-employed person during the period when their spouse is entitled to the benefit for temporary incapacity for work.
[RT I, 02.07.2012, 8 – entry into force 01.08.2012]

§ 11. Duration of insurance cover of persons considered equal to insured persons

(1) The insurance cover of a person specified in subsection 5 (4) of this Act will commence as of the making of an entry on commencement of the insurance cover in the health insurance database. The documents required for entering a person in the health insurance database must be submitted to the health insurance fund by the person or by their legal representative.
[RT I, 16.04.2014, 3 – entry into force 01.07.2014]

(2) The documents necessary for a person specified in clause 5 (4) 3) of this Act to be entered in the health insurance database must be submitted by the Social Insurance Board and, in the events provided by law, by the Chancellery of the *Riigikogu*.

(3) The documents necessary for a person studying in Estonia specified in clause 5 (4) 5) of this Act to be entered in the health insurance database must be submitted by the Ministry of Education and Research. A person

studying in a foreign state specified in clause 5 (4) 5) must submit the documents necessary for insurance cover to commence by themselves.

(4) The insurance cover of the persons specified in clauses 5 (4) 1)–4) of this Act will terminate if the person no longer meets the conditions provided for in the relevant clause of subsection 5 (4), taking into account the specifications provided for in § 12 of this Act.

(5) The submitters of the documents specified in subsection (2) or (3) of this section must notify the health insurance fund of the termination of the insurance cover of the persons specified in clause 5 (4) 3) or 5) of this Act within ten calendar days.
[RT I 2004, 56, 400 – entry into force 01.08.2004]

§ 12. Specifications concerning duration of insurance cover of persons considered equal to insured persons

(1) The insurance cover of a person declared permanently incapacitated for work will terminate three months after termination of their permanent incapacity for work.

(1^1) The insurance cover of a person specified in clause 5 (4) 1) of this Act will terminate three months after the estimated date of delivery as determined by a doctor or midwife.
[RT I 2009, 29, 176 – entry into force 01.04.2010]

(2) The insurance cover of a person specified in clause 5 (4) 5) of this Act will terminate three months after their graduation from the educational institution.
[RT I, 23.03.2015, 5 – entry into force 01.07.2015]

(2^1) If a student of at least 19 years of age acquiring general secondary education as specified in clause 5 (4) 5) of this Act is expelled from the educational institution before graduation within three consecutive academic years after commencement of acquisition of the general secondary education, their insurance cover will terminate one month after the expulsion. If a student of at least 19 years of age acquiring formal vocational education as specified in clause 5 (4) 5) of this Act fails to graduate from the educational institution within the standard period of study prescribed for completion of the curriculum (except for medical reasons) or is expelled from the educational institution before graduation, his or her insurance cover terminates one month thereafter. If a student specified in clause 5 (4) 5) of this Act fails to graduate from the educational institution within one year after the end of the standard period of study prescribed for completion of the curriculum (except for medical reasons) or is expelled from the educational institution before graduation, their insurance cover will terminate one month thereafter.
[RT I, 02.07.2013, 1 – entry into force 01.09.2013]

(3) Insurance cover will be suspended for any period of academic leave. The conditions under which insurance cover is not suspended for a period of academic leave will be established by a regulation of the minister responsible for the field. After expiry of the period of suspension, the insurance cover will continue without a waiting period.
[RT I 2005, 65, 498 – entry into force 01.01.2006]

§ 13. Submission of documents and information

(1) Information required for the commencement, suspension or termination of the insurance cover must be submitted in writing or in an electronic form that is considered equal thereto.
[RT I, 16.04.2014, 3 – entry into force 01.07.2014]

(1^1) A person providing a person specified in clause 5 (2) 1), 2), 4) or 5) of this Act with work must submit the information specified in these provisions, which serves as the basis for the commencement, suspension and termination of the person's insurance cover on the grounds and in accordance with the procedure provided for in the Taxation Act to the employment register and the latter will forward it to the health insurance fund.
[RT I, 16.04.2014, 3 – entry into force 01.07.2014]

(2) Documents and information necessary for insurance cover to commence, to be suspended or to terminate may, in addition to the person obligated to submit the documents or information, also be submitted by the person applying for insurance cover or by the insured person.

(3) A person required to submit documents or information necessary for the commencement of the insurance cover must perform the obligation within seven calendar days as of the emergence of the obligation. The employment register will forward the information after the person having the registration obligation has entered it in the employment register.
[RT I, 16.04.2014, 3 – entry into force 01.07.2014]

(4) [Repealed – RT I, 16.04.2014, 3 – entry into force 01.07.2014]

(5) The health insurance fund will issue a certificate concerning the receipt of documents or information at the request of the person submitting the documents or information.

(6) The following will be established by a regulation of the minister responsible for the field:
1) a list of the documents necessary for insurance cover to commence, to terminate and to be suspended, and the composition of the information contained in such documents;
2) if necessary, the procedure for recognition of documents issued in foreign states.

§ 14. Liability of persons obligated to submit documents

(1) If a person applying for insurance cover would have had the right to receive health insurance benefits if a person obligated to submit documents necessary for insurance cover to commence had performed such obligation as required, the person who violated the obligation must compensate the person applying for insurance cover for the loss incurred due to the failure to receive the health insurance benefits.

(1^1) If a person applying for insurance cover would have had the right to receive health insurance benefits if the person required to submit documents necessary for the commencement of the insurance had performed the obligation as required, the person who violated the obligation must compensate the person applying for the insurance cover for the loss suffered due to the failure to receive the health insurance benefits.
[RT I, 16.04.2014, 3 – entry into force 01.07.2014]

(2) [Repealed – RT I 2005, 39, 308 – entry into force 01.01.2006]

(3) [Repealed – RT I 2005, 39, 308 – entry into force 01.01.2006]

(4) In the event of violation of the obligation provided for in subsection 13 (1^1) of this Act, the health insurance fund has the right to recover the health insurance benefits from the person who violated the obligation, which the health insurance fund has paid for the person or to the person whose insurance cover was not terminated or suspended by the right time.
[RT I, 16.04.2014, 3 – entry into force 01.07.2014]

Division 3
Health Insurance Database and Data Protection

§ 15. Health insurance database

(1) The health insurance fund must establish a database for the purpose of performing functions relating to health insurance.

(2) The official name of the database is " *Ravikindlustuse andmekogu*" [health insurance database].

§ 16. Chief processor and authorised processor of health insurance database

(1) The chief processor of the health insurance database is the health insurance fund.

(2) The authorised processor of the health insurance database is the health insurance fund.

§ 17. Information to be entered in health insurance database

(1) The following information is entered in the health insurance database:
1) personal data;
2) information that serves as the basis for the commencement, termination or suspension of insurance cover;
3) information that serves as the basis for payment for health insurance benefits in kind;
4) information that serves as the basis for payment of pecuniary health insurance benefits.

(2) The detailed composition of the information to be entered in the health insurance database is provided by the statutes for the maintenance of the database.

(3) Courts and enforcement officers have the right to use the health insurance database in the part of personal data.
[RT I 2005, 39, 308 – entry into force 01.01.2006]

§ 18. Right to collect information

(1) In the events provided by legislation, the health insurance fund has the right to demand that insured persons and persons applying for insurance cover submit information, including sensitive personal data, in so far as such information is necessary for performance of the functions assigned to the health insurance fund by law.

(2) In the events provided by legislation, the health insurance fund has the right to demand that persons who have concluded a contract with the fund, and other persons and state and local authority agencies submit information concerning insured persons, including sensitive personal data and other information, in so far as such information is necessary for performance of the functions assigned to the health insurance fund by law.

(3) The persons specified in subsections (1) and (2) of this section cannot demand remuneration for releasing information to the health insurance fund.

(4) Information may be released to the health insurance fund without the knowledge and consent of the insured person.

(5) A person obligated to release information must perform the obligation immediately or not later than within the term granted by the health insurance fund when demanding the information, or provide written justification to the health insurance fund as to why the obligation cannot be performed as required.

(6) A person obligated to release information may refuse to release the information and contest the demand to submit the information in court or initiate intra-agency proceedings in accordance with the Administrative Procedure Act.

§ 19. Entries in health insurance database

(1) If the documents on the basis of which an entry is to be made in the health insurance database are in compliance with the requirements, the entry will be made within five calendar days after the documents arrive with the health insurance fund.

(1^1) The entries of commencement, suspension and termination of the insurance cover of the persons specified in clauses 5 (2) 1), 2), 4) and 5) of this Act are made on the basis of the data of the employment register.
[RT I, 16.04.2014, 3 – entry into force 01.07.2014]

(2) The facts contained in an entry in the health insurance database acquire legal effect as of the making of the entry, unless a different date is prescribed by law.

(2^1) [Repealed – RT I, 16.04.2014, 3 – entry into force 01.07.2014]

(3) The health insurance fund may make an entry on termination or suspension of the insurance cover of a person on its own initiative if the fund has sufficient information that the conditions of insurance of the person are not complied with and the fund has, if possible, previously ascertained the insured person's opinion. The health insurance fund must notify the insured person of the making of the entry on the same day in writing. The insured person has the right to present objections against the making of the entry within ten days after the receipt of the notice.
[RT I 2004, 56, 400 – entry into force 01.08.2004]

§ 20. Statutes for maintenance of health insurance database

(1) The statutes for the maintenance of the health insurance database will be established by the supervisory board of the health insurance fund.

(2) The statutes for the maintenance of the health insurance database set out:
1) the structure and organisational structure of the database;
2) the term for storing information in the database;
3) a list of the source documents necessary for information to be entered in the database;
4) the procedure for maintaining records on the receipt and release of information;
5) the procedure for access to and release of information and the fee payable for the release in accordance with § 22 of the Personal Data Protection Act and other legislation;
[RT I 2007, 24, 127 – entry into force 01.01.2008]
6) the procedure for the correction of inaccurate information and for giving notice of the correction;
7) the conditions and procedure for closure of access to information;
8) the bases and procedure for expansion and liquidation of the database and for combination of the database with other databases;
9) other conditions necessary for the maintenance of the database.

§ 21. Proof of insurance cover

(1) A person who is entered in the health insurance database must present an identity document in order to prove their insurance cover in Estonia. In order to prove insurance cover in other member states of the European Union, a person who is entered in the health insurance database must present the European health insurance

card or the provisional replacement certificate of the European health insurance card (hereinafter *provisional replacement certificate*).

(2) In order to prove insurance cover, a person under 15 years of age who is entered in the health insurance database may present, instead of the identity document, the European health insurance card or the health insurance card until the issue of the European health insurance card.

(3) The conditions and procedure for the issue of European health insurance cards and provisional replacement certificates will be established by a regulation of the minister responsible for the field.

(4) If a person's insurance cover is suspended or terminated, they must not use the European health insurance card or provisional replacement certificate.
[RT I 2008, 34, 210 – entry into force 01.08.2008]

Division 4
Persons Considered Equal to Insured Persons on Basis of Contract

§ 22. Persons considered equal to insured persons on basis of contract

(1) The following permanent residents of Estonia and persons residing in Estonia under a temporary residence permit or the right of residence are considered equal to insured persons on the basis of a contract:
1) persons who during the two years prior to the month of entry into the contract have been insured for at least twelve months on the grounds provided for in subsection 5 (2), (3), (3^1) or clause 5 (4) 5) of this Act, or
1^1) persons who have paid social tax for themselves or for whom social tax has been paid in the calendar year preceding the conclusion of the social tax contract on at least the twelvefold monthly amount established for the budgetary year in the state budget on the ground set out in clause 5 (2) 1), 2), 4) or 5) or subsection 5 (3) or (3^1) of this Act, or
[RT I, 11.03.2015, 2 – entry into force 21.03.2015]
2) persons receiving a pension from a foreign state, unless otherwise provided by an international agreement.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

(2) A person who complies with the requirements provided for in clause 1) of subsection (1) of this section can conclude the contract specified in subsection (1) to the benefit of their dependant who is a permanent resident of Estonia or resides in Estonia under a temporary residence permit or the right of residence.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

(3) The health insurance fund has the right, if it provides a reasoned explanation, to refuse to conclude a contract specified in subsection (1) of this section if the person has failed to duly perform contracts previously concluded with the health insurance fund or to comply with legislation regulating health insurance or if they have knowingly submitted false information to the health insurance fund.

§ 23. Application of Acts

(1) Unless otherwise provided by this Act, all the rights and obligations of insured persons provided by this Act extend to the persons considered equal to insured persons on the basis of a contract specified in subsection 22 (1) of this Act.

(2) The provisions of the Law of Obligations Act that regulate insurance contracts apply to the contracts specified in subsection 22 (1) of this Act insofar as they are not in conflict with the provisions of this Act. The provisions of the Insurance Activities Act do not apply to such contracts.
[RT I 2005, 39, 308 – entry into force 01.01.2006]

§ 24. Conditions under which person is considered equal to insured persons on basis of contract

(1) The standard conditions of the contract specified in subsection 22 (1) of this Act will be approved by the supervisory board of the health insurance fund on the proposal of the management board.

(2) The term of the contract must be at least one year.

(3) The size of an insurance premium payable in a calendar month on the basis of a contract is the product of the average gross wage of the previous calendar year as published by the Statistical Office, multiplied by 0.13 and rounded with the accuracy of 10 cents. The health insurance fund has the right to change the size of an insurance premium payable in a calendar month once a year after the Statistical Office has published the average gross wage of the previous calendar year.
[RT I 2010, 22, 108 – entry into force 01.01.2011]

(4) Insurance cover will commence one month after entry into the contract. If an insurance contract is concluded during the period of validity of the compulsory insurance cover of a person, the insurance cover

of the person will commence as of the termination of the currently valid compulsory insurance cover without interruption.

(5) [Repealed – RT I 2005, 39, 308 – entry into force 01.01.2006]

(6) [Repealed – RT I 2005, 39, 308 – entry into force 01.01.2006]

(7) The contract will terminate once the insurance cover of the compulsory insurance becomes effective or once a person considered equal under the contract or, in the event specified in subsection 22 (2) of this Act, once their dependant takes up residence abroad.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

Chapter 3
HEALTH INSURANCE BENEFIT

Division 1
General Conditions

§ 25. Definition and types of health insurance benefit

(1) Health insurance benefit is a high quality and timely health service, necessary medicinal product or medical device which is provided to an insured person under the conditions provided for in this Act by the health insurance fund or a person who has concluded a corresponding contract with the fund (benefit in kind), or a sum of money that the health insurance fund must pay to an insured person under the conditions provided for in this Act for the health care expenses incurred by the person or upon their temporary incapacity for work (pecuniary benefit).
[RT I 2008, 3, 22 – entry into force 01.09.2008]

(2) A health insurance benefit in kind is any of the following that is wholly or partially financed by the health insurance fund:
1) a health service provided to prevent or treat a disease (health service benefit);
2) a medicinal product or medical device (benefit for medicinal products and benefit for medical devices).
[RT I 2008, 3, 22 – entry into force 01.09.2008]

(3) The expenses incurred by the health insurance fund to provide benefits for medicinal products must not exceed 20 per cent of the expenses prescribed for health service benefits in the annual health insurance budget. The funds of the risk reserve provided for in § 39^1 of the Estonian Health Insurance Fund Act may be used on the basis of a decision of the supervisory board of the health insurance fund in order to cover the additional expenses incurred for benefits for medicinal products in the case of an unanticipated growth in disease contraction.

(4) A pecuniary health insurance benefit is any of the following that is paid to an insured person by the health insurance fund:
1) the benefit for temporary incapacity for work;
2) the adult dental care benefit;
3) [Repealed – RT I 2004, 89, 614 – entry into force 01.01.2005]
4) the supplementary benefit for medicinal products;
5) the benefit for a health service provided outside the waiting list;
[RT I, 29.11.2013, 1 – entry into force 09.12.2013]
6) the benefit for a cross-border health service.
[RT I, 29.11.2013, 1 – entry into force 09.12.2013]

(4^1) A pecuniary health insurance benefit will be paid to the bank account of the recipient of the benefit, which has been entered into the health insurance database or, on the basis of a written application of the recipient of the benefit, to the bank account of a third party. The account details saved in the health insurance database can be updated by the insured person via the interface of the data exchange layer of information systems (hereinafter *X-road*) or on the basis of a written application.
[RT I, 08.10.2014, 1 – entry into force 18.10.2014]

(5) An insured person does not have the right of recourse against the health insurance fund in respect of the money or other assets spent on the services, medicinal products or medical devices classified as health insurance benefits in kind.
[RT I 2008, 3, 22 – entry into force 01.09.2008]

§ 26. Right of recourse of health insurance fund

(1) The health insurance fund has the right of recourse against a person who is liable for the occurrence of an insured event due to which an insured person receives health insurance benefits, and against the insurers who are required to provide benefits in connection with that insured event.

(2) The health insurance fund has the right of recourse to the extent of a health insurance benefit paid by the fund in accordance with the procedure provided for in the State Liability Act in the case of loss caused to an insured person by a public authority through damage to health or a bodily injury.

(3) Based on § 1041 of the Law of Obligations Act, the health insurance fund has the right of recourse concerning persons who use the European health insurance card or the provisional replacement certificate of the European health insurance card after the suspension or termination of their insurance cover to the extent of the health insurance benefit paid by the fund to such persons.
[RT I 2008, 34, 210 – entry into force 01.08.2008]

(4) If a legal person specified in clause 5 (2) 4) of this Act or the other party to the contract specified in clause 5) of the same subsection is, under clause 9 (1) 2) of the Social Tax Act, required to pay for a person social tax calculated at least on the monthly rate established for least the budgetary year in the state budget and such legal person or party has failed to perform the duty at the specified rate, the health insurance fund will have the right to recover from the person or party in breach of the obligation the health insurance benefits that the health insurance fund paid for the person or to the person who lacked the right to the insurance cover during the period of entitlement to the health insurance benefit.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

(5) In the event specified in subsection (4) of this section, the health insurance fund may issue a precept along with a warning to the person or party in breach of the obligation.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

(6) In the event of failure to comply with a percept within the term set out in a warning specified in subsection (5) of this section, the health insurance fund will have the right to issue a precept for compulsory enforcement in accordance with the procedure provided in the Code of Enforcement Procedure.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

§ 27. Territorial effect of health insurance benefits

(1) Except in the events provided for in subsection (2) of this section and subsection 36 (3) of this Act, an insured person has the right to receive health insurance benefits in kind only in Estonia.

(2) If an insured person has been provided with a health service in a foreign state, the insured person may receive health service benefits in accordance with the procedure established in § 27^1 of this Act on the basis of a respective authorisation granted by the health insurance fund or a written contract concluded beforehand between the insured person or their legal representative and the health insurance fund.

(3) The health insurance fund will refuse to grant the authorisation or conclude the contract specified in subsection (2) of this section if the health service applied for can be rendered to the insured person in Estonia, but the health insurance fund does not grant the insured person monetary health insurance benefits or health insurance benefits in kind in Estonia in the event of provisions of the health service applied for.

(4) The adult dental care benefit is paid on the conditions provided for in this Act regardless of the place of provision of the service.
[RT I, 29.11.2013, 1 – entry into force 09.12.2013]

§ 27^1. Health service benefit upon provision of health service in foreign state

(1) The health insurance fund may grant the authorisation specified in subsection 27 (2) of this Act or conclude a contract specified in the same section on the basis of an application of an insured person or their legal representative if:
1) the health service applied for or an alternative health service cannot be rendered to the insured person in Estonia;
2) provision of the health service applied for is therapeutically justified with regard to the insured person;
3) the medical efficacy of the health service applied for has been proved;
4) the average probability of the aim of the health service applied for being achieved is at least 50 per cent.

(2) At least two medical specialists, one of whom is the medical specialist providing health service to the insured person, must assess the conformity of the insured person to the criteria specified in subsection (1) of this section.

(3) At the request of the health insurance fund, the insured person must undergo an additional evaluation of their state of health, which will be carried out by a doctor appointed by the health insurance fund for the purpose of identifying the conformity of the state of health of the person to the criteria specified in subsection (1) of this section.

(4) The health insurance fund may give preference to the provision of the health service applied for upon granting the authorisation or concluding the contract specified in subsection 27 (2) of this Act in a Member State of the European Union.
[RT I, 29.11.2013, 1 – entry into force 09.12.2013]

§ 28. Restrictions on receipt of health insurance benefits

(1) If a person fails to follow the medically justified treatment prescribed by a doctor or a family nurse, they will lose the right to receive health insurance benefits in connection with the case of disease for the prevention of which or against which the particular treatment was prescribed.
[RT I 2009, 67, 461 – entry into force 01.01.2010]

(2) In the events provided for in subsection (1) of this section, the health insurance fund will decide on the loss of a right to receive health insurance benefits in accordance with the procedure provided for in the Administrative Procedure Act, taking into account the specifications prescribed in this Act.

(3) Intra-agency proceedings with regard to a decision made by the health insurance fund on the basis of subsection (2) of this section may be initiated by an insured person within ten calendar days in accordance with the procedure provided for in the Administrative Procedure Act.

(4) The provisions of subsection (1) of this section do not apply if:
1) the monetary value of the health insurance benefit concerned does not justify restriction of the insured person's right to bodily self-determination;
2) application of the provisions would constitute a significant breach of the insured person's right to bodily self-determination;
3) the insured person or their legal representative has good reason for refusing to grant consent to or follow the treatment prescribed by a doctor or family nurse;
[RT I 2009, 67, 461 – entry into force 01.01.2010]
4) the health service prescribed is likely to cause a risk of serious health damage to the insured person or their death;
5) the health service prescribed causes great pain or a danger of prolonged pain to the insured person.

(5) An insured person does not have the right to receive a health insurance benefit if the need for the benefit has arisen as a result of participation in scientific research, including a clinical trial.

(6) The right to receive a health insurance benefit expires within three years as of the creation of the right unless otherwise provided by this Act.

Division 2
Health Service Benefit

Subdivision 1
Health Services

§ 29. Scope of insurance cover

(1) The health insurance fund will assume the obligation of an insured person to pay for health services if the services are entered in the list of health services of the health insurance fund and the provision thereof is therapeutically justified.

(2) Except in the events provided for in § 33 of this Act, the health insurance fund will not assume the obligation of an adult insured person to pay for dental care services.

(3) The health insurance fund must also assume an obligation of a person to pay for health services if an insured event occurring during the period of validity of the insurance cover of the person directly causes the need for emergency medical care to be provided to the person after termination of the insurance cover.

§ 30. List of health services of health insurance fund

(1) The list of health services of the health insurance fund (hereinafter *list of health services*) will be established by a regulation of the Government of the Republic on the proposal of the minister responsible for the field to which the written opinion of the supervisory board of the health insurance fund concerning the proposal is appended.

(2) The following is entered in the list of health services:
1) the name of the health service;
2) the code of the health service;
3) the reference price of the health service;
4) the limits for the payment obligation of an insured person assumed by the health insurance fund;
5) the extent of cost-sharing by an insured person;
6) the conditions for application of the reference price of the health service, the limits for the payment obligation of an insured person assumed by the health insurance fund, and the extent of cost-sharing by an insured person.

(3) The extent of cost-sharing by an insured person is that part of the reference price of a health service for which the payment obligation is not assumed by the health insurance fund. The same extent of cost-sharing applies to all insured persons and the extent must not exceed 50 per cent of the reference price of a health service.

(4) A reference price set out in the list of health services covers all expenses necessary for the provision of the health service, except for expenses on research and the training of pupils and students.

§ 31. Amendment of list of health services

(1) The following criteria are taken into account upon entry of a service in the list of health services:
1) the proven medical efficacy of the health service;
2) the cost-effectiveness of the health service;
3) the necessity of the health service in society and the compatibility of the service with national health policy;
4) correspondence to the financial resources of health insurance.

(1^1) Upon entry of a complex service in the list of health services and upon changes in information specified in clauses 30 (2) 2), 4), 5) and 6) of this Act and also upon deletion of a service from the list of health services, at least the criteria provided for in clauses 31 (1) 3) and 4) are taken into account.

(1^2) If the reference price of a health service is changed, at least the criteria provided for in clauses 31 (1) 2), 3) and 4) are taken into account.

(2) The detailed contents of the criteria provided for in subsection (1) of this Act, the persons to assess compliance with the criteria and the conditions and procedure for assessment thereof will be established by a regulation of the Government of the Republic.

(3) A health service may be entered in the list of health services subject to cost-sharing by the insured person if:
1) the aim of the provision of the health service can be achieved by other, cheaper methods which do not involve significantly greater risks or have any other significant adverse effects on the situation of the insured person;
2) the health service is directed more at improving quality of life than at treating or alleviating a disease;
3) insured persons are generally prepared to pay for the health service themselves and the decision of an insured person to conclude a contract for the provision of the health service depends primarily on the assumption of the obligation to pay for the health service by the health insurance fund or on the extent to which the payment obligation is assumed.

(4) A health service may be entered in the list of health services with a condition.

(5) The making of a proposal for amendment of the list of health services may be initiated by the associations and professional associations of interested health care providers by entering into negotiations with the health insurance fund. The making of a proposal for amendment of the list of health services may be initiated by the health insurance fund by entering into negotiations with the associations and professional associations of interested health care providers.

(6) An application submitted to the minister responsible for the field for amendment of the list of health services must contain as annexes the positions of the initiator of the amendment and of the other party to the negotiations.
[RT I 2004, 56, 400 – entry into force 01.08.2004; 1.01.2005]

§ 32. Payment to health care providers

The procedure for the assumption of a payment obligation of an insured person by the health insurance fund and the methods for calculation of the payments to be made to health care providers will be established by a regulation of the minister responsible for the field on the proposal of the supervisory board of the health insurance fund.

§ 33. Dental care benefit for insured person under 19 years of age

(1) The health insurance fund will assume a payment obligation arising from a contract for the provision of dental care services concluded by or for the benefit of an insured person under 19 years of age, on the condition that the dental care service provided is entered in the list of health services.

(2) Subsection (1) of this section applies to an insured person under 19 years of age and the provider of the dental care service must conclude a contract for the provision of dental care services with the insured person if:
1) provision of the dental care service to the insured person within one year after the person attains 19 years of age is based on therapeutic indications and if such indications were or should have been evident at the time of the insured person's last visit to the provider of the dental care service before the person attained 19 years of age;
[RT I 2008, 34, 210 – entry into force 01.08.2008]
2) provision of the dental care service to the insured person is based on therapeutic indications and if such indications have arisen from the need to treat the effects of dental care services provided to the person before they attained 19 years of age or due to the fact that the expected recovery did not occur within one year after they attained 19 years of age.
[RT I 2004, 56, 400 – entry into force 01.08.2004]

§ 34. Disease prevention

The health insurance fund participates in financing projects specifically aimed at disease prevention to the extent of the amounts prescribed for such purpose in the budget of the health insurance fund and with approval of the Ministry of Social Affairs.

Subdivision 2
Contract for Financing Medical Treatment

§ 35. Contract for Financing Medical Treatment

(1) By a contract for financing medical treatment, the health insurance fund assumes the obligation of an insured person to pay for the provision of health services under the conditions provided for in the contract and in legislation.

(2) A contract for financing medical treatment is a public law contract. The provisions of Chapter 7 of the Administrative Procedure Act together with the specifications provided by this Act apply to contracts for financing medical treatment.

§ 36. Entry into contract for financing medical treatment

(1) The health insurance fund concludes a contract for financing medical treatment with a health care provider or providers.

(2) The health insurance fund is not required to conclude a contract for financing medical treatment with all health care providers.

(3) The health insurance fund has the right to conclude a contract for financing medical treatment with health care providers located in foreign states. The reference prices and limits provided for in the list of health services apply to a contract for financing medical treatment which is concluded with a health care provider located in a foreign state if the health insurance fund undertakes to assume the obligation to pay for the provision of a health service entered in the list of health services.

(4) In order for a decision to be made on entry into a contract for financing medical treatment and on the term of the contract, the health insurance fund takes into account the following circumstances:
1) the need of the insured persons for the service, and the availability of the service;
2) the quality of and conditions for the provision of the service;
3) the price of the service;
4) the possibility of the service being provided in accordance with the standard conditions of accommodation;
5) the maximum number of health care providers providing the health service;
6) figures regarding the average density of provision of the health service;
7) developments in national health policy;
8) whether the health care provider has performed previous contracts for financing medical treatment or other similar contracts as required;
9) the existence or absence of tax arrears and the general financial situation of the health care provider;
10) compliance with legislation regulating health insurance and health by the health care provider or the employer thereof.

(4^1) The health insurance fund concludes contracts for financing medical treatment, taking into account the circumstances specified in subsection (4) of this section, with a term of at least three years.
[RT I 2004, 56, 400 – entry into force 01.04.2005]

(4^2) If the health insurance fund, taking into account the circumstances specified in subsection (4) of this section, concludes a contract for financing medical treatment with a health care provider for the first time, the contract will be concluded for a term of at least three years.
[RT I 2004, 56, 400 – entry into force 01.04.2005]

(5) The health insurance fund will conclude a contract for financing medical treatment for a term of at least five years with a person who owns a hospital specified in the development plan of the hospital network established by a regulation of the Government of the Republic in accordance with subsection 55 (1) of the Health Services Organisation Act.
[RT I 2004, 56, 400 – entry into force 01.04.2005]

(5^1) The health insurance fund will conclude a contract for financing medical treatment for a term of at least five years with a person who provides general medical care based on the approved list of family doctors.
[RT I 2009, 29, 176 – entry into force 19.06.2009]

(6) [Repealed – RT I 2004, 56, 400 – entry into force 01.04.2005]

§ 37. Conditions of contract for financing medical treatment

The following conditions will be agreed upon in a contract for financing medical treatment:
1) the term of the contract;
2) the amount of obligations of insured persons assumed by the health insurance fund during a specific period of time and the total amount of obligations, and, if necessary, amounts for each of the medical professions established by the minister responsible for the field or amounts calculated on any other basis;
3) the price payable for the provision of the health service, taking into consideration the reference price and limit provided for in the list of health services;
4) the minimum volume of health services provided;
5) a list of health care professionals who provide health services for which the payment obligation is assumed by the health insurance fund, and the procedure for giving notice of amendment of the list and for co-ordinating the amendments with the health insurance fund;
6) the number of hours in a period of time during which the health care provider must provide health services to insured persons;
7) the term during which the health care provider must submit information to the health insurance fund concerning the assumption of obligations to pay for health services provided to insured persons;
8) cases where assumption of the payment obligation of an insured person is contingent upon prior written approval from the health insurance fund;
9) cases where the parties have the right unilaterally to terminate or amend the contract or to suspend performance of the contract in part or in full;
10) the frequency with which information is to be submitted to the health insurance fund concerning waiting lists and the services provided, and the composition of the information to be submitted;
11) the procedure and term for giving notice of health services provided to insured persons outside the waiting list;
12) the scope of the reporting obligation of the health care provider and the obligation to submit information concerning insured persons, and the composition of the information to be submitted;
13) the indicators of the quality and efficacy of the health services;
14) the liability of the parties upon violation of the contract;
15) other conditions necessary for ensuring the efficient and sound use of health insurance funds.

§ 38. Waiting list

(1) A waiting list is a part of a database maintained by a health care provider which contains information concerning insured persons who are waiting for a regular health service benefit and which serves as the basis for the assumption of payment obligations by the health insurance fund.

(2) The health insurance fund will conclude contracts for financing medical treatment only with health care providers who maintain waiting lists in accordance with clause 56 (1) 4) of the Health Services Organisation Act and enable entry into contracts for provision of health service through the health information system.
[RT I 2008, 3, 22 – entry into force 01.09.2008]

(3) The maximum length of a waiting list will be approved by the supervisory board of the health insurance fund. Any extension of the maximum length of a waiting list does not apply to insured persons who have already been entered in the waiting list.

(4) The length of a waiting list may differ from one regional unit of the health insurance fund to another but must not exceed the maximum length of the waiting list.

(5) Only insured persons who, upon their entry in a waiting list, have a proven medical need for a health service may be entered in the waiting list. An insured person who no longer has a proven medical need for a health service will be deleted from the waiting list immediately. The health insurance fund has the right to examine waiting lists at any time or to demand that a waiting list be submitted for examination.

(6) An insured person has the right to obtain a health service outside the waiting list on the condition that this does not prejudice the opportunities of the insured persons in the waiting list to obtain the health service.

§ 39. Assumption of obligations

(1) The health insurance fund is deemed to have assumed an obligation to pay for the provision of a health service if, within thirty calendar days after the receipt of the documents on which assumption of the obligation is based, the health insurance fund has not notified the health care provider in writing of its refusal to assume the obligation.

(2) If there is a waiting list for a health service, the health insurance fund must assume the obligation to pay for the health service if the insured person has been on the list and waiting for the health service to be provided, together with assumption of the payment obligation by the health insurance fund, until their turn or for longer than prescribed by the maximum length of the waiting list.

(3) In the event of existence of a waiting list, the health insurance fund will not assume the obligation to pay for a health service received outside the waiting list, unless otherwise provided for in this Act or legislation established on the basis thereof.
[RT I, 29.11.2013, 1 – entry into force 09.12.2013]

(4) The assumption of an obligation to pay for the provision of a health service may be refused if:
1) provision of the heath service is unjustified or the therapeutic indications are insufficient;
2) the health service is provided to a standard below the general level of medical science;
3) the health service is not provided in conformity with the conditions provided by legislation or the contract for financing medical treatment;
4) the rights of the patient have been violated upon the provision of the health service;
5) the documents on which assumption of the obligation is based have been prepared incorrectly and the health care provider fails to eliminate the deficiencies within the term agreed upon in the contract for financing medical treatment;
6) upon provision of the health service, the health care provider violates this Act, other legislation or a contract concluded with the health insurance fund.

(5) The health insurance fund has the right and a health care provider must notify an insured person in writing within one month of the refusal of the health insurance fund to assume a payment obligation and of the reasons therefor. In the event of a violation of the notification obligation, the health care provider will lose the right to demand payment for the health service from the insured person.

(6) An insured person has the right to submit the same objections to a claim for payment submitted by a health care provider as the health insurance fund.

Division 3
Second Opinion

§ 40. Right to second opinion

(1) For the purpose of this Act, ‘second opinion’ means an independent opinion of another medical specialist who is a health service provider or a medical specialist working for another health service provider (hereinafter *provider of second opinion*), which is aimed at evaluating the correctness of the diagnose given to the insured person by the medical specialist who gave the initial opinion or the necessity of the medical product or health service prescribed to the insured person, the explained alternatives and expected impact and the risks relating to the provision of the health service.

(2) The doctor who gave the initial opinion to the insured person upon provision of a health service must send to the provider of a second opinion all the documents regarding the health services rendered to the insured person or copies thereof and give the insured person a letter referring the insured person to the provider of the second opinion.

(3) The health insurance fund will assume the obligation to pay for the second opinion once per treatment event to the extent specified in the list of the health services of the health insurance fund.

(4) On the conditions of and in accordance with the procedure provided for in § 66^2 of this Act, the health insurance fund will compensate the insured person for the expenses of giving a second opinion of a health service provider operating in another Member State of the European Union.

(5) On the conditions of and in accordance with the procedure provided for in § 66^2 of this Act, the health insurance fund will compensate the insured person for the expenses of giving a second opinion of a health service provider operating outside the European Union.

(6) In order to obtain a second opinion from a health service provider operating in Estonia who does not have a treatment financing contract with the health insurance fund and from a health service provider specified in subsection (5) of this section, the insured person or their legal representative and the health insurance fund will conclude a written contract in advance.
[RT I, 29.11.2013, 1 – entry into force 09.12.2013]

Division 4
Benefits for Medicinal Products, Supplementary Benefits for Medicinal Products and Benefits for Medical Devices

[RT I 2008, 3, 22 - entry into force 01.09.2008]

§ 41. Scope of insurance cover in case of benefits for medicinal products

(1) The health insurance fund will, to the extent and in accordance with the procedure provided by legislation, assume an obligation to pay for the retail sale of medicinal products, food for particular nutritional uses and food supplements used for treatment of congenital metabolism disorders (hereinafter *medicinal products*), which are necessary for the out-patient treatment of an insured person and are entered in the list of medicinal products of the health insurance fund (hereinafter *list of medicinal products*).
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

(1^1) The amount payable on the basis of the obligation to pay assumed by the health insurance fund is calculated based on the retail price of the medicinal product. For the purposes of this Act, the retail price of a medicinal products is the final sales price of one sales packaging of the medicinal product to the consumer, which comprises the wholesale and retail sales mark-ups of the medicinal product, value added tax and the reimbursements granted by the manufacturer or the holder of the marketing authorisation or the wholesale distributor or retailer.
[RT I 2010, 15, 77 – entry into force 01.07.2010]

(2) The health insurance fund will assume an obligation to pay for a medicinal product only if the prescription issued for the medicinal product is in compliance with the conditions and format established by a regulation of the minister responsible for the field on the basis of the Medicinal Products Act. Family doctors operating on the basis of the practice lists of the family doctors, licensed medical specialists, licensed dentists, licensed midwives, doctors (except in events of provision of emergency medical care), dentists and midwives working for a health care provider holding an activity licence for providing specialised medical care, and doctors and dentists registered with the Health Care Board and employed in the Defence Forces have the right to issue prescriptions. A doctor, dentist or midwife issuing a prescription is liable for the justification of the issue of the prescription and for the compliance of the prescription with legislation.
[RT I 2009, 49, 331 – entry into force 01.04.2010]

(3) The health insurance fund will not assume an obligation to pay for the following portions of the price of a medicinal product:
1) the basic rate of cost-sharing per prescription, and
2) in the event of a medicinal product specified in subsection 44 (3) of this Act, the amount exceeding the reference price or the price provided for in the price agreement;
[RT I, 05.07.2012, 14 – entry into force 01.10.2012]
3) in the event of a medicinal product intended for the treatment or alleviation of a disease entered in the list of diseases established on the basis of subsection 44 (1) or (2) of this Act, the amount exceeding the reference price or the price provided for in the price agreement;
4) in the case of a medicinal product specified in subsection 44 (4^1) of this Act, the amount exceeding the reference price or the price provided for in the price agreement;
[RT I 2004, 56, 400 – entry into force 01.08.2004]

(4) The amount payable based on the payment obligation assumed by the health insurance fund is calculated in the event of the medicinal products specified in subsection 44 (3) of this Act in accordance with the reimbursement percentage specified in the list of medicinal products from the difference between the reference price or the price specified in the price agreement and the basic rate of cost-sharing.
[RT I, 05.07.2012, 14 – entry into force 01.10.2012]

(5) The amount payable based on the payment obligation assumed by the health insurance fund is calculated in the event of the medicinal products specified in subsections 44 (1) and (2) of this Act in accordance with the reimbursement percentage specified in the list of medicinal products from the difference between the reference price or the price specified in the price agreement and the basic rate of cost-sharing.
[RT I, 05.07.2012, 14 – entry into force 01.10.2012]

(6) The amount payable based on the payment obligation assumed by the health insurance fund is calculated in the event of the medicinal products specified in subsection 44 (4) of this Act in accordance with the reimbursement percentage specified in subsection 44 (4) from the difference between the reference price or the price specified in the price agreement and the basic rate of cost-sharing.
[RT I, 05.07.2012, 14 – entry into force 01.10.2012]

(6^1) The amount payable based on the payment obligation assumed by the health insurance fund is calculated in the event of the medicinal products specified in subsection 44 (4^1) of this Act in accordance with the reimbursement percentage specified in subsection 44 (4^1) from the difference between the reference price or the price specified in the price agreement and the basic rate of cost-sharing.
[RT I 2010, 15, 77 – entry into force 01.07.2010]

(7) If the retail price of a medicinal product is lower than the reference price or the price specified in the price agreement, the amount payable on the basis of a payment obligation assumed by the health insurance fund will be calculated on the basis of the difference between the retail price and the basic rate of cost-sharing.

(8) With good reason and taking into account the criteria provided for in subsections 43 (2) and 44 (5) and (6) of this Act, the health insurance fund may, at the written request of an insured person or the legal representative thereof to which the written opinion of the doctor treating the insured person has been annexed, assume the obligation to pay a portion of the retail price of a medicinal product, except for the basic rate of cost-sharing, if the medicinal product concerned is necessary for the out-patient treatment of the insured person and is entered in the list of medicinal products or has a single authorisation for import and use.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

§ 42. Reference price, price agreement and basic rate of cost-sharing

[RT I, 05.07.2012, 14 – entry into force 01.10.2012]

(1) A reference price is the price that serves as the basis for assumption of the payment obligation for medicinal products that have the same active substance and route of administration and that are entered in the list of medicinal products.
[RT I 2010, 15, 77 – entry into force 18.04.2010]

(1^1) Reference prices are established for medicinal products if another medicinal product with the same active substance and route of administration is entered in the list of medicinal products with a reimbursement rate of 100, 75 or 50 per cent from another manufacturer or marketing authorisation holder of the medicinal product or two or more medicinal products with the same active substance and route of administration from at least two manufacturers are entered in the list at the same time.
[RT I 2010, 15, 77 – entry into force 01.07.2010]

(1^2) The wholesale purchase price of a medicinal product to which the maximum valid gross margins for wholesale and retail trade and the value added tax are added (hereinafter *maximum retail price*) is the basis for the calculation of a reference price. The calculation of reference prices for two medicinal products is based on the medicinal product the price of which is lower. In the case of three or more medicinal products, reference prices are calculated on the basis of the price of the medicinal product with the next lowest price after the medicinal product with the lowest price.
[RT I 2004, 56, 400 – entry into force 01.01.2005]

(1^3) A person holding an activity licence for the wholesale trade of medicinal products and a person engaged in the wholesale trade of medicinal products holding an activity licence for the manufacture of medicinal products are required to communicate the wholesale purchase prices of all medicinal products to the minister responsible for the field. The persons who communicate the wholesale purchase prices of medicinal products, and the conditions and procedure for the communication will be established by a regulation of the minister responsible for the field.
[RT I 2004, 56, 400 – entry into force 01.08.2004]

(2) The method for the calculation of reference prices, the terms for the establishment and the conditions and terms for the amendment of reference prices will be established by a regulation of the minister responsible for the field, taking into account the provisions of subsection 25 (3) of this Act.
[RT I 2004, 56, 400 – entry into force 01.01.2005]

(2^1) The reference prices of medicinal products will be established by a regulation of the minister responsible for the field.
[RT I 2004, 56, 400 – entry into force 01.01.2005]

(3) If the price level of a medicinal product is lower than or equal to the reference price or if only one medicinal product with a given active substance and route of administration has been issued a valid marketing authorisation in Estonia, the price of the medicinal product will be established by a price agreement.
[RT I 2004, 56, 400 – entry into force 01.01.2005]

(4) A price agreement is a public law contract that is concluded for each particular case between the minister responsible for the field and a manufacturer of medicinal products or a person holding marketing authorisation for a medicinal product and which determines the wholesale purchase price of a medicinal product with a retail price lower than or equal to the reference price or a medicinal product to which a reference price does not apply, and for which the reimbursement rate is 100, 75 or 50 per cent.
[RT I 2010, 15, 77 – entry into force 01.07.2010]

(5) The basic rate of cost-sharing will be established by a regulation of the minister responsible for the field, taking into account, among other things, the principle provided for in subsection 25 (3) of this Act.
[RT I, 05.07.2012, 14 – entry into force 01.10.2012]

(6) Information concerning the valid reference prices and prices determined by price agreements will be available for the consumers of health services on the web pages of the Ministry of Social Affairs and the health insurance fund, at pharmacies and at health care providers who issue prescriptions.

§ 43. List of medicinal products

(1) The list of medicinal products will be established by a regulation of the minister responsible for the field.

(2) The following criteria are taken into account upon establishment of the list of medicinal products:
1) the need of an insured person to obtain a medicinal product as a result of the provision of a health service;
2) the proven medical efficacy of a medicinal product and the need of an insured person to obtain other medicinal products in the course of their treatment;
3) the economic justification of the use of a medicinal product;
4) the existence of alternative medicinal products or means of treatment;
5) conformity with the financial resources of health insurance and with the principle provided for in subsection 25 (3) of this Act.

(3) The procedure for drawing up and amending the list of medicinal products, the detailed contents of the criteria provided for in subsection (2) of this section and the persons to assess compliance with the criteria will be established by a regulation of the minister responsible for the field.

(4) Only medicinal products which have been issued valid marketing authorisations in Estonia may be entered in the list of medicinal products.
[RT I 2004, 56, 400 – entry into force 01.08.2004]

(5) The following information is entered in the list of medicinal products:
1) the active substances and the Anatomical Therapeutic Chemical codes (ATC codes) of the medicinal products;
2) pharmaceutical preparations;
3) the manufacturers of the medicinal products;
4) diseases in the case of which medicinal products containing an active substance intended for the treatment or alleviation of the disease are sold at a reimbursement rate of 100 per cent;
5) diseases in the case of which medicinal products containing an active substance intended for the treatment or alleviation of the disease are sold at a reimbursement rate of 75 per cent;
[RT I 2004, 56, 400 – entry into force 01.08.2004]
6) the reimbursement rates for the pharmaceutical forms, strengths and packaging of medicinal products;
7) code of the medicinal product.
[RT I 2010, 15, 77 – entry into force 18.04.2010]

(5^1) The data specified in clauses 4) to 7) of subsection (5) of this section is binding, while the data specified in clauses 1) to 3) is informative.
[RT I 2010, 15, 77 – entry into force 18.04.2010]

(6) A medicinal product may be entered in the list of medicinal products with a condition the objective of which is to:
1) ensure that the entry in the list of medicinal products enters into force after a price agreement is concluded or a reference price is established;
2) ensure that the medicinal product is deleted from the list of medicinal products upon termination of the price agreement;
3) establish a lower reimbursement rate for a certain pharmaceutical form, strength or packaging of the same medicinal product;
4) restrict a right to issue prescriptions for medicinal products, imposed in the interests of the health of insured persons or in order to ensure that the issue of prescriptions for medicinal products is justified;
5) ensure the efficient and sound use of health insurance funds.

§ 44. Reimbursement rates for medicinal products

(1) A list of the diseases in the case of which a medicinal product intended for the treatment or alleviation of the disease is, upon the existence of a valid reference price or price agreement, subject to entry in the list of medicinal products with a 100 per cent reimbursement rate will be established by a regulation of the Government of the Republic on the proposal of the minister responsible for the field.

(2) A list of the diseases in the case of which a medicinal product intended for the treatment or alleviation of the disease is, upon the existence of a valid reference price or price agreement, subject to entry in the list of medicinal products with a 75 per cent reimbursement rate will be established by a regulation of the Government of the Republic on the proposal of the minister responsible for the field. Upon sale of medicinal products entered in the list of medicinal products with a reimbursement rate of 75 per cent, the 90 per cent reimbursement rate applies to children between 4 and 16 years of age and persons receiving a pension for incapacity for work or an old-age pension on the basis of the State Pension Insurance Act and insured persons over 63 years of age.

(3) Medicinal products that are not intended for the treatment or alleviation of diseases specified in a list of diseases established on the basis of subsection (1) or (2) of this section may be entered in the list of medicinal products with a 50 per cent reimbursement rate.
[RT I, 05.07.2012, 14 – entry into force 01.10.2012]

(4) If a medicinal product that is entered in the list of medicinal products with a reimbursement rate of 100, 75 or 50 per cent is not used for the treatment or alleviation of diseases specified in a list of diseases established on the basis of subsection (1) or (2) of this section, a 50 per cent reimbursement rate will be deemed to be applicable to the medicinal product, taking into account the conditions established on the basis of subsection 43 (6) of this Act.
[RT I, 05.07.2012, 14 – entry into force 01.10.2012]

(4^1) In the event of medicinal products entered in the list of medicinal products, the 100 per cent reimbursement rate applies to children under 4 years of age.

(5) The Government of the Republic will establish the list of diseases specified in subsection (1) of this section on the basis of the following criteria:
1) the gravity and life-threatening nature of a disease;
2) the possibility of a disease spreading epidemically;
3) the need to ease the pain caused by a disease, and other humane considerations;
4) conformity with the financial resources of health insurance and with the principle provided for in subsection 25 (3) of this Act.

(6) Upon establishment of the list of diseases specified in subsection (2) of this section, the Government of the Republic will, in addition to the criteria provided for in subsection (5) of this section, take into consideration the objective to ensure the treatment or alleviation of chronic diseases which severely impair the quality of life.

(7) A disease will not be entered in a list of diseases specified in subsection (1) or (2) of this section if the disease can be treated by other, cheaper methods which do not involve significantly greater risks or have any other significant adverse effects on the situation of the insured person.

(8) A disease may be entered in the list of diseases with a condition the objective of which is to take into account the needs arising from gender, age or medical reasons.
[RT I 2004, 56, 400 – entry into force 01.08.2004]

§ 45. Entry into price agreement

(1) The interest of insured persons to obtain necessary medicinal products at a reasonable price, the budgetary funds of the health insurance fund which are prescribed for the assumption of obligations to pay for medicinal products, and the principle provided for in subsection 25 (3) of this Act will be taken into account upon entry into and amendment of a price agreement.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

(2) The following conditions will be agreed upon in a price agreement:
1) the wholesale purchase price of a medicinal product in euros by each pharmaceutical form, active substance content and packaging subject to a 100, 75 or 50 per cent reimbursement rate;
[RT I 2010, 22, 108 – entry into force 01.01.2011]
2) the estimated retail sale volume of the medicinal product during the term of validity of the price agreement if the medicinal product is the only medicinal product with a given active substance and route of administration entered in the list of medicinal products with a reimbursement rate of 100, 75 or 50 per cent;
[RT I 2010, 15, 77 – entry into force 01.07.2010]
3) the term during which amendment of the price agreement by the parties is prohibited;

4) the conditions whereby a party has the right to demand that the price agreement be amended in addition to the provisions of subsection (3^1) of this section;
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]
5) the due date by which the parties are required to submit requests for amendment of the price agreement in order to prevent automatic extension of the term of validity of the price agreement;
6) the term during which the manufacturer of a medicinal product must sell the medicinal product on the Estonian market and the health insurance fund must assume the obligations of insured persons to pay for the medicinal product under the currently applicable conditions if the parties do not reach an agreement concerning amendment of the price;
7) other conditions and obligations necessary for ensuring the efficient and sound use of health insurance funds and compliance with the conditions of the price agreement.

(3) A proposal for a price agreement to be concluded will be made to the Ministry of Social Affairs by a manufacturer of a medicinal product or a person holding marketing authorisation for a medicinal product. The Ministry of Social Affairs may initiate the proceedings for conclusion of a price agreement.
[RT I 2010, 15, 77 – entry into force 18.04.2010]

(3^1) If a medicinal product is the only medicinal products with the same active substance and manner of administration entered in the list of medicinal products and if the price set out in a price agreement exceeds the highest price effective in the Member States of the European Union, as specified in the regulation established on the basis of subsection 45 (6) of this Act, the Ministry of Social Affairs or the manufacturer will submit a request to amend the price agreement for the purpose of changing the price.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

(4) [Repealed – RT I 2010, 15, 77 – entry into force 18.04.2010]

(5) [Repealed – RT I 2010, 15, 77 – entry into force 18.04.2010]

(5^1) If no agreement is reached on the conditions for entry into or amendment of a price agreement during a reasonable period of time, the Ministry of Social Affairs will, in accordance with the procedure established subsection 43 (3) of this Act, initiate proceedings for the exclusion of the medicinal product from the list of medicinal products.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

(5^2) As of the termination of a price agreement, given the time-limit specified in clause 6) of subsection (2) of this Act, or from the annulment of the reference price of a medicinal product until the exclusion of the medicinal product from the list or until the conclusion of a price agreement, the maximum retail price in force in the Member States of the European Union specified in the regulation established on the basis of subsection 45 (6) of this Act, which is calculated on the basis of the wholesale purchase price and is effective at the time of submission of the request for amendment or conclusion of the price agreement will be deemed by the health insurance fund as the price of the price agreement of the medicinal product upon taking over the obligation to pay for the sale of the medicinal product.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

(6) The procedure for entry into price agreements will be established by a regulation of the minister responsible for the field.

§ 46. Assumption of obligations to pay for sale of medicinal products

(1) The retailer of a medicinal product will submit to the health insurance fund an invoice for the sale of the medicinal product for the purpose of assumption of the obligation to pay to the extent and on the conditions provided for in this Act via the Digital Prescription Centre specified in § 81 of the Medicinal Products Act. An obligation is deemed as assumed by the health insurance fund if the health insurance fund has not, within 30 calendar days as of the submission of the invoice, refused to assume the obligation to pay for the medicinal products indicated on the invoice.
[RT I 2010, 15, 77 – entry into force 18.04.2010]

(2) The health insurance fund may refuse to assume an obligation to pay for the sale of a medicinal product if, upon the sale of the medicinal product, the requirements for the sale of the medicinal product were violated.

§ 47. Supplementary benefit for medicinal products

(1) The health insurance fund will additionally compensate for justified and certified amounts starting from 300 euros which were paid during the calendar year for medicinal products entered in the list of medicinal products and necessary for the out-patient treatment of an insured person (hereinafter *supplementary benefit for medicinal products*).
[RT I, 13.12.2014, 1 – entry into force 01.01.2015]

(2) The size of the supplementary benefit for medicinal products will be calculated by the health insurance fund on the basis of an application by an insured person or their legal representative according to the information in the health insurance database.

(3) The amounts paid by the health insurance fund, the basic rate of cost-sharing and the amounts exceeding a reference price or a price established in a price agreement will not be taken into account upon calculation of the supplementary benefit for medicinal products.

(4) If an amount calculated in accordance with subsection (3) of this section is 300 to 500 euros, the health insurance fund will compensate 50 per cent of the portion exceeding 300 euros.
[RT I, 13.12.2014, 1 – entry into force 01.01.2015]

(5) If an amount calculated in accordance with subsection (3) of this section exceeds 500 euros, the health insurance fund will, in addition to the amount calculated in accordance with subsection (4) of this section, compensate 90 per cent of the portion exceeding 500 euros.
[RT I, 13.12.2014, 1 – entry into force 01.01.2015]

(6) [Repealed – RT I, 13.12.2014, 1 – entry into force 01.01.2015]

(7) The detailed procedure for application for and payment of the supplementary benefit for medicinal products will be established by a regulation of the minister responsible for the field.

§ 48. Scope of insurance cover in case of benefits for medical devices

(1) The health insurance fund will, to the extent and in accordance with the procedure provided by legislation, assume an obligation to pay for the medical devices which are necessary for an insured person and are entered in the list of medical devices of the health insurance fund (hereinafter *list of medical devices*).

(2) For the purposes of this Act, a medical device is an instrument, apparatus or device, or a material or other product that an insured person, as a member of the general public, can use separately or in combination for one or more purposes determined by the manufacturer and whose intended main effect to the insured person is neither pharmacological, immunological nor metabolic and that is needed for:
1) monitoring, alleviating or treatment of a disease;
2) alleviating or treatment of an injury.

(2^1) For the purposes of this Act, 'medical device' also means a skin care device used for the treatment of a skin disease involving a congenital disorder of the horny layer of the skin.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

(3) The following is not regarded as a medical device for the purposes of this Act:
1) a surgically invasive device;
2) an implantable device;
3) an active device for diagnostics.

(4) The list of medical devices and the procedure for assumption of the obligation to pay for medical devices entered in the list of medical devices will be established by a regulation of the minister responsible for the field on proposal of the supervisory board of the health insurance fund.

(5) The following information is entered in the list of medical devices:
1) the name of the group of medical devices;
2) code of the medical device;
3) name of the medical device:
4) number of medical devices in the sales packaging;
5) reference price of the medical device or sales packaging of medical devices which will be the retail price agreed upon in the price agreement;
6) the limits for the payment obligation of an insured person assumed by the health insurance fund;
7) the extent of cost-sharing by an insured person;
8) the conditions for application of the reference price of the medical device or sales packaging of medical devices, the limits for the payment obligation of an insured person assumed by the health insurance fund, and the extent of cost-sharing by an insured person.

(6) The limits for the payment obligation of an insured person assumed by the health insurance fund will be 90 % or 50 % of the reference price of the medical device or sales packaging of the medical device entered in the list of medical devices, except in the case specified in subsection 48^1(3) of this Act. The limit for the payment obligation of an insured person assumed by the health insurance fund will be 50 % if there is an alternative method of treatment cheaper than the reference price of the medical device or sales packaging of the medical device, or a cheaper medical device belonging to another group of medical devices or another cheaper medical device available in Estonia.

(7) For the purposes of this Act, a group of medical devices joins medical devices with the same effect and intended purpose in the list of medical devices.

(8) Only medical devices with regard to which the health insurance fund and the manufacturer or the representative thereof have concluded a price agreement may be entered in the list of medical devices.

(9) A medical device may be entered in the list of medical devices with a condition with the objective to regulate the prescription of the medical device, taking into account the criteria provided in subsection 48^1(1) of this Act.
[RT I 2008, 34, 210 – entry into force 01.09.2008]

§ 48^1. Amendment of list of medical devices

(1) The following criteria are taken into account upon entry of medical devices in the list of medical devices or deletion of medical devices from such list:
1) the existence of medically justified indications for the use of the medical device by the general public and existence of alternative medical devices or treatment methods;
2) the optimal quantity of medical devices needed for treatment based on the diagnosis, severity of the disease or other circumstances influencing the course of treatment;
3) correspondence to the funds of health insurance, including the existence of another public source of financing;
4) cost effectiveness of the medical device;
5) conformity of the medical device with the Medical Devices Act, except in the event of a medical device specified in subsection 48 (2^1) of this Act.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

(2) Upon amendment of the reference price that is the basis for assumption by the health insurance fund of an obligation of an insured person to pay for a medical device, the criteria provided in clauses (1) 2) and 3) of this section are taken into account.

(3) If, in the list of medical devices, there are two comparable medical devices in a group of medical devices then, beginning from the third medical device entered in the list of medical devices, the basis for assumption by the health insurance fund of the payment obligation will be the reference price of the comparable medical device that comes second in the list with regard to its reference price.

(4) The possibility to use, instead of a medical device, an alternative method of treatment that is cheaper than the reference price of the medical device, a cheaper medical device belonging to another group of medical devices or a cheaper medical device available in Estonia will be assessed by a relevant association of medical specialists.

(5) The detailed contents of the criteria provided for in subsection (1) of this Act, the persons to assess compliance with the criteria and the procedure for assessment thereof will be established by a regulation of the minister responsible for the field.

(6) The manufacturer of a medical device or an authorised representative of the manufacturer may initiate a proposal for amendment of the list of medical devices by entering into negotiations with the health insurance fund. The Health Board or the health insurance fund may initiate a proposal for amendment of the list of medical devices by entering into negotiations with the manufacturer of a medical device or an authorised representative of the manufacturer. The applicant will make public all the circumstances known thereto which are relevant to the negotiations.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

§ 49. Assumption of obligation to pay for medical devices and contracts with sellers

[RT I 2008, 34, 210 – entry into force 01.09.2008]

(1) The retailer of a medical device will submit to the health insurance fund an invoice for the sale of the medical device for the purpose of assumption of the obligation to pay to the extent and on the conditions provided for in this Act via the Digital Prescription Centre specified in § 81 of the Medicinal Products Act. An obligation is deemed as assumed by the health insurance fund if the health insurance fund has not, within 45 calendar days as of the submission of the invoice, refused to assume the obligation to pay for the medical device indicated on the invoice.
[RT I 2010, 15, 77 – entry into force 18.04.2010]

(2) The seller of a medical device, except for a pharmacy, will conclude a contract with the health insurance fund in which the following conditions are agreed upon:
1) the term of the contract;
2) the circumstances under which a party has the right to terminate the contract unilaterally;
3) a term shorter than the term specified in subsection (1) of this section;
4) the circumstances under which assumption of an obligation is contingent upon prior written approval from the health insurance fund;
5) the scope of the reporting obligation of the seller of the medical device and the obligation to submit information concerning insured persons to the health insurance fund, and the composition of the information to be submitted;

6) other conditions necessary for ensuring the efficient and sound use of health insurance funds.
[RT I 2008, 34, 210 – entry into force 01.09.2008]

(3) Assumption of an obligation to pay for the sale of a medical device may be refused if the sale of the medical device is not in conformity with the provisions of legislation or of a contract concluded with the health insurance fund.
[RT I 2008, 34, 210 – entry into force 01.09.2008]

Division 5
Pecuniary Benefits

Subdivision 1
Benefit for Temporary Incapacity for Work

§ 50. Benefit for temporary incapacity for work, types thereof and events of payment

[RT I, 02.07.2012, 8 – entry into force 01.08.2012]

(1) Benefit for temporary incapacity for work is financial compensation paid by the health insurance fund to an insured person on the basis of a certificate of incapacity for work in cases where the person does not receive income subject to individually registered social tax due to a temporary release from the their duties or economic or professional activity.

(1^1) The benefit for temporary incapacity for work is paid to a person insured on the basis of subsection 5 (3^1) of this Act if a deletion entry or an entry on suspension of operations has not been made in the commercial register with regard to a self-employed person who pays social tax or if a deletion entry has not been made in the register of taxable persons with regard to the spouse participating in the undertaking of a self-employed person by the start date of release from work specified on their certificate of incapacity for work.
[RT I, 02.07.2012, 8 – entry into force 01.08.2012]

(2) The benefit for temporary incapacity for work will not be paid to persons covered by insurance on the grounds specified in clauses 5 (2) 3) and 6) or subsection 5 (4) of this Act or to persons considered equal to insured persons on the basis of a contract.

(3) The types of the benefit for temporary incapacity for work are:
1) sickness benefit;
2) maternity benefit;
3) adoption benefit;
4) care benefit.
[RT I 2004, 56, 400 – entry into force 01.08.2004]

§ 51. Insured event of temporary incapacity for work

(1) Sickness benefit is paid to an insured person in the case of the following insured events:
1) a disease or injury of the insured person in respect of which the doctor or dentist treating the person has diagnosed that the person is temporarily unable to work in their position or continue to perform their duties or their economic or professional activity due to the disease or injury;
2) quarantine established with regard to the insured person;
3) provision of the insured person with work corresponding to their state of health on the basis of subsection 18 (1) of the Employment Contracts Act or the temporary easing of service conditions on the basis of subsection 48 (1) of the Public Service Act;
[RT I, 06.07.2012, 1 – entry into force 01.04.2013]
4) the refusal of the insured person from work on the basis of subsection 18 (2) of the Employment Contracts Act or the temporary release of the insured person from the performance of service duties on the basis of subsection 48 (2) of the Public Service Act;
[RT I, 06.07.2012, 1 – entry into force 01.04.2013]
5) the removal of an organ or blood stem cells from the insured person in order to transfer the organ or the cells to another person for treatment purposes whereby the treating doctor has diagnosed that the person is temporarily unable to work in their position or continue to perform their duties or their economic or professional activity due to such removal.
[RT I, 26.02.2015, 1 – entry into force 01.03.2015]

(2) The insured event in respect of which maternity benefit is paid to an insured person is the pregnancy and maternity leave of the insured person. Maternity benefit is paid to persons specified in clauses 5 (2) 4) or 5) or subsections 5 (3) and (3^1) of this Act without pregnancy and maternity leave.
[RT I, 02.07.2012, 8 – entry into force 01.08.2012]

(3) The insured event in respect of which adoption benefit is paid to an insured person is the adoptive parents leave of the insured person. Adoption benefit is paid to persons specified in clauses 5 (2) 4) or 5) or subsections 5 (3) and (3^1) of this Act without adoptive parents leave.
[RT I, 02.07.2012, 8 – entry into force 01.08.2012]

(4) The care benefit is paid to an insured person in respect of the following insured events:
1) nursing a child of under 12 years of age;
2) nursing a family member who is ill at home;
3) caring for a child of under three years of age or for a disabled child of under 16 years of age when the person caring for the child is themselves ill or is receiving obstetrical care.

§ 52. Certificate of incapacity for work

(1) A certificate of incapacity for work is a document certifying the temporary incapacity for work of an insured person and their temporary release from the performance of their duties, which the doctor or dentist treating the person or the midwife providing the service issues to the insured person electronically and which, upon termination of the certificate of incapacity for work, is immediately sent to the health insurance database via the X-road interface.
[RT I, 08.10.2014, 1 – entry into force 18.10.2014]

(1^1) A certificate of incapacity for work may be issued on paper if the data cannot be sent to the health insurance database via the X-road interface due to technical reasons. In such an event the issuer of the certificate of incapacity for work will sent the details of the certificate to the health insurance database via the X-road interface as soon as possible.
[RT I, 08.10.2014, 1 – entry into force 18.10.2014]

(2) Family doctors operating on the basis of the practice lists of the family doctors, licensed medical specialists, licensed dentists and licensed midwives, and doctors (except in cases of the provision of emergency medical care), dentists and midwives working for a health care provider holding an activity licence for providing specialised medical care have the right to issue certificates of incapacity for work. The issuer of a certificate of incapacity for work is liable for the correct assessment of the insured event of temporary incapacity for work and for ensuring that the temporary incapacity for work is justified.
[RT I, 08.10.2014, 1 – entry into force 18.10.2014]

(2^1) A midwife has the right to issue a certificate of temporary incapacity for work only for the purpose of the temporary easing of the working conditions of a pregnant woman or for the temporary transfer of a pregnant woman to a different job under subsections 18 (1) and (2) of the Employment Contracts Act and for the temporary easing of the service conditions of a pregnant woman under § 48 of the Public Service Act and in the event of the pregnancy and maternity leave of a person.
[RT I, 06.07.2012, 1 – entry into force 01.04.2013]

(3) The types of certificate of incapacity for work are certificates for sick leave, certificates for maternity leave, certificates for adoption leave and certificates for care leave.

(4) The composition of the data of the certificate of incapacity for work, the paper form of the certificate as well as the conditions and procedure for the registration and issue of the certificate and forwarding the certificate to the health insurance fund will be established by a regulation of the minister responsible for the field.
[RT I, 08.10.2014, 1 – entry into force 18.10.2014]

§ 53. Procedure for grant and payment of benefit for temporary incapacity for work

(1) The benefit for temporary incapacity for work is paid on the basis of a certificate of incapacity for work. If an insured event specified in clause 51 (1) 1) or subsections 51 (2)-(4) of this Act occurs when the insured person is in a foreign state, the certificate of incapacity for work is replaced by a paper certificate issued by the doctor or dentist who treated the person in the foreign state. On request of the health insurance fund, the certificate must be accompanied by a translation into Estonian prepared by a person specified in subsection 2 (1) of the Sworn Translators Act; the costs of such translation must be covered by the insured person.
[RT I, 08.10.2014, 1 – entry into force 18.10.2014]

(1^1) [Repealed – RT I, 08.10.2014, 1 – entry into force 18.10.2014]

(2) [Repealed – RT I 2009, 15, 93 – entry into force 01.07.2009]

(3) [Repealed – RT I, 08.10.2014, 1 – entry into force 18.10.2014]

(3[1]) The insured person must inform the employer of the termination of the certificate of incapacity for work as soon as possible.
[RT I, 08.10.2014, 1 – entry into force 18.10.2014]

(4) The employer of the insured person or the self-employed person must make their entries in the certificate of incapacity for work within seven calendar days as of learning of the termination of the certificate from the insured person.
[RT I, 08.10.2014, 1 – entry into force 18.10.2014]

(5) The benefit will be granted and paid if the employer of the insured person or the self-employed person has made their entries in the electronic certificate of incapacity for work via the X-road interface not later than by the 90th calendar day after the date specified in the certificate when the insured person commended the performance of employment or service duties or resumed economic or professional activities or participation in the activities of the undertaking of the self-employed person. The benefit will not be granted or paid if the entries were not made in the certificate of incapacity for work within the time limit provided for in this subsection.
[RT I, 08.10.2014, 1 – entry into force 18.10.2014]

(5[1]) If the insured person submits to the employer or the self-employed person a certificate of incapacity for work on paper, the employer or the self-employed person will make their entries in the respective electronic certificate of incapacity for work of the insured person via the X-road interface within seven calendar days after the date of receipt of the paper certificate from the insured person.
[RT I, 08.10.2014, 1 – entry into force 01.01.2015]

(5[2]) If the insured person submits to the employer or the self-employed person the paper certificate issued by a doctor or dentist who treated the person abroad (hereinafter *certificate*), the employer or the self-employed person will, within seven days after the date if receipt of the certificate from the insured person, submit to the health insurance fund the certificate and other documents required for granting and payment of the benefit.
[RT I, 08.10.2014, 1 – entry into force 01.01.2015]

(5[3]) The insured person may submit to the health insurance fund the certificate and other documents necessary for the granting and payment of the benefit themselves.
[RT I, 08.10.2014, 1 – entry into force 01.01.2015]

(5[4]) The benefit will be granted and paid on the basis of the certificate if:
1) the insured person's certificate along with other documents required for granting and paying the benefit has been submitted to the health insurance fund not later than by the 90th calendar days following the date of commencement of the employment or service duties or resuming the economic or professional activities, or
2) the insured person's certificate along with other documents required for granting and paying the benefit has been submitted to the health insurance fund not later than by the 90th calendar days following the date of resuming participation in the activities of the undertaking of the self-employed person.
[RT I, 08.10.2014, 1 – entry into force 01.01.2015]

(5[5]) The benefit will not be granted or paid if the certificate was not submitted within the time limit provided for in subsection 54 of this section.
[RT I, 08.10.2014, 1 – entry into force 01.01.2015]

(6) The health insurance fund will pay the benefit for temporary incapacity for work within 30 calendar days following the date when the employer of the insured person or the self-employed person has made the required entries in the electronic certificate of incapacity for work or if, in the event of the certificate, the properly compiled documents have reached the health insurance fund. In the event of a delay in payment, the health insurance fund must pay a fine for delay in accordance with law.
[RT I, 08.10.2014, 1 – entry into force 01.01.2015]

(7) The composition of the documents and information necessary for the grant and payment of the benefit for temporary incapacity for work, and the procedure for the grant and payment thereof will be established by a regulation of the minister responsible for the field.

§ 54. Size of benefit for temporary incapacity for work

(1) The health insurance fund will pay the benefit for temporary incapacity for work to an insured person per calendar day as a percentage of their average income per calendar day, as follows:
1) 70 per cent in the event of refusal from the provision of in-patient and out-patient health services and from work that does not correspond to the state of health and in the event of the temporary release from the performance of service duties and in the event of a quarantine;
[RT I 2009, 35, 232 – entry into force 01.07.2009]

1[1]) 80 per cent in the event of taking care of a child of under three years of age or of a disabled child of under 16 years of age if the person providing care is ill or being provided with childbirth assistance, is taking care of an ill family member at home or if a child of under 12 years of age is treated in a hospital or at home;
[RT I 2009, 35, 232 – entry into force 01.07.2009]
2) [Repealed – RT I 2009, 35, 232 – entry into force 01.07.2009]
3) [Repealed – RT I 2009, 35, 232 – entry into force 01.07.2009]
4) 100 per cent in the event of pregnancy and maternity leave;
5) 100 per cent in the event of adoptive parents leave;
6) 100 per cent in the event of an illness or injury caused as a result of an occupational disease or an accident at work;
[RT I 2004, 56, 400 – entry into force 01.08.2004]
7) 100 per cent in the event of preventing a criminal offence, protecting national or public interests or saving a human life;
8) 100 per cent in the event of the removal of an organ or blood stem cells in order to transfer the organ or cells to another person for treatment purposes.
[RT I, 26.02.2015, 1 – entry into force 01.03.2015]

(2) Upon calculation of the amount of the benefit, the sum is rounded with the accuracy of one cent.
[RT I 2010, 22, 108 – entry into force 01.01.2011]

(3) If an employee has been provided with work corresponding to their state of health on the basis of subsection 18 (1) of the Employment Contracts Act or their service conditions have been temporarily eased on the basis of subsection 48 (1) of the Public Service Act, the health insurance fund will pay the insured person the benefit in such an amount that the benefit along with the wage or salary to be received for the period (hereinafter *wage*) divided by the calendar days of the period is equal to the average income of the insured person per calendar day.
[RT I, 06.07.2012, 1 – entry into force 01.04.2013]

§ 55. Calculation of average income per calendar day

(1) Average income per calendar day is calculated on the basis of the information concerning social tax calculated or paid to the insured person, as submitted by the Tax and Customs Board, and the information certifying the right to receive the benefit as submitted by the persons specified in clauses 5 (2) 1), 2), 4) or 5) and subsections 5 (3) and (3[1]) of this Act. Social tax paid by the state, rural municipality, city or artistic association under clauses 6 (1) 1) to 3) and 6) to 13) and subsections (1[1]) and (1[2]) of the same section of the Social Tax Act is not taken into account upon calculating the average income per calendar day.
[RT I, 10.01.2014, 2 – entry into force 20.01.2014]

(2) The average income of a person insured on the basis of clause 5 (2) 1) or 2) of this Act per calendar day is deemed to be equal to the income calculated on the basis of the social tax calculated for the insured person during the calendar year preceding the calendar year of the date on which release from the performance of their duties commenced as specified in the certificate of incapacity for work, divided by 365.
[RT I 2009, 29, 176 – entry into force 01.07.2009]

(3) If social tax was not paid for a person insured on the basis of clause 5 (2) 1) or 2) of this Act during the calendar year serving as the basis for calculation of their average income per calendar day, the average income per calendar day will be deemed to be equal to the negotiated wage of the employee divided by 30, but not more than the amount of the minimum monthly wage established by the Government of the Republic and divided by 30. Calculation of average income per calendar day is based on the negotiated wage of the employee or the minimum monthly wage established by the Government of the Republic as applicable on the date preceding the date on which the release from the performance of duties commenced as specified in the certificate of incapacity for work.
[RT I 2009, 15, 93 – entry into force 01.07.2009]

(4) If average income per calendar day calculated in accordance with the procedure provided for in subsection (2) of this section is lower than average income per calendar day calculated in accordance with the procedure provided for in subsection (3) of this section, average income per calendar day will be calculated in accordance with the procedure provided for in subsection (3) of this section.

(5) The average income of a person insured on the basis of clause 5 (2) 4) or 5) or subsection 5 (3) of this Act per calendar day is deemed to be equal to the income calculated on the basis of the social tax paid by or for the insured person during the calendar year preceding the calendar year of the date specified in the certificate of incapacity for work as the date on which release from performance of the duties arising from a contract specified in clause 5 (2) 4) or 5) of this Act or from economic or professional activity commenced, divided by 365.
[RT I 2009, 15, 93 – entry into force 01.07.2009]

(5[1]) The average wage of a person insured on the basis of subsection 5 (3[1]) of this Act per calendar day equals the income calculated on the basis of the social tax paid for the insured person in the calendar year preceding the calendar year of the start date of the release of the person from participating in the activities of the undertaking of a self-employed person, divided by 365.
[RT I, 02.07.2012, 8 – entry into force 01.08.2012]

(6) If social tax was not paid for a person insured on the basis of clause 5 (2) 4) or 5) or subsection 5 (3) or (3^1) of this Act during the calendar year serving as the basis for calculation of their average income per calendar day, the average income per calendar day is deemed to be equal to the monthly rate provided for in § 2^1 of the Social Tax Act, divided by 30. The average income per calendar day is calculated on the basis of the monthly rate provided for in § 2^1 of the Social Tax Act in force on the date preceding the date of the release of the person from performing duties, engaging in economic or professional activities or participating in the activities of the undertaking of a self-employed person.
[RT I, 02.07.2012, 8 – entry into force 01.08.2012]

(7) The provisions of subsection (6) of this section do not apply if, on the date preceding the date on which release from the performance of duties commenced as specified in a certificate of incapacity for work, the insured person did not have the obligation to make advance payments of social tax.

(7^1) The provisions of subsection (7) of this section do not apply to a person insured on the basis of subsection 5 (3^1) of this Act.
[RT I, 02.07.2012, 8 – entry into force 01.08.2012]

(8) If an insured person has the right to receive the benefit for temporary incapacity for work on more than one ground specified in subsections(2), (5) and (5^1) of this section, their average income per calendar day will be calculated on the ground that is more favourable for the insured person.
[RT I, 02.07.2012, 8 – entry into force 01.08.2012]

§ 56. Right to receive benefit for temporary incapacity for work

(1) The right to receive sickness benefit arises as of the ninth day of release from the performance of employment or service duties as specified in the certificate of incapacity for work.
[RT I 2009, 15, 93 – entry into force 01.07.2009]

(1^1) If the basis for payment of sickness benefit is the employee's temporary refusal to perform the employment duties under subsection 18 (2) of the Employment Contracts Act or the temporary release of the person specified in clause 5 (2) 2) of this Act from the performance of service duties under subsection 48 (2) of the Public Service Act, the benefit will be calculated as of the second day when the employee or the person specified in clause 5 (2) 2) of this Act temporarily refused to perform the employment duties or was temporarily released from the performance of service duties.
[RT I, 06.07.2012, 1 – entry into force 01.04.2013]

(1^2) In the event of pregnancy, the persons specified in clauses 5 (2) 1), 2) 4) and 5) and subsections 5 (3) and (3^1) of this Act are entitled to the sickness benefit as of the second day of release from the performance of the employment or service duties or from engaging in economic or professional activities or from participating in the activities of a self-employed person specified in the certificate of incapacity for work in the event of occurrence of an insured event specified in clause 51 (1) 1) of this Act.
[RT I, 02.07.2012, 8 – entry into force 01.08.2012]

(1^3) If the sickness benefit is paid on the basis of clauses 54 (1) 6) and 7) of this Act, the right to receive the benefit will arise as of the second day of release from performance of the employment or service duties or from engaging in economic or professional activities specified in the certificate of incapacity for work in the event of occurrence of an insured event specified in clause 51 (1) 1) of this Act
[RT I 2009, 29, 176 – entry into force 01.07.2009]

(1^4) If the sickness benefit is paid on the basis of clause 54 (1) 8) of this Act, the right to receive the benefit will arise as of the first day of release from performance of the employment or service duties or from engaging in economic or professional activities specified in the certificate of incapacity for work in the event of occurrence of an insured event specified in clause 51 (1) 5) of this Act
[RT I, 26.02.2015, 1 – entry into force 01.03.2015]

(2) If the basis for payment of the sickness benefit is the provision of work corresponding to the state of health of an employee under subsection 18 (1) of the Employment Contracts Act or the temporary easing of the service conditions of an official under subsection 48 (1) of the Public Service Act, the benefit will be calculated as of the first day when the employee commenced the performance of the work corresponding to their state of health or the official commenced service on the eased service conditions.
[RT I, 06.07.2012, 1 – entry into force 01.04.2013]

(3) The right to receive the care benefit, maternity benefit or adoption benefit arises as of the first day of release from the performance of duties as specified in the certificate of incapacity for work.

§ 57. Period of time serving as basis for calculation of sickness benefit

(1) In the event of a disease or injury, an insured person has the right to receive sickness benefit until the date on which their capacity for work is restored as specified in the certificate for sick leave or until the date on which of their permanent incapacity for work is declared, but not for more than 240 consecutive calendar days in the event of tuberculosis or 182 consecutive calendar days in the event of any other illness.

(2) In the event of long-term temporary incapacity for work, the doctor treating the insured person must send the documents necessary for expert assessment to the medical assessment committee not later than by the 121stday or, in the event of tuberculosis, not later than by the 178thday as of the date of release from the performance of duties as specified in the certificate of incapacity for work, and the certificate for sick leave extended on the basis of a decision of the Social Insurance Board serves as the basis for continuing payment of the sickness benefit after the expiry of the term provided for in this subsection.
[RT I 2007, 71, 437 – entry into force 01.10.2008]

(3) In the event of quarantine, the insured person has the right to receive the sickness benefit until the date of termination of the quarantine as established by the county governor, but not for more than seven calendar days.

(4) [Repealed – RT I 2009, 5, 35 – entry into force 01.07.2009]

(5) The insured person has the right to receive the sickness benefit not more than for a total of 250 calendar days per calendar year.

(6) Insured persons receiving a pension for incapacity for work under the State Pension Insurance Act have the right to receive the sickness benefit in the event of an illness or injury for up to 60 consecutive calendar days for one illness but not for more than a total of 90 calendar days per calendar year.
[RT I, 10.06.2011, 7 – entry into force 07.06.2011, the words „or insured persons who are at least 65 years of age" in subsection (6) of § 57 of the Health Insurance Act are declared unconstitutional and repealed by a judgment of the Supreme Court *en banc*.]

(7) If the reason for the temporary incapacity for work of an insured person receiving a state pension for incapacity for work is an illness or injury which is not the reason for the granting of the pension for incapacity for work to them, the provisions of subsections (2) and (6) of this section do not apply upon the granting of the sickness benefit to them.
[RT I 2004, 56, 400 – entry into force 01.08.2004]

§ 58. Period of time serving as basis for calculation of maternity benefit or adoption benefit

(1) A pregnant woman has the right to receive maternity benefit on the basis of a certificate for maternity leave for 140 calendar days if her pregnancy and maternity leave commences at least 30 calendar days before the estimated date of delivery as determined by a doctor or midwife. The number of the days by which the pregnancy and maternity leave of the woman commences after the term provided for in this subsection will be deducted from the period for which the woman has the right to receive maternity benefit.
[RT I 2009, 29, 176 – entry into force 01.04.2010]

(2) If a pregnant woman has been provided with work corresponding to her state of health or the conditions of service of a pregnant woman have been eased during her pregnancy, she will have the right to receive the maternity benefit for 140 calendar days if the pregnancy and maternity leave commences at least 70 calendar days before the estimated date of delivery as determined by a doctor or midwife. The number of the days by which the pregnancy and maternity leave of the woman commences after the date provided for in this subsection will be deducted from the period for which she has the right to receive the maternity benefit.
[RT I 2009, 29, 176 – entry into force 01.04.2010]

(3) A person specified in clauses 5 (2) 4) and 5) and in subsections 5 (3) and (3^{1}) of this section has the right to receive the maternity benefit for 140 calendar days on the basis of a certificate for maternity leave. The number of the days by which the certificate for maternity leave is issued later than the term provided for in subsection (1) of this section will be deducted from the period for which the woman has the right to receive the maternity benefit.
[RT I, 02.07.2012, 8 – entry into force 01.08.2012]

(4) One person adopting a child of under 10 years of age has the right to receive the adoption benefit for 70 calendar days on the basis of a certificate for adoption leave.
[RT I 2004, 56, 400 – entry into force 01.08.2004]

§ 59. Period of time serving as basis for calculation of care benefit

(1) An insured person has the right to receive the care benefit on the basis of a certificate for care leave for up to 14 calendar days in the event of nursing a child of under 12 years of age or for up to seven calendar days in the event of nursing another family member at home.

(1[1]) On the basis of a certificate for care leave, an insured person has the right to receive the care benefit for up to 60 calendar days in the event of caring for a child of under 12 years of age if the reason for the illness is a malignant tumour and the treatment of the child commences in a hospital.
[RT I, 11.03.2015, 2 – entry into force 01.07.2015]

(2) On the basis of a certificate for care leave, an insured person has the right to receive the care benefit for up to ten calendar days in the event of caring for a child of under three years of age or for a disabled child of under 16 years of age if the person caring for the child is ill or is receiving obstetrical care.

(3) If a certificate for care leave is issued to several persons caring for one and the same person, the persons will have the right to receive the care benefit for not more than the total number of the calendar days specified in subsections (1) to (2) of this section.
[RT I, 11.03.2015, 2 – entry into force 01.07.2015]

§ 60. Restriction on right to receive benefit for temporary incapacity for work

(1) The insured person does not have the right to receive the benefit for temporary incapacity for work if:
[RT I 2004, 56, 400 – entry into force 01.08.2004]
1) the illness or injury of the insured person or the person being nursed is caused by the intent of the person;
2) the illness or injury of the insured person or the person being nursed is caused by a state of intoxication ascertained in accordance with the procedure established on the basis of the Traffic Act or by an examination conducted by a doctor;
3) the insured person or the person being nursed fails to comply with the medically justified treatment prescribed by a doctor, as a result of which the recovery of the person is hindered;
4) the insured person fails to appear at a doctor's consultation at the prescribed time without good reason;
5) the insured person receives income subject to social tax specified in clause 2 (1) 1) or 3) of the Social Tax Act for the period of the temporary incapacity for work.
[RT I 2004, 56, 400 – entry into force 01.08.2004]
6) [Repealed – RT I 2004, 89, 614 – entry into force 01.01.2005]

(2) If the insured person or the person being cared for performs their duties or is engaged in business during their temporary incapacity for work, the person will lose the right to receive the benefit for temporary incapacity for work as of the date on which they commenced performing the duties or engaging in business.

(3) If the insured person or the person being cared for fails to appear at a doctor's consultation at the prescribed time without good reason, the person will lose the right to receive the benefit for temporary incapacity for work as of the date of their failure to appear at the consultation.

(4) The insured person does not have the right to receive the benefit for temporary incapacity for work if the insured person is:
[RT I, 08.10.2014, 1 – entry into force 18.10.2014]
1) on holiday;
2) on care cleave during a holiday.
[RT I 2009, 5, 35 – entry into force 01.07.2009]

(5) In the events listed in subsection (4) of this section, the insured person obtains the right to receive the benefit as of the day when they interrupt their holiday and assume or must assume their employment or service duties.
[RT I 2009, 5, 35 – entry into force 01.07.2009]

(6) The insured person who has the right to receive the maternity benefit or the adoption benefit does not have the right to receive the sickness benefit or the care benefit for the same period. The insured person who has the right to receive the sickness benefit does not have the right to receive the care benefit for the same period.

§ 61. Prohibition on permitting insured person who is temporarily incapacitated for work to assume employment or service

(1) The employer must not permit the insured person specified in clause 5 (2) 1) or 2) of this Act to assume their duties at a time when they are released from the performance of their duties as specified in the certificate of incapacity for work.

(2) In the event of a violation of the prohibition specified in subsection (1) of this section, the insured person will lose the right to receive the benefit for temporary incapacity for work as of the date of the violation.

§ 62. Rights of health insurance fund upon payment of benefit for temporary incapacity for work

(1) The health insurance fund may, by a decision, extend the term for payment of the benefit for temporary incapacity for work by up to 30 calendar days if there is reason to suspect that the person does not have the right

to receive the benefit. If such doubt is not confirmed, the health insurance fund must pay late interest as of the expiry of the term provided for in subsection 53 (6) of this Act.

(2) Before making the decision specified in subsection (1) of this section, the health insurance fund must grant the insured person a term of at least five calendar days to submit their opinion on and objections to the matter.

(3) The health insurance fund may issue a precept together with a warning concerning unjustified payment of the benefit for temporary incapacity for work and recover the benefit from the insured person or withhold the unfounded benefit from the payments of subsequent periods.

(4) If unfounded payment of the benefit for temporary incapacity for work occurs due to the submission of incorrect information by the employer of the insured person or due to a violation of the prohibition specified in subsection 61 (1) of this Act, the health insurance fund may issue a precept together with a warning and recover the unfounded benefit from the employer of the insured person.

(5) The health insurance fund will recover from the employer the difference between the benefit paid at the rate of 100 per cent on the basis of clause 54 (1) 6) of this Act as a result of an accident at work or an occupational disease and the benefit calculated at the rate of 80 per cent, depending on the treatment regime, on the basis of clause 54 (1) 1) or 2) of this Act.

(6) In the event of failure to comply with a precept within the term set out in a warning specified in subsection (3) or (4) of this section, the health insurance fund will have the right to issue a precept for compulsory execution in accordance with the procedure provided in the Code of Enforcement Procedure.
[RT I 2005, 39, 308 – entry into force 01.01.2006]

Subdivision 2
Other Pecuniary Benefits

§ 63. Adult dental care benefit

(1) The health insurance fund will, to the extent, on the conditions and in accordance with the procedure established by a regulation of the minister responsible for the field, compensate the amounts paid for dental care services during one calendar year to insured persons receiving the pension for incapacity for work or the old-age pension in accordance with the State Pension Insurance Act, insured persons of at least 63 years of age, pregnant women, mothers of children under one year of age and persons who have an increased need for dental care services as a result of health services provided to them.
[RT I 2008, 56, 313 – entry into force 01.01.2009]

(2) A higher rate of the benefit for pregnant women, mothers of children under one year of age and persons who have an increased need for dental care services as a result of health services provided to them will be established by a regulation of the minister responsible for the field.

(3) The health insurance fund will, to the extent, on the conditions and in accordance with the procedure established by a regulation of the minister responsible for the field, compensate a person receiving the pension for incapacity for work or the old-age pension under the State Pension Insurance Act and an insured person of at least 63 years of age for amounts paid for dentures once every three years.
[RT I 2008, 34, 210 – entry into force 01.08.2008]

(4) [Repealed – RT I 2008, 34, 210 – entry into force 01.08.2008]

§ 64. [Repealed – RT I 2004, 89, 614 – entry into force 01.01.2005]

§ 65. Documents necessary for receipt of adult dental care benefit

A list of the documents required for receiving the adult dental care benefit, the composition of the information contained in the documents and the procedure for submission of the documents will be established by a regulation of the minister responsible for the field.

§ 66. Connection between adult dental care benefit and specific period of time

If the insured person does not acquire the right to receive the adult dental care benefit in whole or in part during one calendar year because the insured person does not incur expenses subject to compensation or incurs such expenses in an amount lower than the extent subject to compensation, the benefit subject to payment during the following calendar year will not be increased by the amount of the benefit not received or by the part of the benefit not received during the preceding calendar year.
[RT I 2004, 89, 614 – entry into force 01.01.2005]

§ 66[1]. Reimbursement for health service provided outside waiting list

(1) On a proposal of the supervisory board of the health insurance fund, the minister responsible for the field may establish a regulation setting out the list of health services, except dental services, and the procedure for reimbursement of the costs of such health services, which have been rendered to insured persons outside the waiting list by health service providers operating in Estonia and holding a treatment financing contract with the health insurance fund at the time of provision of the health service (hereinafter *contracting partner of health insurance fund*).

(2) The proposal of the supervisory board of the health insurance fund may be based on:
1) the need to ensure sufficient access to high-quality health services, or
2) the need to control expenses and prevent wasting financial, technical or human resources.

(3) The regulation specified in subsection (1) of this section may set out health services that:
1) considerably affect the quality of life of the patient, preventing the development of a disability or permanent damage to health;
2) cause the hospitalisation of the patient for at least one night, or
3) call for using specialised medical infrastructures and equipment.

(4) On the conditions and threshold prices set out in the list of health services established on the basis of subsection 30 (1) of this Act and without exceeding the sum paid for a health service by an insured person, the health insurance fund will reimburse the costs of provision of the health service provided for medical reasons by a contracting partner of the health insurance fund outside the waiting list to the insured person entered in the waiting list by a health service provider.

(5) Upon reimbursement of a health service provided outside the waiting list, the insured person will not be reimbursed for the additional fee or additional cost-sharing established in this Act or on the basis thereof.

(6) If the maximum length of the waiting list of a health service established in Estonia on the basis of subsection 38 (3) of the Health Insurance Act is at least one year, the reimbursement for health services provided outside the waiting list will be paid out on the date specified in the reimbursement decision taken by the health insurance fund, but not later than on the last day of the appropriate maximum term of the waiting list of provision of the health service.
[RT I, 29.11.2013, 1 – entry into force 09.12.2013]

§ 66[2]. Reimbursement for cross-border health service

(1) The insured person has the right to obtain reimbursements provided in this Act in connection with the provision of a cross-border health service specified in § 50[3] of the Health Services Organisation Act in a Member State of the European Union other than Estonia.

(2) The health insurance fund will reimburse the costs of provision of a cross-border health service provided for medical reasons on the conditions and based on the threshold prices set out in the list of health services established on the basis of subsection 30 (1) without exceeding the sum paid by the insured person for the cross-border health service.

(3) The health insurance fund will reimburse the sum paid for medicinal products prescribed to the insured person for medical reasons in the course of provision of the cross-border health service and entered in the list established on the basis of subsection 43 (1) of this Act on the conditions established in the list, taking into account the threshold prices established on the basis of subsection 42 (2[1]) of this Act and based on the medicinal product prices set under the price agreements made on the basis of subsection 42 (4) of this Act, without exceeding the sum paid by the insured person for the medicinal product.

(4) The health insurance fund will reimburse the sum paid for medical equipment dispensed to the insured person for medical reasons in the course of provision of the cross-border health service and entered in the list established on the basis of subsection 48 (4) of this Act on the conditions and threshold prices established in the list, without exceeding the sum paid by the insured person for the medical equipment.

(5) Upon reviewing an application for reimbursement of a cross-border health service, the health insurance fund has the right to use the Internal Market Information System established on the basis of Regulation (EU) No 1024/2012 of the European Parliament and of the Council on administrative cooperation through the Internal Market Information System (OJ L 316, 14.11.2012, pp. 1–11).

(6) Upon reimbursement of a cross-border health service, the insured person will not be reimbursed for the additional fee or additional cost-sharing established in this Act or on the basis thereof.

(7) The procedure for application for reimbursement for cross-border health services, reviewing applications and payment of reimbursements will be established by a regulation of the minister responsible for the field. [RT I, 29.11.2013, 1 – entry into force 09.12.2013]

§ 66[3]. Prior authorisation for provision of health service

(1) On a proposal of the supervisory board of the health insurance fund, the minister responsible for the field may establish, by a regulation, the prior authorisation requirement for provision of cross-border health services in a Member State of the European Union other than Estonia for the purpose of:
1) ensuring sufficient and stable access to a balanced selection of high-quality medical services, or;
2) controlling expenses and preventing the wasting of financial, technical or human resources.

(2) The prior authorisation requirement specified in subsection (1) of this section may be established for the provision of health services that:
1) depend on the need for planning;
2) cause the hospitalisation of the patient for at least one night;
3) call for using highly specialised and expensive medical infrastructures and equipment;
4) pose a special risk for the patient or population.

(3) The regulation specified in subsection (1) of this section will set out the health service for which the prior authorisation requirement will be established, the purpose of establishment of the prior authorisation requirement and the period of reassessment of the prior authorisation requirement.

(4) The prior authorisation requirement can be established nationwide or for obtaining a health service provided by a certain health service provider.

(5) In the event of a health service the provision of which is subject to the prior authorisation requirement, the health insurance fund will pay the cross-border health service remuneration only if the insured person has obtained a relevant prior authorisation.

(6) The established prior authorisation requirement will be published on the websites of the Ministry of Social Affairs, health insurance fund and national contact point of cross-border health services.

(7) The Ministry of Social Affairs will inform the European Commission about the establishment of the prior authorisation requirement and about the commencement and termination of applying the requirement.

(8) The health insurance fund will grant prior authorisation to the insured person.

(9) The health insurance fund must not refuse to grant prior authorisation if the insured person is entitled in Estonia to a health service whose prior authorisation is applied for and if the health service cannot be provided in Estonia within a medically justified term, given the objective medical evaluation of the status of health of the person, their medical history and the possible progress of the disease, the strength of pain and the type of the disability at the time of filing the application.

(10) The health insurance fund may refuse prior authorisation for the following reasons:
1) according to a clinical evaluation, it has been identified with reasonable certainty that there is a risk to health, which cannot be deemed acceptable, given the possible benefits of the cross-border health service to the person;
2) it has been identified with reasonable certainty that the cross-border health service poses a considerable threat to public safety;
3) the health service is provided by a health service provider with regard to whom there are serious and concrete doubts about following the provisions on the quality of the health service, patient safety standards and guidelines, including supervisory provisions, provided that these standards and guidelines are established in the legal provisions or accreditation systems of the Member State providing the health service;
4) the health service can be provided in Estonia within a medically justified term, taking into account the status of health and possible progress of the disease of the person.

(11) If the insured person applied for prior authorisation for a cross-border health service, the health insurance fund will identify whether the terms and conditions of obtaining the prior authorisation set out in Regulation (EC) No 883/2004 of the European Parliament and of the Council on the coordination of social security systems (OJ L 166, 30.04.2004, pp. 1–123) have been fulfilled. If the terms and conditions have been fulfilled, prior authorisation will be granted in accordance with the Regulation, unless the person explicitly requests otherwise.

(12) Upon reviewing an application for prior authorisation, the health insurance fund has the right to use the Internal Market Information System established on the basis of Regulation (EU) No 1024/2013 of the European Parliament and of the Council for verifying health service providers operating in the Member States of the European Union and circumstances pertaining to health care professionals.

(13) Upon reviewing an application for prior authorisation, the health insurance fund has the right to request and expert evaluation in order to identify the need for provision of the health service applied for and the term of provision of the service.

(14) The conditions of and procedure for obtaining prior authorisation for cross-border health services in a Member State of the European Union other than Estonia and for application and granting of prior authorisation will be established by a regulation of the minister responsible for the field.
[RT I, 29.11.2013, 1 – entry into force 09.12.2013]

§ 66[4]. Restrictions on reimbursement for cross-border health service

(1) In the event of provision of a cross-border health service without a referral by a provider of general medical care or special medical care holding an activity licence for provision of health services in Estonia, the health insurance fund will not reimburse the cross-border health service, except in the events specified in subsection 70 (3) of this Act and to the insured persons specified in clause 5 (4) 5) of this Act.

(2) The insured person who has insurance cover on the basis of Article 17, 24 or 26 of Regulation (EC) No 883/2004 of the European Parliament and of the Council or whose need to receive a cross-border health service arises during their stay in a Member State of the European Union other than Estonia will receive reimbursement for the cross-border health service on the basis of a referral issued by a health service provider of the Member State of the European Union.
[RT I, 29.11.2013, 1 – entry into force 09.12.2013]

Division 6
Additional Fee and Additional Cost-sharing by Insured Person

Subdivision 1
General Conditions

§ 67. Additional fee and prohibition on extension of additional fee

(1) For the purposes of this Act, ‘additional fee’ means expenses that are incurred by the insured person in addition to the amount of cost-sharing in order to receive the health insurance benefit and with regard to which the payment obligation is not assumed by the health insurance fund. Additional fees are the visit fee and the in-patient fee.

(2) The health insurance fund does not compensate for additional fees.

(3) A health care provider that has concluded a contract for financing medical treatment with the health insurance fund must not demand that the insured person participate in paying for a health service entered in the list of health services in any other manner than on the grounds and to the extent provided for in this division in addition to the cost-sharing specified in the list of health services, the list of medicinal products or the list of medical devices.
[RT I 2008, 3, 22 – entry into force 01.09.2008]

§ 68. Obligation to provide health service in standard conditions of accommodation

(1) A health care provider with which the health insurance fund has concluded a contract for financing medical treatment must provide the insured person with accommodation in standard conditions for any period during which the person is receiving in-patient health services.

(2) The standard conditions of accommodation will be established by a regulation of the minister responsible for the field.

(3) If health services are provided in conditions better than the standard conditions of accommodation, the health care provider may charge a fee corresponding to the value of the additional benefits from the insured person in accordance with the price list established by the health care provider. The health care provider must submit such price list to the health insurance fund upon conclusion of a contract for financing medical treatment and to make insured persons aware of the price list before health services are provided.

(4) The insured person has the right to demand that the health care provider provide health services in the standard conditions of accommodation. If a health care provider that has concluded a contract for financing medical treatment with the health insurance fund is only able to provide health services in conditions better than the standard conditions of accommodation, the health care provider must not charge the fee specified in subsection (3) of this section from the insured person.

Subdivision 2

Visit Fee, Additional Cost-sharing, In-patient Fee and Fee for Issue of Documents

§ 69. Fee for home visit

(1) A person providing general medical care may charge a fee from an insured person for a home visit.

(2) A fee for a home visit must not exceed the maximum rate of visit fees set out in subsection 72 (1) of this Act, regardless of the number of insured persons per one home visit.

(3) The visit fee for a home visit cannot be charged from a pregnant woman and from an insured person who is less than two years of age.
[RT I 2009, 29, 176 – entry into force 01.07.2009]

§ 70. Visit fee and additional cost-sharing upon payment for out-patient specialised medical care

(1) If out-patient specialised medical care is provided on the basis of a referral from a person providing general medical care or a person providing specialised medical care or, in the event provided for in subsection (3) of this section, without a referral, the person providing the specialised medical care will have the right to charge the visit fee from the insured person.

(2) If out-patient specialised medical care is provided without a referral from a person providing general medical care or a person providing specialised medical care who holds an activity licence to provide health services in Estonia, the health insurance fund will not assume the obligation to pay for the health services (additional cost-sharing), except in the events specified in subsection (3) of this section.
[RT I, 29.11.2013, 1 – entry into force 09.12.2013]

(3) If out-patient specialised medical care is provided without a referral from a person providing general medical care or a person providing specialised medical care who holds an activity licence to provide health services in Estonia, the health insurance fund will assume the obligation to pay for the health services if the specialised medical care is provided in connection with a trauma, tuberculosis, eye disease, dermatosis or venereal disease or if gynaecological or psychiatric care is provided or if the provider of specialised medical care leaves the patient under observation or treatment by the provider of specialised medical care due to the state of health of the patient.
[RT I, 29.11.2013, 1 – entry into force 09.12.2013]

(4) If the insured person is referred to a person providing out-patient specialised medical care to a health care professional working for the same health care provider but in another speciality or to a health care professional working for another health care provider but providing the same health service, the insured person must not be charged the visit fee.

(5) The visit fee must not be charged if:
1) out-patient specialised medical care is provided to a pregnant woman;
[RT I 2009, 29, 176 – entry into force 01.07.2009]
2) out-patient specialised medical care is provided to the insured person under two years of age;
3) provision of emergency out-patient specialised medical care is directly followed by the provision of in-patient health services.

(6) If the patient terminates a contract for provision of health services less than 24 hours before the time agreed upon for the provision of the health service or fails to appear at the place of performance of the contract by the time agreed for the provision of the service, the provider of the health service will have the right to charge the double visit fee from the patient upon performance of the next contract for the health service.
[RT I 2008, 3, 22 – entry into force 01.09.2008]

§ 71. In-patient fee

(1) A person providing in-patient specialised medical care or a provider of an independent in-patient nursing assistance service may charge an in-patient fee from the insured person for the services provided in standard conditions of accommodation. An in-patient fee may be charged for each calendar day which has commenced during the time spent by a person in hospital, but not for more than ten calendar days for one case of disease.
[RT I, 16.04.2014, 4 – entry into force 26.04.2014]

(2) The in-patient fee must not be charged for a period when intensive care is provided, upon provision of in-patient specialised medical care in connection with pregnancy or delivery, or upon provision of in-patient specialised medical care to a minor.

(3) The supervisory board of a health care provider has the right to establish the in-patient fee.

§ 72. Maximum rate of visit fee and in-patient fee

(1) The fee for a home visit or for a visit for out-patient specialised medical care to be provided must not exceed 5 euros.
[RT I, 31.12.2012, 6 – entry into force 10.01.2013]

(2) The in-patient fee per day must not exceed 2.50 euros.
[RT I, 31.12.2012, 6 – entry into force 10.01.2013]

(3) By March 1 of each calendar year, the maximum rates of the visit fee and in-patient fee will be multiplied by an index the value of which is the yearly change in the Consumer Price Index.

(4) The yearly change in the Consumer Price Index will be calculated by dividing the value of the Consumer Price Index of the previous calendar year by the value of the Consumer Price Index of the year preceding the previous calendar year, proceeding from the value of the Consumer Price Index officially published by the Statistical Office.

(5) The maximum rate of the visit fee and in-patient fee will be approved by a regulation of the minister responsible for the field by February 20 of the given year at the latest.

§ 73. Fee for issue of documents

(1) A health care provider may charge a reasonable fee from the insured person for the documents issued.

(1^1) [Repealed – RT I, 10.07.2012, 2 – entry into force 01.04.2013]

(2) A health care provider must not charge a fee from the insured person for the issue of a certificate of incapacity for work or a prescription.
[RT I, 08.10.2014, 1 – entry into force 18.10.2014]

(3) A health care provider must not charge a fee from the insured person for the issue of a document that is necessary for the health insurance fund, a law enforcement authority, another health care provider in connection with the performance of a contract for the provision of health services, expert assessment concerning incapacity for work, or determination of the degree of severity of a disability, or in any other events provided by law.

(4) A health care provider has the right to charge a fee for the issue of a document concerning a patient who is a minor if the size of the fee does not exceed the average expenses incurred upon the issue of the document.
[RT I 2004, 49, 342 – entry into force 01.07.2004]

Chapter 4
AMENDMENT OF ACTS

§ 74.–§ 87.[Omitted from this text.]

Chapter 5
IMPLEMENTATION AND ENTRY INTO FORCE OF ACT

§ 88. Calculation of average income per calendar day until entry into force of § 55 of this Act

(1) The average income of persons insured on the basis of clause 5 (2) 1) or 2) of this Act per calendar day is deemed to be equal to the income subject to social tax calculated for the insured person by their employers during the six calendar months preceding the date on which release from the performance of duties commenced as specified in the certificate of incapacity for work, divided by the number of calendar days in the six months preceding the date on which the release from work commences. The number of days for which the insured person was temporarily released from the performance of their duties on the basis of a certificate for incapacity for work, was on holiday for more than 28 calendar days on the basis of clause 9 (2) 1) or 2) of the Holidays Act or was on holiday on the basis of § 30 of the Holidays Act will be deducted from the number of calendar days in the six month period.

(2) If the person insured on the basis of clause 5 (2) 1) or 2) of this Act did not receive income subject to social tax during the period serving as the basis for calculation of their average income per calendar day, the average income per calendar day is deemed to be equal to the basic wages of the employee divided by 30, but not more than the minimum monthly wage established by the Government of the Republic and divided by 30. Calculation of average income per calendar day is based on the basic wages of the employee or the minimum monthly wage

established by the Government of the Republic as applicable on the date preceding the date on which release from the performance of duties commenced as specified in the certificate of incapacity for work.

(3) If the average income per calendar day calculated in accordance with the procedure provided for in subsection (2) of this section is lower than average income per calendar day calculated in accordance with the procedure provided for in subsection (2) of this section, average income per calendar day will be calculated in accordance with the procedure provided for in subsection (3) of this section.

(4) The average income of a person insured on the basis of clause 5 (2) 4) or 5) or subsection 5 (3) of this Act per calendar day is, in the event of a release from work beginning in the period lasting from July 1 to June 30 of the following calendar year, deemed to be equal to the income calculated on the basis of the social tax paid by or for the insured person during the calendar year (January 1 to December 31) preceding the aforementioned period, divided by 365. The number of days for which the insured person was temporarily released from the performance of their duties or economic or professional activity on the basis of a certificate of incapacity for work will be deducted from the figure 365 before the division.

(5) If social tax was not paid for a person insured on the basis of clause 5 (2) 4) or 5) or subsection 5 (3) of this Act during the calendar year serving as the basis for calculation of their average income per calendar day, the average income per calendar day is deemed to be equal to the monthly rate provided for in subsection 2 (5) of the Social Tax Act, divided by 30. Average income per calendar day is calculated on the basis of the monthly rate provided for in subsection 2 (5) of the Social Tax Act which was applicable on the date preceding the date on which the person was released from the performance of their duties or from economic or professional activity.

(6) The provisions of subsection (5) of this section do not apply if, on the date preceding the date on which release from the performance of duties commenced as specified in a certificate of incapacity for work, the insured person did not have the obligation to pay social tax or make advance payments of social tax.

(7) If the insured person has the right to receive the benefit for temporary incapacity for work on the basis of both subsection (1) and subsection (4) of this section, their average income per calendar day will be calculated on one of the ground provided for in this section as chosen by the insured person.

(8) Calculation of the average income per calendar day of persons insured on the basis of clause 5 (2) 1) or 2) of this Act is based on the information certifying their right to receive the benefit and submitted by the payer of social tax.

(9) Calculation of the average income per calendar day of persons insured on the basis of clause 5 (2) 4) or 5) or subsection 5 (3) of this Act is based on the information submitted by the Tax and Customs Board concerning income subject to social tax.
[RT I 2003, 88, 591 – entry into force 01.01.2004]

§ 89. Transitional provisions

(1) If release from work as specified in a certificate of incapacity for work commences before 1 October 2002, but the certificate is submitted for the grant and payment of the benefit for temporary incapacity for work after 1 October 2002, the provisions of this Act apply to the granting and payment of the benefit.

(2) If the pregnancy and maternity leave of a person insured on the basis of the Republic of Estonia Health Insurance Act ends after the entry into force of this Act, the insured person will have the right to demand extension of the leave in accordance with this Act.

(3) Until 1 January 2003, the health insurance fund may conclude a contract with a person specified in clause 22 (1) 1) of this Act without the restriction concerning insurance by the health insurance fund.

(4) Until 1 January 2003, the dependent spouse of an insured person is also deemed to be a person considered equal to insured persons in accordance with law and social tax is not paid for them.

(5) Until the entry into force of subsection 30 (4) of this Act on 1 July 2003, a reference price set out in the list of health services covers all expenses necessary for the provision of a health service, except expenses on research, the training of pupils and students and the construction or renovation of buildings.

(6) The provisions of Subdivision 2 of Division 2 of Chapter 3 of this Act do not apply to contracts regulating payment for health services which have been concluded between the health insurance fund and health care providers before the entry into force of this Act.

(7) Until a price agreement is concluded, the maximum retail price in force on 31 December 2008 is deemed the price agreement price of a medicinal product.
[RT I 2010, 15, 77 – entry into force 01.07.2010]

(8) [Repealed – RT I 2010, 15, 77 – entry into force 01.07.2010]

(9) [Repealed – RT I 2010, 15, 77 – entry into force 01.07.2010]

(10) Until the entry into force of clause 54 (1) 1) of this Act on 1 April 2003, the health insurance fund will pay the benefit for temporary incapacity for work to an insured person per calendar day in the amount of 60 per cent of the average income per calendar day in the event of the provision of in-patient health services or caring for a child of under 10 years of age in a hospital.

(11) The following students admitted to educational institutions before the academic year 2003/04 are not deemed to be persons considered equal to insured persons under this Act:
1) students in distance learning (except for students enrolled in this form of study for medical reasons);
2) students of at least 24 years of age acquiring vocational education on the basis of secondary education in the form of distance learning or evening courses (except for students who reach 24 years of age within the standard period of study prescribed for completion of the curriculum).

(12) Subsection 57 (7) of this Act does not apply to a person whose release from their duties or economic or professional activity as specified in the certificate of incapacity for work commences after 31 July 2004.
[RT I 2004, 56, 400 – entry into force 01.08.2004]

(13) After 1 January 2009, the insurance cover of a self-employed person registered with a regional structural unit of the Tax and Customs Board will end two months after notification of the Tax and Customs Board of the termination of the business activities of the person or deletion of the self-employed person from the register of taxable persons after 31 December 2009 for the reason that the person has not applied for their entry in the commercial register as a self-employed person or their application for registration in the commercial register was not granted. The Tax and Customs Board must inform the health insurance fund of the termination of the business activities of a person or deletion of a person from the register within ten calendar days.
[RT I 2008, 60, 331 – entry into force 01.01.2009]

(14) Until the end of the release from employment or service duties or economic or professional activities, the provisions of the Health Insurance Act in force until 1 July 2009 are applied to a person whose release from the employment or service duties or economic or professional activities commenced before 1 July 2009.
[RT I 2009, 29, 176 – entry into force 01.07.2009]

(15) For the purposes of this Act, an insured person also means a student acquiring vocational education without the basic education requirement or a student acquiring vocational education based on secondary education on the conditions established in this Act to persons acquiring formal vocational education.
[RT I, 02.07.2013, 1 – entry into force 01.09.2013]

(16) The health insurance fund will pay the insured person the cross-border health service benefit for the health services provided, prescription drugs prescribed and medicinal products dispensed in the course of provision of the health services as of 25 October 2013.
[RT I, 29.11.2013, 1 – entry into force 09.12.2013]

(17) In the event of medicinal products issued to the insured person before 1 January 2015, the health insurance fund applies the provisions of § 47 of this Act in force until 31 December 2014 upon calculation of the amount of the supplementary benefit for medicinal products.
[RT I, 13.12.2014, 1 – entry into force 01.01.2015]

§ 89[1]. Issue of paper certificate of incapacity for work

(1) Until 31 December 2014, doctors, dentists and midwives authorised to issue certificates of incapacity for work may issue certificates of incapacity for work to insured persons on paper.

(2) As of 1 January 2015, doctors, dentists and midwives authorised to issue certificates of incapacity for work may issue certificates of incapacity for work to insured persons on paper only in the event specified in subsection 52 (1[1]) of this Act.
[RT I, 08.10.2014, 1 – entry into force 18.10.2014]

§ 90. Entry into force of Act

(1) This Act will enter into force on 1 October 2002.

(2) Subsection 25 (3) and §§ 47 and 63 of this Act will enter into force on 1 January 2003.

(3) Clause 54 (1) 1) and § 55 of this Act will enter into force on 1 April 2003.

(4) Subsection 30 (4) of this Act will enter into force on 1 July 2003.

(5) [Repealed – RT I 2004, 89, 614 – entry into force 01.01.2005]

[1]Directive 2010/41/EU of the European Parliament and of the Council on the application of the principle of equal treatment between men and women engaged in an activity in a self-employed capacity and repealing Council Directive 86/613/EEC (OJ L 180, 15.07.2010, pp. 1–6); Directive 2011/24/EU of the European Parliament and of the Council on the application of patients' rights in cross-border healthcare (OJ L 88, 04.04.2011, pp. 45–65).
[RT I, 29.11.2013, 1 - entry into force 09.12.2013]